No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
Northern District of California
Case No. 3:16-cv-05337-EMC
The Honorable Edward M. Chen

PETITION FOR PANEL REHEARING AND REHEARING EN BANC

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This Petition seeks rehearing by the Court *en banc* (FRAP 35 and 40) to correct the holdings of the panel and in *United States ex rel. Hartpence v. Kinetic Concepts, Inc.,* 792 F.3d 1121, 1124, 1130 (9th Cir. 2015) (en banc) and *United States ex rel. Lujan v. Hughes Aircraft Co.,* 243 F.3d 1181, 1183, 1186-87 (9th Cir. 2001) that the False Claim Act's "first-to-file" rule, 31 U.S.C. § 3730(b)(5),[1] is a jurisdictional bar which conflict with (a) the Supreme Court's "clear statement principle" in *Gonzalez v. Thaler,* 565 U.S. 134, 132 S.Ct. 641, 181 L.Ed.2d 619 (2012)[2] and related decisions, and (b) sister circuit decisions in *United States, ex rel. Bryant v.*

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[1]31 U.S.C. § 3730(b)(5) states:

> "When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action."

[2]In *Gonzalez*, the Supreme Court set forth the following "clear-statement principle" to determine if a statute is jurisdictional or not:

> "A rule is jurisdictional '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.' [Citation.] But if 'Congress does not rank a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional.' [Citation.]" *Gonzalez*, 565 U.S. at 141-142.

Community Health Systems, Inc., 24 F.4th 1024, 1036 (6th Cir. 2022), *In re Plavix Marketing, Sales Practices and Products Liability Litigation (No. II),* 974 F.3d 228, 232 (3rd Cir. 2020), *United States v. Millenium Labs., Inc.,* 923 F.3d 240, 249-251 (1st Cir. 2019), *United States, ex rel. Hayes v. Allstate Ins. Co.,* 853 F.3d 80, 86-87 (2nd Cir. 2017), and *United States, ex rel. Heath v. AT&T, Inc.,* 791 F.3d 112, 120-121 (D.C. Cir. 2015) holding that the FCA's first-to-file rule is *not* a jurisdictional bar.

As noted by the panel's concurring opinion, "*Hartpence* is inconsistent with current Supreme Court doctrine, and it should be overruled by our en banc court at an appropriate time." Doc. 50-1 at p. 6.[3] Referring to the Supreme Court's clear-statement principle, the concurring opinion observes that the FCA's first-to-file rule "lacks a 'clear statement' establishing that it is jurisdictional," Doc. 50-1 at p. 7, and while other provisions of the FCA expressly address jurisdiction (such as 31 U.S.C. §§ 3730(e)(1) and(e)(2)[4]), 31 U.S.C. § 3730(b)(5)'s first-to-file rule does *not* state

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[3]A copy of the panel's decision is found in the Appendix to this Petition.

[4]31 U.S.C. § 3730(e) states, in relevant part:

> "(e) Certain Actions Barred.--
>
> > (1) *No court shall have jurisdiction* over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

that is affects jurisdiction. Doc. 50-1 at pp. 7-8. Last, the concurring opinion notes that while the D.C., First, Second, Third and Sixth circuit opinions utilizing the clear statement principle held the first-to-file rule is *not* jurisdictional (*see*, *Heath*, 791 F.3d 120-121, *Millenium Labs,* 923 F.3d at 249-251, *Hayes,* 853 F.3d 86-87, *In re Plavix Marketing,* 974 F.3d 232, *Bryant,* 24 F.4th 1036), the Fourth, Fifth, Ninth and Tenth circuits's holdings that the first-to-file bar is jurisdictional failed to utilize the Supreme Court's clear statement principle in their analyses.[5] Doc. 50-1 at pp. 8-9. The concurring opinion concludes that "our en banc court should take the opportunity to bring our precedent regarding the FCA's first-to-file bar in line with the Supreme Court's repeated instruction not to make rules jurisdictional absent clear direction from Congress." Doc. 50-1 at p. 9.

En banc review is warranted to determine that the first-to-file rule is *not* jurisdictional in light of the Supreme Court's clear statement principle, and to overturn this Court's *en banc* holding in *Hartpence* to the contrary.

> (2)(A) *No court shall have jurisdiction* over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought." (*Italics* added.)

[5]*See, Hartpence,* 792 F.3d at 1130 [summarily stating the "[w]e treat the first-to-file bar as jurisdictional"]; *United States, ex rel. Carter v. Haliburton Co.,* 866 F.3d 199, 203 (4th Cir. 2017) [similar]; *United States, ex rel. Branch Consultants v. Allstate Ins. Co.,* 560 F.3d 371, 376 (5th Cir. 2009) [similar]; *Grynberg v. Koch Gateway Pipeline Co.,* 390 F.3d 1276, 1278 (10th Cir. 2004) [similar].

II. THE PANEL DECISION'S HOLDING THAT APPELLANTS' SEPSIS, MALNUTRITION, AND AORTIC ATHEROSCLEROSIS FRAUD CLAIMS ARE BARRED BY THE FIRST-TO-FILE RULE CONFLICTS WITH THE *HARTPENCE* MATERIAL FACTS TEST.

This Petition seeks (rehearing by the panel initially but, barring that, by the Court *en banc*, FRAP 35 and 40) to correct the holding of the panel that Appellants' Sepsis, Malnutrition, and Aortic Atherosclerosis (AA) fraud claims are barred by the first-to-file rule because the panel's holding improperly conflicts with the *Hartpence* material facts test. Doc. 50-1 at pp. 4-5.

In *Hartpence,* this Court *en banc* held while the FCA's first-to-file rule bars a subsequent filed *qui tam* FCA action that is based upon the same material facts as the prior filed FCA action, *Hartpence,* 792 F.3d at 1130, the first-to-file rule does *not* bar the subsequent filed action if (a) it is based upon a different Medicare program requirement that was at issue in the prior file action, and (b) the subsequent filed action alleges a related but distinct fraud that benefits the Government because it might not have discovered the subsequent action's fraud scheme. *Id.* at 1131. So in *Hartpence*, this Court held that the prior action's fraud, based upon the defendant billing Medicare for Vacuum Assisted Therapy (V.A.C.) equipment improperly using a "KX modifier" even though there was no wound improvement, the use of such equipment was neither reasonable nor necessary, wound measurement documentation was absent, falsely claiming that there was wound improvement, and was used for treatment of wounds that were too small for V.A.C. wound therapy, was factually

materially different that the subsequent action's fraud, based on the defendant's failure to obtain required Detailed Written Orders (DWOs) before delivering supplies and beginning the V.A.C. wound therapy. *Id.* at 1131. *Hartpence* held that although the two actions alleged that the same defendant committed billing fraud concerning the same equipment, that the two actions involved two related but distinct frauds because (a) they involved violations of different Medicare requirements, and (b) the Government benefitted from the second action's fraud allegations because investigation of the first action's fraud would not necessarily have led to the discovery of the second action's fraud. *Id.* at 1131-1132. As discussed below, the panel's confirmation of the District Court's first-to-file analysis fails to acknowledge that (a) the frauds alleged in the prior *Osinek, Taylor,* and *Arefi* actions were based on violations of Medicare requirements that were different from the those in Appellants' Sepsis, Malnutrition, and AA fraud claims, and (b) the Government benefitted from Appellants' Sepsis, Malnutrition, and AA fraud claims because the Government would not have discovered claims from an investigation of the *Osinek, Taylor,* and *Arefi* fraud claims.

A. MEDICARE ADVANTAGE AND RISK ADJUSTMENT.

Under Medicare Advantage (MA) or Medicare Part C, medicare beneficiaries have the option of receiving benefits through private health plans as an alternative to the traditional fee-for-service Medicare program. *United States, ex rel Swoben v.*

United Healthcare Ins. Co., 848 F.3d 1161, 1167 (9th Cir. 2016). Under the MA program, the Government pays MA organizations (MAOs) a monthly capitated payment per enrollee to provide medical benefits. *Id.*

The Government adjusts the capitated payments to reflect the health status of their MA enrollees using the risk adjustment methodology, which relies upon enrollee diagnoses submitted to Government's Centers for Medicare and Medicaid Services (CMS). *United States, ex rel Silingo v. Wellpoint, Inc.,* 904 F.3d 667, 672 (9th Cir. 2018). The risk adjustment model deems a MA enrollee to be as healthy as the average MA beneficiary unless CMS receives updated diagnosis codes for the enrollee every year. *Id.*

Medicare has numerous requirements for Appellee MAOs to follow, such as:

1. Every risk adjustment data (RAD) diagnosis submitted to CMS must be based on a "face-to-face" encounter with the patient that is documented in the medical record, *Silingo,* 904 F.3d at 673, 6-ER-1073; 7-ER-1446-1447-1504.

2. Medical records must be validated by qualifying physician/practitioner signatures and credentials, *Id.*, and valid RAD diagnoses must be from a physician or other qualifying clinician identified by CMS, *Medicare Managed Care Manual (MMCM),* Ch. 7, §§ 40, 120.1.1, and Table 19; 6-ER-1073; 7-ER-1446-1447, 1504.

3. RAD diagnoses sent to CMS must be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and

Reporting, *MMCM,* Ch. 7, § 40, 6-ER-1073; 7-ER-1446-1447,1504.

4. When MAOs determine that any diagnosis code submitted to CMS is not a valid RAD submission, the MAO is required to delete the submitted diagnosis code as soon as possible. *MMCM,* Ch. 7, § 40, 6-ER-1074-1075; 7-ER-1448, 1448.

5. Under 42 C.F.R. § 422.326, if an MAO has identified that it has received an overpayment, the MAO must report and return that overpayment in the form and manner set forth in in that section . 6-ER-1100,1117; 7-ER-1473, 1489, 1526-1527, 1537.

6. MAOs must not submit RAD diagnoses based on documentation from laboratory or diagnostic radiology services as a standalone medical record. 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations, Resource Guide (2008 Resource Guide), p. 16, 6-ER-1098-1099; 7-ER-1471.

B. THE FRAUDULENT SCHEMES ALLEGED IN THE *OSINEK*, *TAYLOR*, AND *AREFI* PRIOR ACTIONS.

1. The *Osinek* Action.

The *Osinek* Complaint alleges Kaiser's Refresh Fraud scheme, which violates Medicare's requirement that all RAD be the product of a face-to-face physician encounter. 8-ER-1755, 1760. The Refresh Fraud scheme relies on extensive computer data mining to identify RAD diagnoses submitted in prior years that Kaiser's physicians had not recorded during the current year. 8-ER-1757, 1760-1763. Kaiser's medical group's coders transmitted the "missing" HCC diagnoses to the

enrollee's primary care physician (PCP) via leading coding queries that instructed the PCP to addend the "missing" HCC diagnoses (i.e., "Refresh") to their enrollee's medical record and to include specific text so the addendum would appear valid. 8-ER-1760, 1761-1764. These PCP addendums were routinely six months or more after the PCP's last face-to-face encounter with the enrollee, and falsely asserted the PCP's unequivocal recollection of forgetting to include the Refreshed HCC diagnosis in the prior encounter.[6] 8-ER-1760, 1761-1764. Although Malnutrition and AA diagnoses were among 20 chronic conditions *Osinek* alleged were Refreshed as described above (6-ER-1757-1758), *Osinek* does not allege that Malnutrition was invalidly diagnosed by unauthorized Dieticians nor that AA was diagnosed from x-rays as were alleged by Appellants.

2. The *Taylor* Action.

The *Taylor* Action alleges (a) *Osinek's* Refresh Fraud claim, (b) that Appellees conducted internal medical chart audits that found numerous diagnoses that were submitted to CMS from the reviewed charts were erroneous, but that Appellees failed to withdraw those erroneous diagnosis codes from CMS, (c) Appellees did not try to

[6]Addenda to correct medical records is supposed to be a rare occurrence and performed within a 48 hrs. *Osinek* Compl. ¶ 20 (8-ER-1756) citing, American Association of Professional Coders (AAPC). Two weeks or more is considered to long for an addendum because its not reasonable for the physician to recall the encounter Id. Frequent addendums several months to almost a year later are obviously false due to the physician's inability to recall. *Osinek* Compl. ¶¶ 28, 30 (8-ER-1760-1762).

identify additional false diagnosis codes submitted to CMS, and (d) the above failures resulted in Appellees' annual 42 C.F.R. § 422.504(*l*) certifications to be false. 8-ER-1656-1659, 1711-1714.

These claims allege violations of Medicare requirements that (a) diagnosis codes must be the result of a face-to-face encounter, (8-ER-1652, 1686,1707, 1742), (b) Appellees are required to withdraw erroneous diagnosis codes revealed by their internal audits and failed to do so, (8-ER-1659, 1714), and (c) Appellees must conduct audits and investigations to certify their RAD submission upon their best knowledge and belief pursuant to 42 C.F.R. § 422.504(*l*)(2), 8-ER-1656-1659, 1711-1714.

Taylor does not allege Stein's Sepsis and AA fraud schemes. Although *Taylor* alleges that some Malnutrition diagnoses failed the internal audits, *Taylor* alleges that these diagnoses invalidly code "history of" as an active diagnosis, rather than *Stein's* allegation that Malnutrition diagnoses were invalidly made by unauthorized Dieticians. 8-ER-1676, 1731-1732; 6-ER-1094; 7-ER-1467, 1524.

3. The *Arefi* Action.

The *Arefi* Action, like Osinek's, alleges a Refresh Fraud scheme that violates Medicare's requirement that all RAD be the product of a face-to-face physician encounter and specifically alleged that Kaiser refreshed cachexia. 8-ER-1561, 1567-1568. The *Arefi* Action alleges that the cachexia (a wasting syndrome that is

rarely encountered in North America) diagnoses are false because of (a) the Refresh Fraud scheme, and (b) data mining that recommended this diagnoses relied on a bogus computer algorithm that was medically incorrect. 8-ER-1567-1568. Both violated Medicare's requirement that diagnosis codes must be the result of a face-to-face encounter. 8-ER-1566-1568, 1570.

Arefi's Cachexia fraud scheme is not related to Stein's Malnutrition fraud scheme because the former is based on Refresh Frauds and a bogus computer algorithm, whereas Stein's Malnutrition Fraud is based on diagnoses that were invalidly made by unauthorized Dieticians. 8-ER-1566-1568, 1570; 6-ER-1092; 7-ER-1467, 1524.

C. THE SEPSIS, MALNUTRITION, AND AORTIC ATHEROSCLEROSIS FRADULENT SCHEMES ALLEGED BY APPELLANTS.

1. Sepsis Fraud Scheme.

Appellees' alleged sepsis fraud scheme is based on Appellees' false diagnoses of sepsis and sepsis with organ dysfunction (collectively, "Sepsis"), which violates Medicare requirement that CMS be provided accurate Sepsis diagnoses and failing to withdraw the initial but incorrect diagnosis after ruling out Sepsis. 6-ER-1084-1085; 7-ER-1458, 1515-1516. Medicare requires Appellees to withdraw from CMS an initial submitted Sepsis diagnosis when it is later determined to be incorrect or when the initial Sepsis diagnosis cannot be confirmed. 2008 Resource Guide, pp. 32-

33 (EDI Agreement (A)(5) and (11); *MMCM*, Ch.7 § 40 ["If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible."]; *ICD-9-CM Official Guidelines for Coding and Reporting*[7] (*ICD-9 Guidelines*) p. 18; 6-ER-1073-1074, 1082-1083; 7-ER-1446-1447, 1456-1457, 1504-1505, 1514-1515. This failure to withdraw was caused in part by Kaiser's hospitals adopting policies prohibiting hospital coders from querying physicians as required by the *ICD-9-CM Guidelines*, (and later *ICD-10-CM Official Guidelines for Coding and Reporting),* and also allowing Sepsis to be incorrectly documented in the enrolles' chart by the physician simply noting the term Sepsis, without any supporting clinical documentation. 6-ER-1087-1088; 7-ER-1460-1461, 1518.

All MAOs such as Kaiser must execute an Electronic Data Interchange (EDI) agreement with CMS's data vendor. The EDI agreement requires the submission of accurately coded and documented HCC diagnosis codes and the prompt redaction of

[7]"Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis or severe sepsis was present on admission, the provider should be queried." *ICD-9-CM Guidelines,* p. 18.

any HCC diagnosis codes that were found to be invalid.[8] 2008 Resource Guide, pp. 32-33 (EDI Agreement (A)(5) and (11). 6-ER-1098; 7-ER-1469, 1526-1527.

Kaiser knew that such policies conflicted with the *ICD-9 Guidelines*, rendering many, if not all, their Sepsis diagnoses invalid for submission as RAD. The fundamental requirement for all HCC diagnoses that are submitted as RAD is that they are coded and documented in conformity with the *ICD-9 Guidelines*. 42 C.F.R. §422.310(d)(1); *MMCM*, Ch. 7 § 40, [The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting.*"] 6-ER-1073-1074, 1082-1083, 1086-1087; 7-ER-1446-1448, 1459-1460, 1456-1457, 1504-1507, 1514-1515, 1516-1517.

2. Malnutrition Fraud Scheme.

Stein's Malnutrition fraud scheme alleges that Appellees' Malnutrition RAD were based on dieticians invalidly diagnosing malnutrition of Kaiser's hospital inpatients. 6-ER-1094; 7-ER-1467, 1524. Medicare requires that all RAD must come from acceptable data sources.[9] 2008 Resource Guide, p. 15; *MMCM,* Ch.7 § 120.1.1.

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[8]The EDI Agreement at A(5) and (11) states:

A. Eligible Organization Agrees:

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful; and,

11. That it will research and correct risk adjustment data discrepancies.

[9]The medical record documentation must show that the HCC diagnosis was assigned .... by an appropriate provider type (hospital inpatient, hospital outpatient, or physician) and an acceptable physician data source as defined in the CMS

Dieticians are not physicians and are prohibited from making Medicare diagnoses. *Id.*; 6-ER-1095; 7-ER-1468, 1525. Such HCC diagnoses are invalid to submit as RAD. 6-ER-1095-1096; 7-ER-1468-1469, 7-ER-1525-1526).

Stein also alleged that Kaiser's Compliance Officer required that Kaiser stop allowing dieticians to make malnutrition diagnoses because it created invalid RAD but failed to inform CMS of the overpayments received from Kaiser's invalid Malnutrition RAD submissions. 6-ER-1096; 7-ER-1469, 7-ER-1526.

Although the *Osinek* and *Arefi* complaints alleged that Malnutrition and cachexia were Refreshed, those frauds are separate and distinct from Stein's Malnutrition Fraud Scheme. The Refresh Fraud allegations involve the enrollee's PCP to falsely addend their enrollees' medical records to add a Malnutrition diagnosis that was not the result of a face-to-face encounter. In contrast, Stein's Malnutrition fraud allegations independently involve the improper contemporaneous unauthorized Malnutrition diagnosis of hospital inpatients by dieticians. As such, they would not put the Government on notice of the Malnutrition frauds alleged by Stein.

3. Aortic Atherosclerosis Fraud Scheme.

Stein's FAC and SAC allege an Aortic Atherosclerosis (AA) Fraud Scheme that involved Kaiser hospitals instructing its coders to code AA whenever there is a radiologic report indicating AA or anytime AA is noted in the patient's hospital chart.

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instructions for risk adjustment implementation. 2008 Resource Guide, p. 15.

Medicare requires MAOs *not* submit RAD based on laboratory and diagnostic radiology services as a standalone medical record for data validation. *MMCM,* Ch. 7 §40, §120.1.1. CMS rules and ICD-9 and ICD-10 Coding and Documentation Guidelines require the patients to have received treatment for a chronic condition like AA. 6-ER-1098-10990; 7-ER-1471.

In 2016, Kaiser's Compliance Officer notified all Kaiser hospitals that they must stop having their hospital coders always code AA from X-ray reports because such coding violated the ICD-10 Coding Guidelines. 6-ER-1099; 7-ER-1471-1472. Despite this, Kaiser never attempted to inform CMS of the overpayments it received from submitting invalid AA RAD. 6-ER-1100; 7-ER-1473.

D. THE PANEL'S DECISION CONFLICTS WITH THE *HARTPENCE* MATERIAL FACTS TEST.

The panel's decision approving the District Court's dismissal of Appellants' Sepsis, Malnutrition, and AA frauds conflicts with the *Hartpence* material facts test. As discussed in Section II, above, *Hartpence* held that the first-to-file bar does not apply to a related, but distinct fraud allegation that (a) it is based upon a different Medicare program requirement that was at issue in the prior file action, and (b) the subsequent filed action that alleges a related but distinct fraud that benefits the Government because it might not have discovered the subsequent action's fraud schemes based upon an investigation of the prior actions. *Id.* at 1131.

Here, the prior *Osinek, Taylor,* and *Arefi* actions focused on Appellees' Refresh

fraud scheme which is based upon Appellees' violation of Medicare's requirement that RAD diagnosis submitted to CMS must be based on a "face-to-face" encounter with the patient that is documented in the medical record as the refreshed diagnoses were made and addended to the enrollee's medical well after the patient encounter such that the physician did not remember the encounter. 8-ER-1755-1757, 1760-1761, 1707, 1714, 1652, 1658, 1570. Instead, Appellants' fraud allegation are based on Appellees' violations of different medicare requirements. Appellants' Sepsis fraud allegation is based upon Appellees' violation of Medicare's requirement that Sepsis diagnoses sent to CMS must be coded according to ICD-9 and/or ICD-10 Guidelines, and that Appellees' failed and refused to withdraw their Sepsis RAD from CMS after Appellees had ruled out Sepsis and sent the patient home without hospitalization. 6-ER-1084-1085; 7-ER-1458, 1515-1516. Appellants' Malnutrition fraud allegation is based upon Appellees submitting Malnutrition diagnoses to CMS that were based upon diagnoses from an dieticians that were not authorized to make diagnoses, and failed to return resulting overpayments after Appellees stopped this practice after recognizing that this practice violated Medicare requirements. 6-ER-1094; 7-ER-1467,1524-1523. Last, Appellants' AA fraud allegation is based upon Appellees submitting AA diagnoses to CMS based upon x-ray reports without clinical findings by physicians. 6-ER-1098; 7-ER-1471. Just as the district court in *Hartpence* incorrectly conflated Hartpence's and Godeke's FCA claims, the panel's affirmation

of the District Court's conclusion that Appellees' Sepsis, Malnutrition, and AA fraud schemes were lesser included conduct alleged in *Osinek* (1-ER-42) clearly misapplied and conflicts with the *Hartpence* material facts test. The first-to-file rule does not apply simply because Appellees' Sepsis, Malnutrition, and AA fraud schemes resulted in false diagnosis codes being sent to CMS, just as Hartpence's and Godeke's fraud schemes resulted in CMS being overbilled for the same type of medical equipment.

Further, the Government benefitted from Appellants' Sepsis, Malnutrition, and AA fraud claims because the Government would likely not have discovered these frauds through an investigation of the *Osinek, Taylor,* and *Arefi* actions. An investigation of the prior actions' Refresh Fraud claims would be based upon Appellees' data mined lists of prior years' diagnoses sent to PCPs who then added addendums to the patients' medical records. Such an investigation would not uncover Appellees' Sepsis fraud scheme (which was based on contemporaneous diagnoses, and failure to withdraw previously submitted Sepsis diagnoses that were subsequently ruled out and no alleged addendums), Malnutrition fraud scheme (which was based on contemporaneous diagnoses by unqualified dieticians and failure to repay CMS for resulting overpayments and with no alleged addendums), and AA (which was based upon diagnoses based upon x-rays and with no alleged addendums). Likewise, an investigation of *Taylor's* audit fraud claims would reveal that Appellees failed to

withdraw from CMS the diagnoses codes that were the subject of Appellees' internal audits.

Accordingly, the panel's determination that Appellants' Sepsis, Malnutrition, and AA fraud allegations are first-to-file barred conflicts with Hartpence's material facts test, warranting reversal.

III. CONCLUSION AND SUMMARY OF REQUESTED RELIEF.

The Supreme Court's clear statement principle requires Courts to (a) hold a statute is jurisdictional if the Congress clearly states that the statute's scope is jurisdictional, and (b) hold that a statute is *not* jurisdictional if "Congress does not rank a statutory limitation on coverage as jurisdictional." *Gonzalez*, 565 U.S. at 141-142. The plain wording of the FCA's first-to-file rule, 31 U.S.C. § 3730(b)(5), reflects that it is *not* jurisdictional because it does not clearly state that its scope is jurisdictional. This Court, in the panel's decision and *Lujan*, and this Court *en banc* in *Hartpence*, have held that the FCA's first-to-file rule is jurisdictional without analyzing it using the Supreme Court's clear statement principle. Appellants' respectfully request rehearing *en banc* to determine that the FCA's first-to-file rule is *not* jurisdictional when analyzed under the clear statement principle, in line with the decisions of the First, Second, Third, Sixth and District of Columbia circuits.

Further, rehearing, by the panel or *en banc*, of the panel's ruling that Appellants' Sepsis, Malnutrition, and AA fraud claims is warranted due to the panel's

failure to correctly analyze these claims under the *Hartpence* material facts test, with subsequent reversal warranted.

Accordingly, Appellants pray that rehearing is granted.

Respectfully Submitted,

HANAGAMI LAW
A Professional Corporation

Dated: February 5, 2024

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Appellants,
Marcia Stein and Rodolfo Bone

APPENDIX

FILED

JAN 10 2024

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

MARCIA STEIN; et al., Plaintiffs-Appellants, and UNITED STATES OF AMERICA, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., a California corporation; et al., Defendants-Appellees.	No. 22-15862 D.C. Nos. 3:16-cv-05337-EMC 3:13-cv-03891-EMC MEMORANDUM*

Appeal from the United States District Court
for the Northern District of California
Edward M. Chen, District Judge, Presiding

Argued and Submitted September 15, 2023
San Francisco, California

Before: BOGGS,** S.R. THOMAS, and FORREST, Circuit Judges.
Concurrence by Judge FORREST.

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

** The Honorable Danny J. Boggs, United States Circuit Judge for the U.S. Court of Appeals for the Sixth Circuit, sitting by designation.

Plaintiffs Marcia Stein and Rodolfo Bone (Relators) appeal the district court's dismissal of their False Claims Act (FCA) suit as barred by that statute's first-to-file rule. 31 U.S.C. § 3730(b)(5). We have jurisdiction under 28 U.S.C. § 1291, and we affirm because the district court correctly concluded that under *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121 (9th Cir. 2015) (en banc), the first-to-file rule is jurisdictional and bars this case.

The parties are familiar with the factual and procedural history of the case; we do not recount it here.

1. ***Subject-Matter Jurisdiction.*** We review subject-matter jurisdiction issues de novo. *Sauk-Suiattle Indian Tribe v. City of Seattle*, 56 F.4th 1179, 1184 (9th Cir. 2022). We are bound by *Hartpence*'s holding that "[w]e treat the first-to-file bar as jurisdictional." 792 F.3d at 1130. Although we recognize the friction between *Hartpence* and the Supreme Court's clear-statement requirement—*see, e.g.*, *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153 (2013); *Gonzalez v. Thaler*, 565 U.S. 134, 141–42 (2012)—there is no "intervening higher authority" that is "clearly irreconcilable with" *Hartpence*. *Miller v. Gammie*, 335 F.3d 889, 893, 900 (9th Cir. 2003) (en banc), *overruled on other grounds by Sanchez v. Mayorkas*, 141 S. Ct. 1809 (2021). Rather, post-*Hartpence* the Supreme Court has merely emphasized the need to follow the previously established clear-statement requirement. *See, e.g.*, *Santos-Zacaria v. Garland*, 598 U.S. 411, 416–17 (2023);

Wilkins v. United States, 598 U.S. 152, 155–59 (2023). These cases undoubtedly pose "some tension" with *Hartpence*, but they do not "change the state of the law" in a way that would satisfy this court's "clearly irreconcilable" standard. *Lair v. Bullock*, 697 F.3d 1200, 1207 (9th Cir. 2012) (citations omitted).[1]

2. ***"Related" Actions.*** An analysis of the first-to-file bar requires comparing the complaints at issue to determine whether the later-filed complaint is "related" to the earlier-filed one. 31 U.S.C. § 3730; *U.S. ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1188–89 (9th Cir. 2001); *see also Hartpence*, 792 F.3d at 1130–32. We review the district court's interpretation of the FCA de novo. *Hartpence*, 792 F.3d at 1126, 1130. Here, the district court concluded that the relevant complaints for comparison were Relators' initial complaint and the complaints pending in the potentially related actions when Relators' initial complaint was filed.[2] *Hartpence* suggests that the district court should have considered all pending amended complaints, *i.e.* all operative complaints at the time of the first-to-file analysis. *See Hartpence*, 792 F.3d at 1125 & n.2 ("For purposes of determining jurisdiction, we look to the allegations in the amended complaints.").

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[1] We decline to sua sponte call for en banc review in this case, particularly where there is no intra-circuit conflict. *See Atonio v. Wards Cove Packing Co.*, 810 F.2d 1477, 1478–79 (9th Cir. 1987) (en banc)); *see also* Fed. R. App. P. 35(a); *United States v. Wylie*, 625 F.2d 1371, 1378 n.10 (9th Cir. 1980).

[2] This meant considering the original complaints in *Osinek* and *Arefi*, but the amended complaint in *Taylor*.

Without deciding whether the district court erred in selecting the proper comparators in applying the first-to-file bar, we conclude any error would be harmless because the district court considered in the alternative the allegations Relators added in their amended complaint. Moreover, although the relators in *Osinek* and *Taylor* amended their complaints between when the Relators here filed their complaint and when Kaiser moved to dismiss this action, there were no material differences in the amended *Osinek* and *Taylor* complaints.

The "material facts test" determines whether an action is related and bars "later-filed actions alleging the same elements of fraud described in an earlier suit." *Lujan*, 243 F.3d at 1188–89. The district court held that Relators' complaint was barred under the material facts test because their complaint alleged lesser-included conduct that fell within the broad schemes alleged in *Osinek* and *Taylor*. The district court explained that it would reach the same result even considering the aortic-atherosclerosis-related allegations in Relators' amended complaint. Reviewing de novo, we agree. *Hartpence*, 792 F.3d at 1126, 1130.

Relators' action does not exist "completely independent" of the fraudulent schemes alleged in *Osinek*, *Taylor*, and *Arefi*. *Hartpence*, 792 F.3d at 1131. Rather, this action relates to fraud that is included *within* the broad schemes alleged in those earlier actions. It is true that the relators in *Osinek*, *Taylor*, and *Arefi* alleged more general conduct impacting diagnoses that were "*among*" those in the upcoding

scheme, and here Relators' allegations focus specifically on why Kaiser's sepsis, malnutrition, and aortic-atherosclerosis diagnoses were unsupported. *Lujan*, 243 F.3d at 1185–86 (emphasis added) (citation omitted). But the difference is the Relators here simply provide more details about a few diagnoses "*within* the" overall upcoding scheme alleged in the prior actions. *Id.* (emphasis added) (citation omitted). Therefore, the first-to-file rule bars the Relators' complaint because the allegations in *Osinek*, *Taylor*, and *Arefi* "alerted the government to the essential facts of [the] fraudulent scheme." *Id.* at 1188.

3. ***Denial of Leave to Amend.*** We review the denial of leave to amend for abuse of discretion but review the futility of amendment de novo. *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1172 (9th Cir. 2016). Even if the district court erred in concluding that amendment would be futile because the proper comparator was the Relators' initial complaint, which we do not decide, the district court nonetheless did not abuse its discretion. Dismissal without leave to amend was appropriate because Relators made no showing below—nor on appeal—that any amendment could cure their first-to-file deficiency. *See Metzler Inv. GMBH v. Corinthian Colls., Inc.*, 540 F.3d 1049, 1072 (9th Cir. 2008); *Kendall v. Visa U.S.A., Inc.*, 518 F.3d 1042, 1051–52 (9th Cir. 2008).

AFFIRMED.

FILED

JAN 10 2024

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

Marcia Stein v. Kaiser Foundation Health Plan, No. 22-15862
Forrest, J., concurring in the judgment:

I join the majority in applying *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121 (9th Cir. 2015) (en banc), because it is controlling precedent. I write separately because *Hartpence* is inconsistent with current Supreme Court doctrine, and it should be overruled by our en banc court at an appropriate time.

The Supreme Court has cautioned against the "profligate use of the term 'jurisdiction,'" and it has instructed that rules are non-jurisdictional absent a "clear statement" from Congress otherwise. *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153 (2013). Indeed, the Court repeatedly has emphasized this point in recent years, instructing that a rule is jurisdictional "only if Congress 'clearly states' that it is." *Santos-Zacaria v. Garland*, 598 U.S. 411, 416 (2023) (quoting *Boechler, P.C. v. Comm'r*, 596 U.S. 199, 203 (2022)); *see also id.* at 414–19 (holding that 8 U.S.C. § 1252(d)(1)'s exhaustion requirement is not jurisdictional); *Wilkins v. United States*, 598 U.S. 152, 156–59 (2023) (explaining the Court's "clear statement" requirement and holding that 28 U.S.C. § 2409a(g)'s twelve-year time bar is a non-jurisdictional claims processing rule); *MOAC Mall Holdings LLC v. Transform Holdco LLC*, 598 U.S. 288, 297–301 (2023) (discussing how the Court has sought "to bring some discipline" given the "sometimes-loose use of the word 'jurisdiction'" and holding that 11 U.S.C. § 363(m) is not jurisdictional (citation omitted)).

The False Claims Act's (FCA) first-to-file bar lacks a "clear statement" establishing that it is jurisdictional. This rule—which falls under a section titled "Civil actions for false claims"—states: "When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). This text speaks to *who* may bring an action and *when*. It says nothing about the court's "adjudicatory authority." *Santos-Zacaria*, 598 U.S. at 421. Nor does it include any other textual clue that points to jurisdiction.

As some of our sister circuits have noted, "[t]his is in sharp contrast to other provisions of the FCA that *do* explicitly invoke the jurisdiction of the district courts." *U.S. ex rel. Hayes v. Allstate Ins. Co.*, 853 F.3d 80, 86 (2d Cir. 2017); *see also U.S. ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 120 (D.C. Cir. 2015) ("The statutory structure confirms what the plain text indicates. When Congress wanted limitations on [FCA] suits to operate with jurisdictional force, it said so explicitly.") For example, § 3732—titled "False claims jurisdiction"—identifies which judicial districts have jurisdiction over specific FCA actions and contains a provision authorizing supplemental jurisdiction of state claims.

A further indication that the first-to-file bar is non-jurisdictional is that other provisions within § 3730 expressly address jurisdiction. *Compare* § 3730(e) (titled "Certain Actions Barred" and setting out different contexts in which "[n]o court shall

have jurisdiction over an action brought under subsection (b)" of § 3730), *with* § 3730(b) (first-to-file bar subsection lacking jurisdictional language). These subsections "were added at the same time," *In re Plavix Mktg., Sales Pracs. & Prods. Liab. Litig. (No. II)*, 974 F.3d 228, 232 (3d Cir. 2020), and demonstrate that Congress "knew how to reference 'jurisdiction expressly'" in the FCA where it had a jurisdictional purpose, *Heath*, 791 F.3d at 121–22. "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally." *Kucana v. Holder*, 558 U.S. 233, 249 (2010) (alteration omitted).

There is a circuit split on this issue, but the circuits holding that the first-to-file bar is jurisdictional have not engaged in any analysis. *See Hartpence*, 792 F.3d at 1130 (summarily stating that "[w]e treat the first-to-file bar as jurisdictional"); *U.S. ex rel. Carter v. Halliburton Co.*, 866 F.3d 199, 203 (4th Cir. 2017) (similar); *U.S. ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 376 (5th Cir. 2009) (similar); *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1278 (10th Cir. 2004) (similar). The circuits that *have* analyzed the clear-statement requirement have determined that the bar is not jurisdictional. *See, e.g.*, *Heath*, 791 F.3d at 119–21; *Hayes*, 853 F.3d at 85–86; *In re Plavix*, 974 F.3d at 232. The Sixth and First Circuits were initially among the courts that held the bar was jurisdictional without any analysis, but then reversed course. *See U.S. ex rel. Bryant v. Cmty. Health Sys., Inc.*,

24 F.4th 1024, 1036 (6th Cir. 2022); *United States v. Millenium Lab'ys, Inc.*, 923 F.3d 240, 248–51 (1st Cir. 2019). Both of these circuits held that the Supreme Court's decision in *Kellogg Brown & Root Services, Inc. v. U.S. ex rel. Carter*, 575 U.S. 650 (2015), cast doubt on their prior cases holding the bar was jurisdictional because *Carter* addressed a first-to-file issue after deciding a non-jurisdictional statute of limitations issue, therefore "address[ing] . . . the first-to-file bar on decidedly nonjurisdictional terms." *Millenium Labys*, 923 F.3d at 249 (internal quotation marks and citation omitted); *see also Bryant*, 24 F.4th at 1036.

For these reasons, our en banc court should take the opportunity to bring our precedent regarding the FCA's first-to-file bar in line with the Supreme Court's repeated instruction not to make rules jurisdictional absent clear direction from Congress.

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedPrior Version's Validity Called into Doubt by U.S. ex rel. Schweizer v. Oce, N.V., D.D.C., Feb. 02, 2010

KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 31. Money and Finance (Refs & Annos)
Subtitle III. Financial Management
Chapter 37. Claims (Refs & Annos)
Subchapter III. Claims Against the United States Government (Refs & Annos)

31 U.S.C.A. § 3730

§ 3730. Civil actions for false claims

Effective: December 27, 2022
Currentness

(a) Responsibilities of the Attorney General.--The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.--(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure.[1] The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall--

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.--(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as--

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government

has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.--(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting[2] Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain Actions Barred.--(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 13103(f) of title 5.

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed--

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2)[3] who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

(f) Government not liable for certain expenses.--The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant.--In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Relief from retaliatory actions.--

(1) In general.--Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any

other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter.

(2) Relief.--Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

(3) Limitation on bringing civil action.--A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

CREDIT(S)

(Pub.L. 97-258, Sept. 13, 1982, 96 Stat. 978; Pub.L. 99-562, §§ 3, 4, Oct. 27, 1986, 100 Stat. 3154, 3157; Pub.L. 100-700, § 9, Nov. 19, 1988, 102 Stat. 4638; Pub.L. 101-280, § 10(a), May 4, 1990, 104 Stat. 162; Pub.L. 103-272, § 4(f)(1)(P), July 5, 1994, 108 Stat. 1362; Pub.L. 111-21, § 4(d), May 20, 2009, 123 Stat. 1624; Pub.L. 111-148, Title X, § 10104(j)(2), Mar. 23, 2010, 124 Stat. 901; Pub.L. 111-203, Title X, § 1079A(c), July 21, 2010, 124 Stat. 2079; Pub.L. 117-286, § 4(c)(36), Dec. 27, 2022, 136 Stat. 4358.)

Notes of Decisions (2671)

Footnotes

1 See, now, Rule 4(i) of the Federal Rules of Civil Procedure.

2 So in original. Probably should be “Accountability”.

3 So in original. Probably should be “or (ii) has”.

31 U.S.C.A. § 3730, 31 USCA § 3730
Current through P.L. 118-30. Some statute sections may be more current, see credits for details.

End of Document

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B —Medicare Program
Part 422 —Medicare Advantage Program
Subpart G —Payments to Medicare Advantage Organizations

Source: 70 FR 4729, Jan. 28, 2005, unless otherwise noted.
Authority: 42 U.S.C. 1302, 1306, 1395w–22 through 1395w–28, and 1395hh.
Source: 63 FR 18134, Apr. 14, 1998, unless otherwise noted.

Editorial Note: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

§ 422.310 Risk adjustment data.

(a) ***Definition of risk adjustment data.*** Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.

(b) ***Data collection: Basic rule.*** Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) ***Sources and extent of data.***

(1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Items and services covered under the original Medicare program.

(ii) Medicare covered items and services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) ***Other data requirements.***

(1) MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(5) For data described in paragraph (d)(1) of this section as data equivalent to Medicare fee-for-service data, which is also known as MA encounter data, MA organizations must submit a NPI in a billing provider field on each MA encounter data record, per CMS guidance.

(e) ***Validation of risk adjustment data.*** MA organizations and their providers and practitioners are required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data. MA organizations must remit improper payments based on RADV audits, in a manner specified by CMS. For RADV audits, CMS may extrapolate RADV Contract-Level audit findings for payment year 2018 and subsequent payment years.

(f) ***Use and release of data*** —

(1) ***CMS use of data.*** CMS may use the data described in paragraphs (a) through (d) of this section for the following purposes:

(i) To determine the risk adjustment factors used to adjust payments, as required under §§ 422.304(a) and (c);

(ii) To update risk adjustment models;

(iii) To calculate Medicare DSH percentages;

(iv) To conduct quality review and improvement activities;

(v) For Medicare coverage purposes;

(vi) To conduct evaluations and other analysis to support the Medicare program (including demonstrations) and to support public health initiatives and other health care-related research;

(vii) For activities to support the administration of the Medicare program;

(viii) For activities conducted to support program integrity; and

(ix) For purposes authorized by other applicable laws.

(2) ***CMS release of data.*** Regarding data described in paragraphs (a) through (d) of this section, CMS may release the minimum data it determines is necessary for one or more of the purposes listed in paragraph (f)(1) of this section to other HHS agencies, other Federal executive branch agencies, States, and external entities in accordance with the following:

(i) Applicable Federal laws;

(ii) CMS data sharing procedures;

(iii) Subject to the protection of beneficiary identifier elements and beneficiary confidentiality, including—

(A) A prohibition against public disclosure of beneficiary identifying information;

(B) Release of beneficiary identifying information to other HHS agencies, other Federal executive branch agencies, and States only when such information is needed; and

(C) Release of beneficiary identifying information to external entities only to the extent needed to link datasets.

(iv) Subject to the aggregation of dollar amounts reported for the associated encounter to protect commercially sensitive data.

(v) Risk adjustment data other than data described in paragraphs (f)(2)(iii) and (f)(2)(iv) of this section will be released without the redaction or aggregation described in paragraphs (f)(2)(iii) and (f)(2)(iv) of this section, respectively.

(3) Risk adjustment data will not become available for release under this paragraph (f) unless—

(i) The risk adjustment reconciliation for the applicable payment year has been completed;

(ii) CMS determines that data release is necessary under paragraph (f)(1)(vi) of this section for emergency preparedness purposes before reconciliation; or

(iii) CMS determines that extraordinary circumstances exist to release the data before reconciliation.

(iv) CMS determines that releasing aggregated data before reconciliation is necessary and appropriate to support activities or authorized uses under paragraph (f)(1)(vii) of this section.

(g) ***Deadlines for submission of risk adjustment data.*** Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate. CMS may adjust these deadlines, as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting items and services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary.

(i) Prior to calculation of final risk factors for a payment year, CMS allows a reconciliation process to account for risk adjustment data submitted after the March deadline until the final risk adjustment data submission deadline in the year following the payment year.

(ii) After the final risk adjustment data submission deadline, which is a date announced by CMS that is no earlier than January 31 of the year following the payment year, an MA organization can submit data to correct overpayments but cannot submit diagnoses for additional payment.

(3) Submission of corrected risk adjustment data in accordance with overpayments after the final risk adjustment data submission deadline, as described in paragraph (g)(2) of this section, must be made as provided in § 422.326.

[73 FR 48757, Aug. 19, 2008, as amended at 79 FR 29956, May 23, 2014; 79 FR 50358, Aug. 22, 2014; 80 FR 7960, Feb. 12, 2015; 83 FR 16733, Apr. 16, 2018; 88 FR 6665, Feb. 1, 2023; 88 FR 79539, Nov. 16, 2023]

Title 42 —Public Health
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Part 422 —Medicare Advantage Program
Subpart G —Payments to Medicare Advantage Organizations

Source: 70 FR 4729, Jan. 28, 2005, unless otherwise noted.
Authority: 42 U.S.C. 1302, 1306, 1395w–22 through 1395w–28, and 1395hh.
Source: 63 FR 18134, Apr. 14, 1998, unless otherwise noted.

Editorial Note: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

§ 422.326 Reporting and returning of overpayments.

(a) ***Terminology.*** For purposes of this section—

Applicable reconciliation occurs on the date of the annual final deadline for risk adjustment data submission described at § 422.310(g), which is announced by CMS each year.

Funds means any payment that an MA organization has received that is based on data submitted by the MA organization to CMS for payment purposes, including § 422.308(f) and § 422.310.

Overpayment means any funds that an MA organization has received or retained under title XVIII of the Act to which the MA organization, after applicable reconciliation, is not entitled under such title.

(b) ***General rule.*** If an MA organization has identified that it has received an overpayment, the MA organization must report and return that overpayment in the form and manner set forth in this section.

(c) ***Identified overpayment.*** The MA organization has identified an overpayment when the MA organization has determined, or should have determined through the exercise of reasonable diligence, that the MA organization has received an overpayment.

(d) ***Reporting and returning of an overpayment.*** An MA organization must report and return any overpayment it received no later than 60 days after the date on which it identified it received an overpayment, unless otherwise directed by CMS for purposes of § 422.311.

(1) ***Reporting.*** An MA organization must notify CMS, of the amount and reason for the overpayment, using a notification process determined by CMS.

(2) ***Returning.*** An MA organization must return identified overpayments in a manner specified by CMS.

(e) ***Enforcement.*** Any overpayment retained by an MA organization is an obligation under 31 U.S.C. 3729(b)(3) if not reported and returned in accordance with paragraph (d) of this section.

(f) ***Look-back period.*** An MA organization must report and return any overpayment identified for the 6 most recent completed payment years.

[79 FR 29958, May 23, 2014]

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B —Medicare Program
Part 422 —Medicare Advantage Program
Subpart K —Application Procedures and Contracts for Medicare Advantage Organizations

Source: 63 FR 35099, June 26, 1998, unless otherwise noted.
Authority: 42 U.S.C. 1302, 1306, 1395w–22 through 1395w–28, and 1395hh.
Source: 63 FR 18134, Apr. 14, 1998, unless otherwise noted.

Editorial Note: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

§ 422.504 Contract provisions.

The contract between the MA organization and CMS must contain the following provisions:

(a) ***Agreement to comply with regulations and instructions.*** The MA organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. Compliance with the terms of this paragraph (a) is material to the performance of the MA contract. The MA organization agrees—

(1) To accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of this part.

(2) That it will comply with the prohibition in § 422.110 on discrimination in beneficiary enrollment.

(3) To provide—

(i) The basic benefits as required under § 422.101 and, to the extent applicable, supplemental benefits under § 422.102; and

(ii) Access to benefits as required under subpart C of this part;

(iii) In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

(4) To disclose information to beneficiaries in the manner and the form prescribed by CMS as required under § 422.111;

(5) To operate a quality assurance and performance improvement program and have an agreement for external quality review as required under subpart D of this part;

(6) To comply with all applicable provider and supplier requirements in subpart E of this part, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and the preclusion list requirements in §§ 422.222 and 422.224.

(7) To comply with all requirements in subpart M of this part governing coverage determinations, grievances, and appeals;

(8) To comply with the reporting requirements in § 422.516 and the requirements in § 422.310 for submitting data to CMS;

(9) That it will be paid under the contract in accordance with the payment rules in subpart G of this part;

(10) To develop its annual bid, and submit all required information on premiums, benefits, and cost-sharing by not later than the first Monday in June, as provided in subpart F of this part;

(11) That its contract may not be renewed or may be terminated in accordance with this subpart and subpart N of this part.

(12) To comply with all requirements that are specific to a particular type of MA plan, such as the special rules for private fee-for-service plans in §§ 422.114 and 422.216 and the MSA requirements in §§ 422.56, 422.103, and 422.262; and

(13) To comply with the confidentiality and enrollee record accuracy requirements in § 422.118.

(14) Maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities).

(15) Through the CMS complaint tracking system, to address and resolve complaints received by CMS against the MA organization.

(16) To maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services.

(17) To maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in subpart D of this part. A Part C summary plan rating is calculated as provided in § 422.166.

(18) To comply with the requirements for access to health data and plan information under §§ 422.119 and 422.120 of this chapter.

(19) Not to establish a segment of an MA plan that meets the criteria in § 422.514(d), as determined in the procedures described in § 422.514(e)(3), with the addition of the newly enrolled individuals.

(b) ***Communication with CMS.*** The MA organization must have the capacity to communicate with CMS electronically.

(c) ***Prompt payment.*** The MA organization must comply with the prompt payment provisions of § 422.520 and with instructions issued by CMS, as they apply to each type of plan included in the contract.

(d) ***Maintenance of records.*** The MA organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the bid) of MA organizations.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.

(iii) Enable CMS to audit and inspect any books and records of the MA organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the bid proposal.

(v) Establish component rates of the bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(2) Include at least records of the following:

(i) Ownership and operation of the MA organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and 10 prior periods.

(iii) Federal income tax or informational returns for the current contract period and 10 prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts, and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.

(e) ***Access to facilities and records.*** The MA organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection, audit, or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(iii) The facilities of the MA organization to include computer and other electronic systems; and

(iv) The enrollment and disenrollment records for the current contract period and 10 prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the MA organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The MA organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of audit, whichever is later unless—

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or allegation of fraud or similar fault by the MA organization, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or

(iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit the MA organization at any time.

(f) ***Disclosure of information.*** The MA organization agrees to submit—

(1) To CMS, certified financial information that must include the following:

(i) Such information as CMS may require demonstrating that the organization has a fiscally sound operation.

(ii) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA organization.

(2) To CMS, all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(i) The benefits covered under an MA plan;

(ii) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including—

(A) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(E) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

(3) To its enrollees all informational requirements under § 422.64 and, upon an enrollee's, request the financial disclosure information required under § 422.516.

(g) ***Beneficiary financial protections.*** The MA organization agrees to comply with the following requirements:

(1) Effective January 1, 2010, each MA organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the MA organization. To meet this requirement, the MA organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any enrollee liable for payment of any such fees;

(ii) Indemnify the enrollee for payment of any fees that are the legal obligation of the MA organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA organization, to provide services to the organization's enrollees; and

(iii) For all MA organizations with enrollees eligible for both Medicare and Medicaid, specify in contracts with providers that such enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts, and inform providers of Medicare and Medicaid benefits, and rules for enrollees eligible for Medicare and Medicaid. The MA plans may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. The contracts must state that providers will—

(A) Accept the MA plan payment as payment in full, or

(B) Bill the appropriate State source.

(iv) Ensure that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracted individual or entity on the preclusion list, as defined in § 422.2 and as described in § 422.222.

(v) Ensure that the plan's provider agreement contains a provision stating that after the expiration of the 60-day period specified in § 422.222:

(A) The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per § 422.504(g)(1)(iv); and

(B) The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the beneficiary will have already received notification of the preclusion.

(2) The MA organization must provide for continuation of enrollee health care benefits—

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge.

(3) In meeting the requirements of this paragraph, other than the provider contract requirements specified in paragraph (g)(1)(i) of this section, the MA organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS.

(h) ***Requirements of other laws and regulations.*** The MA organization agrees to comply with-

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

(i) ***MA organization relationship with first tier, downstream, and related entities.***

(1) Notwithstanding any relationship(s) that the MA organization may have with first tier, downstream, and related entities, the MA organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.

(2) The MA organization agrees to require all first tier, downstream, and related entities to agree that—

(i) HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the MA organization.

(ii) HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph (i)(2)(i) of this section directly from any first tier, downstream, or related entity.

(iii) For records subject to review under paragraph (i)(2)(ii) of this section, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated.

(iv) HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(v) They will ensure that payments are not made to individuals and entities included on the preclusion list, defined in § 422.2.

(3) All contracts or written arrangements between MA organizations and first tier, downstream, and related entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the MA organization.

(ii) Accountability provisions that indicate that the MA organization may only delegate activities or functions to a first tier, downstream, or related entity, in a manner consistent with the requirements set forth at paragraph (i)(4) of this section.

(iii) A provision requiring that any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract are consistent and comply with the MA organization's contractual obligations.

(4) If any of the MA organizations' activities or responsibilities under its contract with CMS are delegated to other parties, the following requirements apply to any first tier, downstream and related entity:

(i) Each and every contract must specify delegated activities and reporting responsibilities.

(ii) Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) Each and every contract must specify that the performance of the parties is monitored by the MA organization on an ongoing basis.

(iv) Each and every contract must specify that either—

(A) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization; or

(B) The credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions.

(5) If the MA organization delegates selection of the providers, contractors, or subcontractor to another organization, the MA organization's contract with that organization must state that the CMS-contracting MA organization retains the right to approve, suspend, or terminate any such arrangement.

(j) ***Additional contract terms.*** The MA organization agrees to include in the contract such other terms and conditions as CMS may find necessary and appropriate in order to implement requirements in this part.

(k) ***Severability of contracts.*** The contract must provide that, upon CMS's request—

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

(l) ***Certification of data that determine payment.*** As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify.

(1) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.

(2) The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the data it submits under § 422.310 are accurate, complete, and truthful.

(3) If such data are generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

(4) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the information in its bid submission is accurate, complete, and truthful and fully conforms to the requirements in § 422.254.

(5) ***Certification of accuracy of data for overpayments.*** The CEO, CFO, or COO must certify (based on best knowledge, information, and belief) that the information provided for purposes of reporting and returning of overpayments under § 422.326 is accurate, complete, and truthful.

(m) ***Issuance of compliance actions for failure to comply with the terms of the contract.*** The MA organization acknowledges that CMS may take compliance actions as described in this section or intermediate sanctions as defined in subpart O of this part.

(1) CMS may take compliance actions as described in paragraph (m)(3) of this section if it determines that the MA organization has not complied with the terms of a current or prior Part C contract with CMS.

(i) CMS may determine that an MA organization is out of compliance with a Part C requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations in this chapter, or guidance.

(ii) If CMS has not already articulated a measure for determining noncompliance, CMS may determine that an MA organization is out of compliance when its performance in fulfilling Part C requirements represents an outlier relative to the performance of other MA organizations.

(2) CMS bases its decision on whether to issue a compliance action and what level of compliance action to take on an assessment of the circumstances surrounding the noncompliance, including all of the following:

(i) The nature of the conduct.

(ii) The degree of culpability of the MA organization.

(iii) The adverse effect to beneficiaries which resulted or could have resulted from the conduct of the MA organization.

(iv) The history of prior offenses by the MA organization or its related entities.

(v) Whether the noncompliance was self-reported.

(vi) Other factors which relate to the impact of the underlying noncompliance or the lack of the MA organization's oversight of its operations that contributed to the noncompliance.

(3) CMS may take one of three types of compliance actions based on the nature of the noncompliance.

(i) ***Notice of noncompliance.*** A notice of noncompliance may be issued for any failure to comply with the requirements of the MA organization's current or prior Part C contract with CMS, as described in paragraph (m)(1) of this section.

(ii) ***Warning letter.*** A warning letter may be issued for serious and/or continued noncompliance with the requirements of the MA organization's current or prior Part C contract with CMS, as described in paragraph (m)(1) of this section and as assessed in accordance with paragraph (m)(2) of this section.

(iii) ***Corrective action plan.***

(A) Corrective action plans are requested for particularly serious or continued noncompliance with the requirements of the MA organization's current or prior Part C contract with CMS, as described in paragraph (m)(1) of this section and as assessed in accordance with paragraph (m)(2) of this section.

(B) CMS issues a corrective action plan if CMS determines that the MA organization has repeated or not corrected noncompliance identified in prior compliance actions, has substantially impacted beneficiaries or the program with its noncompliance, or must implement a detailed plan to correct the underlying causes of the noncompliance.

(n) ***Acknowledgements of CMS release of data*** —

(1) ***Summary CMS payment data.*** The contract must provide that the MA organization acknowledges that CMS releases to the public summary reconciled CMS payment data after the reconciliation of Part C and Part D payments for the contract year as follows:

(i) For Part C, the following data—

(A) Average per member per month CMS payment amount for A/B (original Medicare) benefits for each MA plan offered, standardized to the 1.0 (average risk score) beneficiary.

(B) Average per member per month CMS rebate payment amount for each MA plan offered (or, in the case of MSA plans, the monthly MSA deposit amount).

(C) Average Part C risk score for each MA plan offered.

(D) County level average per member per month CMS payment amount for each plan type in that county, weighted by enrollment and standardized to the 1.0 (average risk score) beneficiary in that county.

(ii) For Part D plan sponsors, plan payment data in accordance with § 423.505(o) of this subchapter.

(2) ***MA bid pricing data and Part C MLR data.*** The contract must provide that the MA organization acknowledges that CMS releases to the public data as described at §§ 422.272 and 422.2490.

(o) ***Business continuity.***

(1) The MA organization agrees to develop, maintain, and implement a business continuity plan containing policies and procedures to ensure the restoration of business operations following disruptions to business operations which would include natural or man-made disasters, system failures, emergencies, and other similar circumstances and the threat of such occurrences. To meet the requirement, the business continuity plan must, at a minimum, include the following:

(i) ***Risk assessment.*** Identify threats and vulnerabilities that might affect business operations.

(ii) ***Mitigation strategy.*** Design strategies to mitigate hazards. Identify essential functions in addition to those specified in paragraph (o)(2) of this section and prioritize the order in which to restore all other functions to normal operations. At a minimum, each MA organization must do the following:

(A) Identify specific events that will activate the business continuity plan.

(B) Develop a contingency plan to maintain, during any business disruption, the availability and, as applicable, confidentiality of communication systems and essential records in all forms (including electronic and paper copies). The contingency plan must do the following:

(*1*) Ensure that during any business disruption the following systems will operate continuously or, should they fail, be restored to operational capacity on a timely basis:

(*i*) Information technology (IT) systems including those supporting claims processing at point of service.

(*ii*) Provider and enrollee communication systems including telephone, Web site, and email.

(*2*) With respect to electronic protected health information, comply with the contingency plan requirements of the Health Insurance Portability and Accountability Act of 1996 Security Regulations at 45 CFR parts 160 and 164, subparts A and C.

(C) Establish a chain of command.

(D) Establish a business communication plan that includes emergency capabilities and procedures to contact and communicate with the following:

(*1*) Employees.

(*2*) First tier, downstream, and related entities.

(*3*) Other third parties (including pharmacies, providers, suppliers, and government and emergency management officials).

(E) Establish employee and facility management plans to ensure that essential operations and job responsibilities can be assumed by other employees or moved to alternate sites as necessary.

(F) Establish a restoration plan including procedures to transition to normal operations.

(G) Comply with all applicable Federal, State, and local laws.

(iii) ***Testing and revision.*** On at least an annual basis, test and update the business operations continuity plan to ensure the following:

(A) That it can be implemented in emergency situations.

(B) That employees understand how it is to be executed.

(iv) ***Training.*** On at least an annual basis, educate appropriate employees about the business continuity plan and their own respective roles.

(v) ***Records.***

(A) Develop and maintain records documenting the elements of the business continuity plan described in paragraphs (o)(1)(i) through (iv) of this section.

(B) Make the information specified in paragraph (o)(1)(v)(A) of this section available to CMS upon request.

(2) ***Restoration of essential functions.*** Every MA organization must plan to restore essential functions within 72 hours after any of the essential functions fail or otherwise stop functioning as usual. In addition to any essential functions that the MA organization identifies under paragraph (o)(1)(ii) of this section, for purposes of this paragraph (o)(2) of the section essential functions include, at a minimum, the following:

(i) Benefit authorization (if not waived) for services to be immediately furnished at a hospital, clinic, provider office, or other place of service.

(ii) Operation of call center customer services.

[63 FR 35099, June 26, 1998]

Editorial Note: For FEDERAL REGISTER citations affecting § 422.504, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

Medicare Managed Care Manual
Chapter 7 – Risk Adjustment

Table of Contents
(Rev. 118, 09-19-14)

Transmittals for Chapter 7

10 - Introduction
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

This manual chapter addresses the policies and operations related to the data collection for, calculation of, and use of risk scores in Part C and Part D payments through 2011. For detailed information on payment policies and formulas, refer to Chapter 8 for Part C payment (a chapter for Part D payment is forthcoming). CMS risk adjusts Part C payments made to Medicare Advantage (MA) plans and Program of All Inclusive Care for The Elderly (PACE) organizations, and Part D payments made to Part D sponsors, including Medicare Advantage-Prescription Drug plans (MA-PDs) and standalone Prescription Drug Plans (PDPs).

20 - Purpose of Risk Adjustment
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee. Risk scores measure individual beneficiaries' relative risk and risk scores are used to adjust payments for each beneficiary's expected expenditures. By risk adjusting plan bids, CMS is able to use standardized bids as base payments to plans.

30 - Statutory and Regulatory Authority for Risk Adjustment
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The Medicare Advantage (MA) program provides Parts A and B services under Part C of Title XVIII of the Social Security Act ("the Act"). CMS administers risk adjusted payments to MA organizations in accordance with Subpart G of 42 CFR §422.304. This regulatory provision is based on sections 1853, 1854, and 1858 of the Act. CMS risk adjusts Part C payments made to MA plans under Section 1853(a) (3) of the Act; these rules are codified at 42 CFR 422.310. CMS risk adjusts payments to PACE organizations under 1894(d) (2).

MA plans include MA-only plans, MA-PD plans, regional plans, employer group health plans, and Special Needs Plans (SNPs). CMS risk adjusts certain demonstration plan payments, such as the Part C payments made to the dual demonstration plans (Wisconsin Partnership Program, MassHealth Senior Care Options, and Minnesota Senior Health Options and Minnesota Disability Health Options), and Social Health Maintenance Organizations (SHMOs).

CMS risk adjusts Part D payments to Medicare Advantage Prescription Drugs plans (MA-PDs), standalone Prescription Drug Plans (PDPs), and PACE organizations under 1860(d); these rules are codified at 42 CFR 423.

40 - Role and Responsibilities of Plan Sponsors
(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

MA organizations, PACE organizations, 1876 Cost HMOs/Competitive Medical Plans (CMPs), and starting in 2012, Health Care Prepayment Plans (HCPPs) like the United Mine Workers of America Health and Retirement Funds, must submit risk adjustment data, as required by CMS.

This section provides a high-level checklist of plan requirements. Detailed information about risk adjustment data collection, submission, reporting, and validation are outlined in later sections within this chapter.

Risk Adjustment Data Submission Requirements – Plan Sponsors (Medicare Advantage Organizations (MAOs), PACE organizations, and 1876 Cost HMO/CMPs) must:

- Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.

- Implement procedures to ensure that diagnoses are from acceptable data sources. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians. Plan sponsors are responsible for determining provider type based on the source of the data.

- Submit the required data elements from acceptable data sources according to the coding guidelines.

- Submit all required diagnosis codes for each beneficiary and submit unique diagnoses at least once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clusters.

    - For Part B-only beneficiaries enrolled in a plan, the plan sponsor must submit diagnosis codes under the same rules as for a beneficiary with both Parts A and B. The plan should also submit *diagnosis* codes for Part A services provided under a non-Medicare contract.

  If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible.

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of diagnosis codes on an ongoing basis.

- Once CMS calculates the final risk scores for a payment year, plan sponsors may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that

had an impact on the final payment. Plan sponsors must inform CMS immediately upon such a finding.

50 - History of Risk Adjustment

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The Balanced Budget Act of 1997 (BBA) mandated that a risk adjustment payment methodology, incorporating information on beneficiaries' health status, be implemented in the Medicare+Choice (M+C) program (now the Medicare Advantage program) no later than January 2000. Under the BBA, risk adjustment of M+C payments was initially to be based only on data from enrollees' inpatient hospital stays, with later implementation of risk adjustment based on data from additional sites of care. CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method to be implemented in 2000. This model recognizes diagnoses for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

To assist managed care organizations, CMS provided for a gradual phase-in of risk adjusted payment, initially adjusting only a portion of the total payment based on the PIP-DCG methodology - and later the CMS Hierarchical Condition Category (HCC) methodology - with the remainder still adjusted under the pre-BBA method based only on demographic information. This phase in was intended to provide more stable payments to M+C organizations.

The phase in schedule was as follows:

<table>
<tr><td>Payment year</td><td>MA plans</td><td>Evercare*</td><td>SHMO*</td><td>PACE and dual demonstrations*</td></tr>
<tr><td>2000-2003</td><td>10% risk/90% demographic</td><td>100% demographic</td><td>100% demographic</td><td>100% demographic</td></tr>
<tr><td>2004</td><td colspan="3">30% risk/70% demographic</td><td>10% risk/90% demographic</td></tr>
<tr><td>2005</td><td colspan="2">50% risk/50% demographic</td><td colspan="2">30% risk/70% demographic</td></tr>
<tr><td>2006</td><td colspan="2">75% risk/25% demographic</td><td colspan="2">50% risk/50% demographic</td></tr>
<tr><td>2007</td><td colspan="2" rowspan="2">100% risk/0% demographic</td><td colspan="2">75% risk/25% demographic</td></tr>
<tr><td>2008 and later</td><td colspan="2">100% risk/0% demographic</td></tr>
</table>

*Note: For MA plans (formerly M+C plans), the demographic-only portion of the payment was adjusted for age, gender, Medicaid eligibility, institutional status, and working aged status. For certain demonstrations, the non-risk portion of the payment may have involved a demonstration-specific payment methodology.

ESRD risk adjustment was implemented at 100% in 2005. Part D risk adjustment was implemented at 100% in 2006.

The Benefits Improvement and Protection Act of 2000 (BIPA) required the implementation of a risk adjustment model using not only diagnoses from inpatient hospital stays, but also from ambulatory settings beginning in 2004. The draft CMS-HCC risk adjustment payment model was released on March 29, 2002. The CMS-HCC risk adjustment payment model incorporates disease groups that have a significant impact on Part C expenditures. Submission of ambulatory risk adjustment data (physician and hospital outpatient) began on October 1, 2002 for dates of service beginning July 1, 2002. On March 28, 2003, CMS announced the proposed final version of the CMS-HCC risk adjustment model for use in payment beginning in January 2004.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted in December 2003, extending prescription drug coverage to Medicare enrollees. With the passage of the MMA, "Medicare+Choice" plans became known as Medicare Advantage (MA) plans. In 2006, the MMA made it possible for Medicare Advantage plans to offer Part D coverage to beneficiaries in addition to coverage comparable to Part A and Part B. The MMA also established a bidding methodology for MA organizations and drug plans in 2006. With the enactment of the MMA, risk adjustment was also established for the Part D program.

60 - Annual Schedule

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Table 1 provides key dates associated with risk adjustment, and provides an illustration of the data collection periods and related payment months. The most current dates can be found in the annual combined Call Letter posted on the CMS Web site at, http://www.cms.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage.

Key Payment dates are:

Mid-February: 45 days prior to the release of the Rate Announcement, CMS releases the Advance Notice of Methodological Change for the following payment year.

First Monday in April: CMS releases the Rate Announcement for the following payment year.

First Monday in June: Plan bids are due.

Table 1. Risk Adjustment Payment Timeline for 2011 Payments

	2009						2010												2011												2012
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Initial Payment																															
Dates of Service	**Dates of service for 2011 Initial risk scores**																														
Submission Deadline															**X**																
Payment Months																			**Prospective payments**												
Midyear Payment																															
Dates of Service							**Dates of service for 2011 Midyear risk scores**																								
Submission Deadline																					**X**										
Payment Months																			**Retroactive adjustments**						**Prospective payments**					
Final Payment																															
Dates of Service							**Dates of service for 2011 Final risk scores**																								
Submission Deadline																															**X**
Payment Months																			**Retroactive adjustments**												
Submission Deadlines: (X)																															
Initial: First Friday in September 2010																															
Midyear: First Friday in March 2011																															
Final: January 31, 2012																															

70 - Risk Adjustment Models - Overview

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The CMS-HCC risk adjustment models are used to calculate risk scores, which predict individual beneficiaries' health care expenditures, relative to the average beneficiary. Risk scores are used to adjust payments and bids based on the health status (diagnostic data) and demographic characteristics (such as age and gender) of an enrollee. Both the Medicare Advantage and Prescription Drug programs include risk adjustment as a component of the bidding and payment processes. CMS uses risk adjustment to:

- Standardize bids so that each plan has a bid for the average Medicare beneficiary
- Compare bids based on populations with different health statuses and other characteristics
- Adjust plan payment based on the characteristics of the enrolled population

CMS has developed separate risk adjustment models for the Parts A and B benefits offered by plans under Part C and for the Part D benefits offered by prescription drug plans. Within each benefit, CMS also developed segments of the models for subpopulations with distinct cost patterns.

The Part C model has segments for the following subpopulations of beneficiaries:

- Aged/disabled Community
- Aged/disabled Institutional
- Aged/disabled New enrollee
- ESRD Dialysis
- ESRD Dialysis New Enrollee
- ESRD Transplant
- ESRD Functioning Graft – Community
  - Add-on for 4-9 months
  - Add-on for 10+ months
- ESRD Functioning Graft – Institutional
  - Add-on for 4-9 months
  - Add-on for 10+ months
- ESRD Functioning Graft – New Enrollee
  - Add-on for 4-9 months
  - Add-on for 10+ months

From 2006 through 2010, the Part D model uses a base model with multipliers for:

- Low Income (partial)
- Low Income (full)
- Long Term Institutional (aged)
- Long Term Institutional (disabled)

Starting in 2011, the Part D model has the following segments:

- Aged, non-low income
- Aged, low income
- Disabled, non-low income
- Disabled, low income
- Institutional
- New Enrollee, non-low income
- New Enrollee, low income
- New Enrollee, institutional

Table 2 below summarizes the common characteristics across all HCC-based risk adjustment models.

Table 2. HCC Specific Characteristics

Characteristic	Descriptions
Selected Significant Disease (SSD) Model	Model considers serious manifestations of a condition rather than all levels of severity of a condition. Include most body systems and conditions.
Models are Additive	Individual risk scores are calculated by adding the coefficients associated with each beneficiary's demographic and disease factors.
Prospective Model	Uses diagnostic information from a base year to predict Medicare benefit costs for the following year.
Site Neutral	Models do not distinguish payment based on a site of care.
Diagnostic Sources	Models recognize diagnoses from hospital inpatient, hospital outpatient, and physician settings.
Multiple Chronic Diseases Considered	Risk adjusted payment is based on assignment of diagnoses to disease groups, also known as Condition Categories (CCs). Model is most heavily influenced by Medicare costs associated with chronic disease.
Hierarchies	Condition Categories are placed into hierarchies, reflecting severity and cost dominance. Beneficiaries get credit for the disease with the highest severity or that subsumes the costs of other diseases. Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist.
Disease and Disabled Interactions	Interactions allow for higher risk scores for certain conditions when the presence of another disease or demographic status, e.g., disabled status, is indicative of higher costs. Disease interactions are additive factors and

	increase payment accuracy.
Demographic Variables	Models include five demographic factors: age, sex, disabled status, original reason for entitlement, Medicaid or low income status. These factors are typically measured as of the data collection period.

70.1 - Calibration of the CMS-HCC Risk Adjustment Models

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The CMS-HCC risk adjustment model is used to adjust payments for Part C benefits offered by MA plans and PACE organizations to aged/disabled beneficiaries. The CMS-HCC model includes both diseases and demographic factors. There are separate sets of coefficients for beneficiaries in the community, beneficiaries in long term care institutions, and new enrollees. The CMS-HCC model was first used for payment in 2004 and has been recalibrated two times since then (2007 and 2009).

When CMS recalibrates the CMS-HCC risk adjustment model, it uses data from fee-for-service (FFS) claims, using one year's diagnoses to predict the following year's expenditures. When developing the model, CMS consulted with a panel of outside clinicians to review the *diagnosis* codes in order to group them with other clinically similar *diagnosis* codes. These diagnosis groupings were then mapped to condition categories based on similar clinical characteristics and severity, and cost implications. Both the panel of clinicians and analyses of cost data informed the creation of condition categories.

Coefficients for condition categories were estimated by regressing the total expenditure for Medicare Parts A and B benefits for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (e.g., age/sex group, Medicaid status, disability status).

While all *diagnosis* codes are mapped to a condition category, not all condition categories are included in the model used in payment. The decision to include a condition category in the model is based on each category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that don't predict costs well – because the coefficient is small, the t-value is low, the number of beneficiaries with a certain condition is small so the coefficient is unstable, or the condition does not have well specified diagnostic coding – are not included in the model.

In a final step, hierarchies were imposed on the condition categories, assuring that more advanced and costly forms of a condition are reflected in the risk score.

In order to use the risk adjustment model to calculate risk scores for payment, CMS creates a relative factor for each demographic factor and HCC in the model. CMS does

this by dividing all the dollar coefficients by the average per capita predicted expenditure for a specific year (i.e., the "denominator year"). See Table 3 below for a list of data years and denominator years in each version of the risk adjustment model. The relative factors are used to calculate risk scores for individual beneficiaries, which will average 1.0 in the denominator year for the FFS population.

Each time the risk adjustment model is recalibrated, the relative factors can change. Changes in the dollar coefficients resulting from the regression – the marginal cost attributable to an HCC – can change relative to the average cost. For example, the coefficient for diabetes can increase, reflecting higher costs for the disease; but if the average cost for Medicare beneficiaries has increased even more than for diabetes, then the relative cost of diabetes will decrease. This decrease in relative cost will be reflected in a decrease in the relative factor, even though the costs associated with diabetes have increased.

Although recalibrated models retain an average 1.0 risk score, individual beneficiaries' risk scores may change, as may plan average risk scores, depending on each individual beneficiaries' combination of diagnoses.

Table 3. Data Years and Denominator Years

Payment Years	Diagnoses Year	Costs Year	Denominator Year
2004, 2005, 2006	1999	2000	2000
2007, 2008	2002	2003	2005
2009, 2010, 2011	2004	2005	2007

70.2 - CMS-HCC Risk Adjustment Model

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The CMS-HCC risk adjustment model is used to calculate risk scores for aged/disabled beneficiaries and is used in bidding and payment for Part A and B benefits, under the Part C program. In this section, CMS will discuss in detail the specific characteristics of the CMS-HCC risk adjustment model.

70.2.1 - Community, Institutional, and New Enrollee Segments

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

MA uses separate models for aged/disabled (non-ESRD) community and long-term institutional residents. CMS created the separate models because there are significant cost differences between the community-based Medicare beneficiaries and the long-term institutionalized beneficiaries with the same disease profile. Adjusting payment for place of residence improves payment accuracy.

Long-term institutionalized MA enrollees are individuals residing in an institution for more than 90 days as identified using 90-day assessments in the Minimum Data Set

(MDS). Short term institutionalized MA beneficiaries are included in the community population.

During the payment year, CMS assigns a new enrollee factor to any beneficiary who does not have 12 months of diagnoses to support a risk score. Operationally, CMS identifies new enrollees as those beneficiaries with less than 12 months of Medicare Part B entitlement during the data collection year.

Part A only enrollees are defined as beneficiaries with 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period and are treated as new enrollees, unless the enrolling organization elects to have them treated as a full risk enrollee.

Starting in payment year 2006, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision is applied to **all** "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.

- If an organization elects the option, it remains turned "on" until CMS is notified otherwise. Notification must occur prior to August 31st of any successive year.

- CMS will apply the option only during final reconciliation for a payment year, and not prospectively.

- Plans interested in the option must contact CMS at Andrew.Keenan@cms.hhs.gov by August 31st prior to each payment year to elect the option.

Table 4 provides information on which risk adjustment factor applies to payment.

Table 4. Which Risk Adjustment Factor Applies to Payment*

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	**Time Period Beneficiary Has Been Entitled to Benefits Under Part A Medicare****	
	0 - 11 months	≥ 12 months
0 – 11 months	new enrollee factors	Plan's option: new enrollee or full risk adjustment factors
≥ 12 months	full risk adjustment factors	full risk adjustment factors

*Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that Medicare beneficiaries must be entitled to benefits under Part A and enrolled in Part B to enroll in an MA plan.

**During data collection period. The data collection year is a lagged year for initial risk scores and is the previous calendar year for mid-year and final risk scores.

70.2.2 - Risk Score for Long Term Institutionalized Beneficiaries
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The Part C risk adjustment model applies a beneficiary's institutional risk score to payment in those payment months when the enrollee has long term institutional (LTI) status. Unlike most factors in CMS-HCC risk adjustment models, which are recognized in the year prior to the payment year, institutional status is recognized in the payment year itself; this concurrent approach more accurately reflects treatment patterns upon which costs are based.

To determine a beneficiary's LTI status for payment purposes, CMS uses the reporting of a 90-day assessment. This information is collected routinely from nursing homes, which report to the States and CMS on at least a quarterly basis. This data is stored in the Minimum Data Set (MDS). Payment at the long-term rate starts in the month following the assessment date. Once persons are identified, they remain in long-term status until discharged to the community for more than fourteen days. The costs of the short term institutionalized (less than 90 days) are recognized in the community model.

Note that the institutional marker used for demographic payments is used differently from the institutionalized marker that is used in the CMS-HCC risk adjustment model. The institutional marker that was used in demographic payments increased payments over a demographic base and had the effect of capturing the higher costs of older and sicker people who go into skilled or unskilled levels of care. In the risk adjustment model, the health status markers capture most of these characteristics.

Because CMS calculates initial and mid-year risk scores before it has complete data on beneficiaries' LTI status in the payment year, CMS uses the presence of a 90-day assessment reported for any one month during the 12-month data collection period as a proxy for LTI in the payment year. At the final payment reconciliation that takes place post-contract year, CMS uses each beneficiary's actual month-by-month LTI status in the payment year to determine which risk score or multiplier to apply.

CMS turns on the LTI flag and applies an institutional risk score for initial payments starting January of the payment year when a beneficiary has had a 90-day assessment reported for any one month during July - June prior to the payment year (e.g., July 2008 through June 2009 for 2010 – this is the data collection period for initial payments). CMS would apply this same score until it calculates the mid-year risk scores, at which time CMS will update the LTI flag and institutional risk score if the person had a 90-day assessment reported for any one month during data collection year (e.g., 2009 for 2010 payment year) for mid-year updates. (Mid-year scores take effect in July, and remain in effect through the end of the contract year.)

Membership Monthly Report (MMR) fields specific to LTI status.

1. Part C LTI FLAG (field 20; position 67) - This flag means that the beneficiary has been institutionalized for at least 90 days as of the payment month. CMS will turn on LTI for risk adjustment when a beneficiary has a reported 90-day assessment. It continues to be populated until the beneficiary has a more than 14-day absence from the facility.

2. RA Factor Type Code (field 47; positions 189-90) – A value of "I" means that the enrollee has been institutionalized 90+ days as of the payment month.

70.2.3 - Demographic Factors in the CMS-HCC Model
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The CMS-HCC model is a combination of demographic and disease-based factors.

The demographic variables include:

- **Age** as of February 1st of the payment year.
- **Sex** of the beneficiary.
- **Disabled Status** results in the inclusion of additional factors in the risk scores of community residents who are disabled beneficiaries under 65 years old.
- **Original Reason for Entitlement** results in the inclusion of a factor in the risk score for beneficiaries 65 years of age or older who were originally entitled to Medicare due to disability; the factor differs by the age and sex of the beneficiary.
- **Medicaid Eligibility** results in the inclusion of an additional factor in the risk score.

70.2.4 - Original Reason for Entitlement Code (OREC)
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

In CMS' calculation of the MA payment, CMS includes an additional factor in the risk score based on the original reason the beneficiary became eligible for Medicare. Table 5 outlines the application of the factor based on original reason for entitlement. The Monthly Membership Report reflects the OREC identified in MARx.

Table 5. Original Reason for Entitlement Codes and Descriptions

OREC	Description	Factor Application
0	Beneficiary insured due to age	CMS applies no additional factor.
1	Beneficiary insured due to disability	CMS applies the same factor for OREC 1 and 3.

2	Beneficiary insured due to ESRD	CMS applies no additional factor under the CMS-HCC model.
3	Beneficiary insured due to disability and current ESRD	CMS applies the same factor for OREC 1 and 3.

Example (example uses the CMS-HCC risk adjustment model used in payment for years 2009 through 2011):

- An 83 year old man who originally became entitled to Medicare as disabled is diagnosed with pneumococcal pneumonia (ICD-9 code 481, HCC112).
- Originally insured due to disability, OREC = 1
- Originally disabled, male = 0.168
  Pneumococcal Pneumonia, Emphysema, Lung Abscess, HCC112 = 0.249
- Risk Score = (demographics) + 0.168+0.249

Example (example uses the CMS-HCC ESRD dialysis risk adjustment model used in payment for years 2008 through 2011):

- A 72 year old man who became had originally been entitled to Medicare as disabled is diagnosed with End-Stage Renal Disease (ESRD) with renal dialysis status (ICD-9 code V451, HCC130).
- Originally insured due to disability with current ESRD, OREC = 3
- Male, originally entitled due to disability (non-ESRD) = 0.032
  Renal Dialysis Status, V451, HCC130 = 0.0000
- Risk Score = (demographics) + 0.032+0.000

70.2.5 - Medicaid

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The CMS-HCC and ESRD risk adjustment models include a Medicaid factor. If a beneficiary has Medicaid status in the appropriate time period, the relative factor associated with Medicaid is included in the calculation of the beneficiary risk score. Medicaid is defined as being eligible for Title XIX under an approved Medicaid State Plan, including eligibility for full Medicaid benefits as well as those who are eligible only under one of the Medicare Savings Program categories, e.g., Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB).

Full risk beneficiaries:

The Medicaid factor is included in the risk score when CMS has data indicating that the beneficiary is Medicaid eligible for one month or more in the data collection year. For example, when calculating final 2009 risk scores, the beneficiary will have Medicaid included in their risk score if they were eligible for Medicaid at least one month in 2008. (Note: When calculating initial and mid-year risk scores, CMS may look to early time periods to determine whether or not to assign Medicaid status in the risk score.)

New enrollees:

For individuals with less than 12 months of Part B enrollment in the data collection period the Medicaid factor is included in the calculation of the risk score when the beneficiary is Medicaid for one or more months in the payment year. For example, when calculating final 2009 risk scores, the beneficiary will have Medicaid included in their risk score if they were eligible for Medicaid at least one month in 2009.

In order to appropriately assign Medicaid status to beneficiaries, CMS obtains data on Medicaid eligibility from several sources. For payment year 2008 and later, the following data sources are used:

1. MMA Medicare/Medicaid Dual Eligible monthly file (MMA State files): These files provide monthly identification of each actively enrolled Medicare/Medicaid dual eligible beneficiary, including a person-month record for each Medicare/Medicaid dual eligible in a State Medicaid program in the reporting month. The MMA State files also report information on changes in the circumstances for individuals in a prior month. The files include those eligible for comprehensive Medicaid benefits (whether eligible through the state plan or a section 1115 demonstration), as well as those for whom the State pays Medicare premiums and/or cost sharing (Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals). CMS also uses this data to identify low income beneficiaries under Part D.

2. Puerto Rico monthly submission file: CMS has arranged with Puerto Rico to submit files similar to the MMA State files for beneficiaries who are Medicaid eligible in Puerto Rico.

3. Point-of-Sale data: Submitted to assist pharmacies in identifying low income beneficiaries under Part D.

4. Plan-reported Medicaid status: Plans can report retroactive Medicaid status via the Retro Processing Contractor (RPC). The RPC requires documentation of Medicaid eligibility and confirmation that the beneficiary is not already in CMS data systems prior to updating the beneficiary record based on plan submissions. Please note that plan-reported Medicaid status must be posted to the CMS data systems in time for risk score calculation runs. For more information on plan-reported updates of Medicaid status, including timing and documentation needs, please refer to the Standard Operation Procedure (SOP) for the RPC.

CMS changed the sources used to identify beneficiaries as Medicaid with the 2008 payment year. Table 6 below shows the data sources used by payment year:

Table 6. Data sources for identifying the Medicaid eligibility of Medicare beneficiaries:

	Payment year 2007 and earlier years	**Payment year 2008**	**Payment year 2009 and later years**
New enrollees	1. Third Party Buy-In file 2. Plan-reported Medicaid • Batch "01" transactions • Retroactive updates through the Retro Processing Contractor (RPC)	1. MMA State files 2. Plan-reported • Retroactive updates through the RPC	1. MMA State files 2. Plan-reported • Retroactive updates through the RPC
Full risk enrollees		1. MMA State files 2. Third Party Buy-In file 3. Plan-reported Medicaid • Batch "01" transactions • Retroactive updates through the RPC	

Notes: CMS considers full risk Medicare beneficiaries as dually-eligible if they were eligible for Title XIX during any month in the year prior to the payment year. Full risk Medicare beneficiaries have 12 months of Part B enrollment in the year prior to the payment year. CMS assigns Medicaid status for new enrollees on a concurrent basis, i.e., if a newly-enrolled Medicare beneficiary is eligible for Title XIX during any month during the payment year, they are considered Medicaid for that year.

Checking Medicaid status used in payment:

While plans are permitted to submit Medicaid status for their enrollees who are not otherwise reported as Medicaid, plans first must conduct analyses of the available data from CMS to confirm that CMS does not already have Medicaid status reported for the beneficiary.

Table 7 below illustrates how to use the MMR to determine Medicaid status. For a description of fields 19, 21, 23, and 47, please see the latest version of the Monthly Membership Report.

Table 7. Using the MMR to identify Medicaid status

If the enrollee is a "full risk" enrollee, i.e., has 12 months of Part B in the data collection period	Field 47 (RA Factor Type code) = C, C1, C2, D, G1, G2, I, I1, or I2 and Field 23 (Default Risk Factor code) = blank
Medicaid is used in calculating the risk score if enrollee was Medicaid for at least one month in the data collection period	Field 19 = blank **Use Field 21 to determine Medicaid status –** Field 21 = Y Indicates that Medicaid status was used in calculating the risk score, i.e., at least a one month period of Medicaid eligibility during the data collection period was established in CMS systems at the time that risk scores were calculated. Field 21 = blank, Indicates that no Medicaid period of eligibility was established in CMS systems during the data collection period.
If the enrollee is a "new enrollee," i.e., does not have 12 months of Part B in the data collection period – And they were present in the Medicare Beneficiary Database at the time that the Risk Adjustment System (RAS) pulled data for calculating risk scores… A "new enrollee" risk score will be assigned in RAS.	Field 47 (RA Factor Type code) = E, ED, E1, or E2 and Field 23 (Default Risk Factor code) = blank
Medicaid is used in assigning the new enrollee risk score if the enrollee was Medicaid for at least one month in the payment year.	Field 19 = blank **Use Field 21 to determine Medicaid status –** Field 21 = Y Indicates that Medicaid status was used in assigning the new enrollee risk score, i.e., at least a one month period of Medicaid eligibility during the payment year was established in CMS systems at the time that the risk score was assigned. Field 21 = blank

	Indicates that no Medicaid period of eligibility was established in CMS systems during the payment year. Note: The application of Medicaid status based on Medicaid periods during the payment year will happen at final payment reconciliation (conducted in the year following the payment year). New enrollees who are assigned a RAS risk score during the initial risk score run are assigned Medicaid status if they are Medicaid for at least one month during the lagged data collection period (July-June prior to the payment year) or during any one month after June, but prior to the risk score run. New enrollees who are assigned a RAS risk score during the mid-year risk score run are assigned Medicaid status if they are Medicaid for at least one month during the year prior to the payment year or any one month during the payment year. At final payment reconciliation, Medicaid status will be applied to the final risk score if there is a Medicaid period of at least one month during the payment year.
If the enrollee does not have a RAS-generated risk score, either because – o the enrollee was <u>not</u> present in the Medicare Beneficiary Database at the time that RAS pulled data for calculating risk scores, i.e., they were neither entitled to Part A nor enrolled in Part B at the time of the risk score run, or o the enrollee has RAS factors for community and institutional, but has a newly-reported ESRD status (RAS did not know to generate a CMS-HCC ESRD risk score for the beneficiary) – The payment system will not have the appropriate risk score passed to it from RAS for these beneficiaries; the payment system will assign the appropriate default risk score in these cases (aged/disabled, ESRD).	Field 23 is populated with 1, 2, 3, 4, 5, 6, or blank depending on type of default score used (see the PCUG for more information about the MMR file layout). Prior to 2009: Field 47 (RA Factor Type code) = blank and Field 23 (Default Risk Factor code) = Y (indicates that a default risk score was assigned by the payment system) Note: Default risk scores may be needed throughout the payment year, since RAS may not be able to generate the appropriate risk scores during the initial and mid-year risk score runs. At final payment reconciliation (conducted in the year following the payment year), all beneficiaries enrolled during the payment year – both full risk and new enrollees - will receive RAS-generated risk scores, i.e., no default risk scores are assigned at final payment reconciliation.
Medicaid is used in assigning the default risk score if the enrollee was Medicaid for at least one month in the payment year.	Field 21 = blank **Use Field 19 to determine Medicaid status –** Field 19 = Y

	Indicates that Medicaid status was used in assigning the new enrollee risk score, i.e., at least a one month period of Medicaid eligibility during the payment year was established in CMS payment system at the time that the default risk score was assigned. Field 19 = N Indicates that no Medicaid period of eligibility was established in CMS systems during the payment year. Note: For default risk scores assigned to beneficiaries at the beginning of a payment year, the payment system assigns default risk scores using Medicaid if the beneficiary has Medicaid for at least one month in the year previous to the payment year (since payment-year Medicaid status is unknown). During the payment year, the payment system checks quarterly for updates to the Medicaid status of default beneficiaries and adjusts their Medicaid status according to the rules for default enrollees.

Notes: The data collection period is the 12 month period from which CMS uses diagnoses when calculating risk scores. For mid-year and final risk scores, the data collection period is the calendar year prior to the payment year (2007 for 2008 payment year). For initial risk scores (those used for prospective payments from January – June in a payment year), the data collection period is the July (two years prior) – June (in the year prior to payment year). For example, for 2010 initial risk scores, CMS used July 1, 2008 – June 30, 2009 for the data collection period.

70.2.6 - Disease Hierarchy

(Rev.114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Disease hierarchies address situations when multiple levels of severity for a disease, with varying levels of associated costs, have been reported for a beneficiary. The hierarchies prioritize the inclusion in a risk score of multiple HCCs where diagnoses are clinically related and ranked by costs. In the case of a disease hierarchy, Part C payment is based only on the most severe and costly manifestation of the disease. Hierarchies are published in the Rate Announcement for the years when CMS recalibrated the CMS-HCC model.

The following example demonstrates how the hierarchy logic is applied in the CMS-HCC risk adjustment model used for payment. :

An individual residing in the community with diabetes, which progresses over a year from having no complications (ICD-9 code 2500, HCC19) to having diabetes with ketoacidosis (ICD-9 code 2501). Diabetes with ketoacidosis is in the HCC for diabetes

with acute complications (HCC17). The progression of the disease would trigger the payments for HCC17, but not for HCC19. HCC17 is the more severe manifestation of the disease and the payments for HCC17 are higher than for HCC19.

CMS-HCC DISEASE HIERARCHIES

If the Disease Group is Listed in This Column…		**…Then Drop the Associated Disease Group(s) Listed in This Column**	
HCC Disease Group	**Label**	**HCC Disease Group**	**Label**
17	Diabetes with Ketoacidosis	19	Diabetes without Complications

Factor 1: Diabetes with Ketoacidosis, HCC17 = 0.339
Factor 2: Diabetes without Complications, HCC19 = 0.162

Risk Score = (demographics) + 0.339

70.2.7 - Disease and Disabled Interactions

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Disease Interactions - Certain combinations of coexisting diagnoses for an individual can increase medical costs more than the additive nature of the CMS-HCC model reflects. The CMS-HCC model recognizes these higher costs by incorporating disease interactions in the model.

Disabled Interactions - Interactions between certain diseases and disabled status for an enrollee can increase medical costs. The CMS-HCC model recognizes these higher costs by incorporating disease and disabled interactions in the model.

In calculating the interaction part of the risk score for an individual, the disease or disabled interaction factor is added to the remaining factors.

The following example uses the CMS-HCC risk adjustment model used in payment for years 2009 through 2011:

An individual who is disabled, lives in the community, and has been diagnosed with rheumatoid arthritis (ICD-9 code 7140, HCC38) and cystic fibrosis (ICD-9 code 2770, HCC107).

Factor 1: Rheumatoid Arthritis and Inflammatory Connective Tissue, HCC38 = 0.346
Factor 2: Cystic Fibrosis, HCC107 = 0.399
Factor 3: Disabled * Cystic Fibrosis, D_HCC107 = 1.097

Risk Score = (demographics) + 0.346 + 0.399 + 1.097

70.3 - End Stage Renal Disease (ESRD)
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

In addition to the CMS-HCC model used to improve payment accuracy for aged/disabled beneficiaries enrolled in MA plans and PACE organizations, CMS implemented the ESRD model to improve accuracy for enrollees with ESRD, including those in dialysis status, having transplants, and in post-graft status. The CMS-HCC ESRD model is based on the CMS-HCC model for aged/disabled beneficiaries: it uses the same HCCs and therefore retains the characteristics of the CMS-HCC model. The coefficients differ as they are estimated for the ESRD dialysis and transplant populations, which have different costs for their Part A and B benefits and different cost patterns among the various diagnoses.

The following are the segments of the ESRD model:

- Dialysis,
- Transplant, and
- Post-Graft/Functioning Graft

70.3.1 - Dialysis
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Dialysis Status – Payments for beneficiaries are made using CMS-HCC ESRD dialysis risk scores when CMS has notification from a dialysis facility that the beneficiary is receiving dialysis in a Medicare certified facility. The dialysis facility submits the notification to CMS on the CMS-2728 form and the payment system uses this information to apply an ESRD dialysis risk score.

Payment for Medicare beneficiaries in dialysis status is made using the ESRD State ratebook: the risk score is multiplied by the appropriate State rate. See Chapter 8: Payments to Medicare Advantage Organizations.

70.3.2 - Transplant
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Another component of the CMS-HCC ESRD model are the transplant factors. CMS pays for the high one-time cost of a transplant by making payments over three months to cover the costs for the transplant and the immediate subsequent services.

To estimate the factors for the month of the transplant and the two following months, CMS uses fee-for-service expenditures in these three months and attributes 50% of the costs to the first month, and half of the remaining costs to each of the second and third months following the transplant. The factors are calculated by dividing by the denominator for the CMS-HCC ESRD model.

CMS will make payment by determining the month of transplant and paying the three lump sum monthly amounts over the three-month period starting with the transplant month. The payments are calculated by multiplying the transplant factor by the applicable State rate. See Chapter 8: Payments to Medicare Advantage Organizations.

70.3.3 - Post-Transplant (Functioning Graft)

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

In addition to dialysis and transplant, post-transplant (functioning graft) is a component of the ESRD model. CMS defines these enrollees as those who received a kidney transplant at least three months before the payment month and have not returned to dialysis status since the transplant. This model segment includes additional factors in the risk score that account for the extra costs of immunosuppressive drugs and higher intensity of care for this group. These additional factors differ for months 4-9 after a transplant, and for months 10 onward. CMS calculates payments for functioning graft enrollees with risk scores calculated using the aged-disabled CMS-HCC model coefficients, with the exception of the coefficient for HCC174 (Major Organ Transplant).

MA organizations may locate the ratebook used to calculate payments to transplant enrollees on the CMS website at: http://www.cms.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage.

70.3.4 - New Enrollee Factors for Beneficiaries in ESRD Status

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The dialysis and functioning graft models have new enrollee factors for enrollees who do not have 12 months of Part B enrollment in the data collection period and for whom full risk scores cannot be determined. CMS uses a new enrollee risk adjustment factor based on the beneficiary's demographic characteristics, including age, disability, and ESRD status when a beneficiary is too new to Medicare to have a risk adjustment factor. New enrollees with transplants receive the same transplant factors as full risk enrollees.

For ESRD enrollees who do not have an ESRD risk score calculated for them before the payment month (which may happen prior to final reconciliation), a default risk score is used in payment. Beginning in November 2008, plans can determine the payment model CMS used for the new enrollee beneficiary by reviewing the "Default Risk Factor Code" CMS communicated on the Monthly Membership Report in field 23. Table 8 outlines the Default Risk Factor Codes.

Table 8. Default Risk Factors
[Field 23 on the Monthly Membership Report]

Default Risk Factor Code	Definition
1	Default Enrollee – Aged/Disabled
2	Default Enrollee – ESRD Dialysis
3	Default Enrollee ESRD with Kidney Transplant, Month 1
4	Default Enrollee – ESRD with Kidney Transplant, Months 2 – 3
5	Default Enrollee – ESRD Post Graft, Months 4 – 9
6	Default Enrollee – ESRD Post Graft, Months 10 +
Blank	Not a default enrollee - Risk Adjustment Factor calculated by CMS

MA organizations may locate the ratebook used to calculate payments to transplant enrollees on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage.

70.4 - Prescription Drug Hierarchical Condition Categories (RxHCC)
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Starting in 2006, with the implementation of the Part D program, CMS introduced a second major HCC-based risk adjustment model. Created with the passage of the Medicare Modernization Act (MMA) of 2003, the Medicare Part D Prescription Drug benefit became the second major Medicare capitated payment system. CMS developed the Part D RxHCC risk adjustment model to apply to monthly capitated payments to both Medicare Advantage (MA-PDs) and standalone prescription drug plans (PDPs). The Part D RxHCC risk adjustment model implemented in 2006 was developed using a structure similar to the CMS-HCC model, in that it included demographic and diagnosis information clustered into hierarchical condition categories. CMS obtains diagnoses for all Medicare beneficiaries from either fee-for-service claims or Medicare Advantage reporting. In 2011, CMS implemented an updated Part D RxHCC risk adjustment model, incorporating program data derived from prescription drug event (PDE) data. The data used to calibrate this updated model was more recent cost and utilization data, resulting in a model that reflects more recent drug cost and utilization patterns.

70.4.1 - RxHCC Risk Adjustment Model Segments
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)
The RxHCC model includes some of the same characteristics as the CMS-HCC Model: it is a prospective model with additive coefficients subject to the application of hierarchies, and contains a model for new enrollees based on demographics. However, to address cost patterns that differ for subgroups of Part D eligible beneficiaries, the RxHCC model has segments that differ from those in the CMS-HCC model.

For the RxHCC risk adjustment model used in all years, the following rules apply:

- Beneficiaries can be either LTI or LIS, but the beneficiary cannot be both for purposes of risk adjustment.

- When a beneficiary has both LTI and LIS status, the LTI status is used for risk adjustment.

RxHCC Model from 2006 through 2010

The RxHCC model in place from 2006 through 2010 differs from the CMS-HCC model by incorporating LTI or LIS multipliers for qualifying beneficiaries (if applicable) to account for the incremental costs associated with each. These multiplicative factors are applied to a benficiary's base risk factor, when appropriate. Table 9 describes the LTI and LIS multipliers. Table 10 provides the LTI and LIS factors.

Table 9. LTI and LIS Multipliers: 2006 – 2010 Payment Years

Multiplier	Description
General Rules	The demographic and disease factors are additive; the LTI and LIS factors are multipliers. After adding the demographic and disease factors for a total score in the base RxHCC model, the score is multiplied by the LTI or LIS factor, if applicable.
LTI	LTI factor is assigned to the risk scores of beneficiaries with 90 days of residence or greater in a nursing home and reported by the Minimum Data Set (MDS). LTI status is determined based on the data collection period. Accounts for higher overall spending because it is expected that the prices for specific packages of drugs beneficiaries receive are somewhat higher in the institution than the same drugs in the community.
LIS	Two LIS factors (full subsidy and partial subsidy) – one or the other is assigned to the risk score for enrollees based on their Part D determined LIS status. LIS status is determined during the payment year.

Table 10. LTI and LIS Factors: 2006 – 2010 payment years

Long-Term Institutional		Low Income	
Aged ≥ 65	Disabled < 65	Group 1 Full subsidy eligible	Group 2 Partial subsidy eligible (15%)
1.08	1.21	1.08	1.05

RxHCC Model Segments from 2011 to present:

- Aged, non-low income
- Aged, low income
- Disabled, non-low income

- Disabled, low income
- Institutional
- New Enrollee, non-low income
- New Enrollee, low income
- New Enrollee, institutional

70.4.2 - Low Income Status

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

From 2006 through 2010, the Part D risk adjustment model used a multiplier to adjust risk scores when the beneficiary had low income subsidy eligibility. Under the 2006-2010 RxHCC model, the multiplier differed if the beneficiary was full subsidy eligible or partial subsidy eligible. Starting in 2011, the Part D risk adjustment model no longer uses multipliers and instead uses a separate risk score for beneficiaries who have low income status. This new model applies an aged low income or disabled low income risk score when the beneficiary has either full or partial low income status and does not have long term institutional status. Low income status is determined as of the payment month.

70.4.3 - Long Term Institutional Status

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

From 2006 through 2010, the Part D risk adjustment model used a multiplier to adjust risk scores when the beneficiary enrolled in the Part D plan had Long Term Institutional status. Starting in 2011, the Part D risk adjustment model no longer uses multipliers and instead uses a separate risk score for beneficiaries who have LTI status. Regardless of payment year and risk model used, the Part D risk adjustment model will consider a beneficiary's LTI status in the payment year, not the data collection year; this approach more accurately reflects treatment patterns upon which costs are based.

CMS uses information from the Minimum Data Set (MDS), collected routinely from nursing homes, to identify the population of long-term institutionalized. MDS assessments are sent to CMS on at least a quarterly basis. CMS uses the presence of a 90-day assessment to identify the long-term residents for payment purposes. Payment using a long term institutional risk score will begin at the start of the month following the 90-day assessment. Once persons are so identified, they remain in long-term status until discharged to the community for more than fourteen days. The costs of the short term institutionalized (less than 90 days) are recognized in the community model.

At the final payment reconciliation that takes place post-contract year, CMS uses each beneficiary's actual month-by-month LTI status in the payment year to determine which risk score or multiplier to apply. Because CMS calculates initial and mid-year risk scores before it has complete data on beneficiaries' LTI status in the payment year, it uses the presence of a 90-day assessment reported for any one month during the 12-month data collection period as a proxy for LTI in the payment year.

MMR fields specific to LTI status.

- RA Factor Type Code (field 47; positions 189-90) – A value of "I" means that the enrollee has been institutionalized 90+ days as of the payment month.

- Part D Long Term Institutional Indicator (field 70; position 325) - Values are A (aged), D (disabled), or blank. The enrollee has been in an institution for 90+ days as of the payment month. The Part D LTI multiplier is applied on a concurrent basis and based on the person's current Medicare entitlement status (aged, or disabled). For example, "LTI Aged" means that an Aged (65+) beneficiary has a 90+ day assessment during the month that the LTI Aged multiplier was applied for payment.

70.5 - CMS RxHCC Risk Adjustment Model Compared with the CMS-HCC Risk Adjustment Model

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

This section describes the similarities and differences between the Part D RxHCC risk adjustment model and the Part C CMS-HCC risk adjustment model.

70.5.1 - Model Similarities

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The CMS-HCC and the CMS RxHCC risk adjustment models are constructed and calibrated using the same methodology and many of the same data sources.

Source of diagnoses: Individual ICD diagnosis codes, both for the calibration of the models, and to calculate risk scores for payment, are taken from FFS claims and MA-reported diagnosis data.

***Regression model to predict expenditures*:** The models for continuing enrollees and new enrollees are calibrated using a multiple regression analysis of actual expenditures. Both models predict benefit costs for which the plans are responsible for covering. The CMS-HCC model predicts full Part A and B Medicare expenditures. The RxHCC model predicts those expenditures for which Part D sponsors are responsible, i.e., drug costs excluding cost sharing amounts for which the enrollee or the government is responsible for paying. This RxHCC model is sometimes referred to as the plan liability model, to distinguish it from the total spending model, which has been calibrated for analytic purposes only.

Additive and hierarchical model: The two models generate enrollee risk scores by adding relative risk weights for individual risk markers that have been assigned to the beneficiary. This allows more than one disease to impact the final risk score. Both of the models use diagnostic hierarchies. Hierarchies prevent multiple diagnoses in the same

disease group from inappropriately increasing the risk score. In this way, someone with metastatic cancer and breast cancer receives credit only for the former, rather than both. This is clinically appropriate and lessens the impact of variations in diagnosis coding completeness.

***Used to adjust capitated payment amounts*:** Risk adjustment is intended to adjust capitated payment amounts to pay plans fairly and accurately, thereby decreasing incentives for health plans to avoid enrolling sicker beneficiaries. Both of these models adjust standardized payments for the underlying health status of the beneficiaries enrolled in the plan. The RxHCC model adjusts the monthly Part D direct subsidy. The CMS-HCC model adjusts Part C monthly payments to Medicare Advantage plans and PACE organizations.

Risk scores are relative and reflect the standard benefit: Each beneficiary's risk score is calculated to estimate that specific beneficiary's expected costs, relative to the average beneficiary. For each model, a risk score of 1.0 reflects the Medicare-incurred expenditures of an average beneficiary. An RxHCC risk score of 1.0 indicates the beneficiary is expected to incur the average liability amount for prescription drugs when covered by the standard Part D Medicare benefit. A CMS-HCC risk score of 1.0 indicates the beneficiary is expected to incur the average Medicare program expenditure for Parts A and B services.

70.5.2 - Model Differences

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

While both the CMS-HCC and the RxHCC models use health status (diagnoses) to predict expenditures, the total expenditures that each model is predicting are quite different (medical versus prescription drug) and, therefore, may result in different weights on similar HCCs, as well as different risk scores for an individual beneficiary.

Risk adjustment attempts to account for the differences in expenditures incurred by a plan due to differences in the health status of the beneficiaries enrolled in the plan. Since the impact of health status factors, and the benefit design, are different between Parts C and D, two risk adjustment models have been designed.

80 - Frailty Adjuster

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The Balanced Budget Act of 1997 (BBA) mandated that Medicare capitated payments to Program of All-Inclusive Coverage for the Elderly (PACE) organizations be based on MA payment rates, adjusted to account for the comparative frailty of PACE enrollees. The frailty adjuster is included as part of risk adjusted payments for PACE organizations and, between 2004 and 2011, for certain demonstration organizations.

The frailty adjustment approach that was implemented in 2004 is to be applied in conjunction with the CMS-HCC risk adjustment model. Risk adjustment predicts (or

explains) the future Medicare expenditures of individuals based on diagnoses and demographics. But risk adjustment may not explain all of the variation in expenditures for frail community populations. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by risk adjustment.

CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model on counts of activities of daily living (ADLs). CMS uses the number of functional limitations represented by the Activities of Daily Living (ADL) scale to calibrate the frailty model and then to determine the relative organization-level frailty of those in the community that are 55 years of age and older. There are six ADLs:

- Bathing and showering
- Dressing
- Eating
- Getting in or out of bed or chairs
- Walking
- Using the toilet

CMS obtains ADLs from surveys of the general Medicare population. The frailty model used during payment years 2004-2007 was calibrated using ADLs from the Medicare Current Beneficiary Survey (MCBS). The frailty model used 2008 onward was calibrated using ADLs from the Fee-For-Service (FFS) Consumer Assessment of Health Providers & Systems (CAHPS).

The MCBS is a face-to-face survey, while the FFS CAHPS data is a mail survey with a telephone follow-up. By using the FFS CAHPS ADL results to calibrate the frailty factors, CMS uses methodologically-similar surveys for both calibrating the frailty model and for calculating annual frailty scores. The annual frailty scores are calculated using results from the Health Outcomes Survey – Modified (HOS-M), which is an anonymous mail-in survey with telephone follow-up.

In addition, the CAHPS frailty calibration sample is much larger than the MCBS sample. The CAHPS data can better determine the relationship between frailty and costs given Medicaid and non-Medicaid status in the general Medicare population. As a result, starting in 2008, the frailty model includes separate factors for Medicaid and non-Medicaid beneficiaries. The result is more accurate payment because Medicaid and non-Medicaid frail populations show differences in the relationships between unexplained expenditures (in the CMS-HCC model) and functional impairments.

Contract-level frailty scores are calculated by multiplying the proportion of respondents in each ADL category by the factor for that category, and then summing the products across each category. In some cases, a transition blend or phase out factor has been used

(see below) to transition from one frailty model to another. See below for examples of calculations of frailty scores.

At payment, CMS adjusts the payment for an enrollee in an eligible organization, if that beneficiary is age 55 and over, and living in the community. Because the CMS-HCC model has been designed to pay appropriately for the long-term institutionalized population, frailty adjustments are added to the risk scores only for community-based and short-term institutionalized enrollees (i.e., the frailty adjustment for long-term institutionalized enrollees is zero).

For PACE organizations and demonstrations between 2004 and 2011, the frailty score that is added to the beneficiary's risk score is calculated at the contract-level, using the aggregate counts of ADLs among survey respondents enrolled in a specific organization. Updated frailty factors are published in the Rate Announcement for the payment year in which they are first used.

Example – how to calculate a frailty score:

CMS calculates PACE organizations' frailty scores at the contract level. Below is an example of the calculation of a PACE frailty score for payment year 2009.

Frailty factors used to calculate 2009 frailty scores for PACE organizations:

	2007	2009	
		Non-Medicaid	Medicaid
0 ADLs	-0.141	-0.093	-0.180
1-2 ADLs	0.171	0.112	0.035
3-4 ADLs	0.344	0.201	0.155
5-6 ADLs	1.088	0.381	0.200

The following table provides an example of results from the Health Outcome Survey-Modified (HOS-M) for a sample PACE organization:

ADL count among respondents to HOS-M	Medicaid	Non-Medicaid	Total
0	13	15	28
1-2	35	32	67
3-4	40	22	62
5-6	36	33	69
Total respondents			226

1. Calculate the organization's frailty score using 2007 frailty factors

Frailty score =
28/226*(-0.141) + 67/226*(0.171) + 62/226*(0.344) + 69/226*(1.088)
=0.460

2. Calculate the organization's frailty score using the 2009 frailty factors:

Frailty score =
13/226*(-0.180) + 15/226*(-0.093) + 35/226*(0.035) + 32/226*(0.112) +
40/226*(0.155) + 22/226*(0.201) + 36/226*(0.200) + 33/226*(0.381)
=0.139

3. Calculate blended frailty score for use in payment:

2009 blend: 70% of the frailty score calculated using pre-2008 frailty factors and 30% of the frailty score calculated using 2009 frailty factors
Frailty score for payment = 0.460*0.7 + 0.139 * 0.3 = 0.364

Example – how to calculate payment with a frailty adjustment

For calendar year 2009, a PACE member resides in the community and is aged 82. The payment to the PACE organization will be calculated with a risk score that is the sum of the regular CMS-HCC risk score plus the organization's frailty score.

Beneficiary's risk score = 2.3
PACE organization's frailty score = 0.364
Risk score used in payment for the beneficiary = 2.664 = 2.3 + 0.364

Frailty Adjustment Transition for PACE Organizations

PACE Organizations are transitioning from the pre-2008 frailty model to the updated frailty model from 2008-2012 payment years. Frailty adjustment will be applied to payment to PACE organizations using the transition schedule published in the 2008 – 2011 Rate Announcements. The full transition schedule is as follows:

- In 2008 (year 1): 90% of the frailty score calculated using the pre-2008 frailty factors and 10% of the frailty score calculated using the 2008 frailty factors.
- In 2009 (year 2): 70% of the frailty score calculated using the pre-2008 frailty factors and 30% of the frailty score calculated using the 2009 frailty factors.
- In 2010 (year 3): 50% of the frailty score calculated using the pre-2008 frailty factors and 50% of the frailty score calculated using the 2009 frailty factors.
- In 2011 (year 4): 25% of the frailty score calculated using the pre-2008 frailty factors and 75% of the frailty score calculated using the 2009 frailty factors.
- In 2012 (year 5): 100% of the most recently calibrated frailty factors.

Frailty Adjustment Transition for Certain Demonstrations

Frailty adjustments will be applied to payments for certain MA plan types using a phase-out schedule between 2008 and 2012. For 2008 – 2010, plans that were participating in the following demonstrations received frailty payments under the schedule below: Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans. For 2011, a subset of these plans continued to receive frailty payments. The full phase out schedule is as follows:

- In 2008: 75% of the frailty score calculated using the pre-2008 frailty factors.
- In 2009: 50% of the frailty score calculated using the pre-2008 frailty factors.
- In 2010: 25% of the frailty score calculated using the pre-2008 frailty factors.
- In 2011: 25% of the frailty score calculated using the pre-2008 frailty factors.
- In 2012: 0% paid under demonstration authority

90 - Normalization Factor

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Each time CMS calibrates a risk adjustment model, it will produce a fixed set of dollar coefficients that are appropriate to the population and data for that calibration year. When CMS divides the dollar coefficients by the average expected expenditures in a given year, CMS converts the dollar coefficients into relative factors in such a way that CMS ensures that the average risk score in the denominator year is 1.0. When the model with fixed coefficients is used to predict risk scores for other years, predictions for prior years are less than 1.0 and predictions for succeeding years are higher than 1.0. Because average predicted FFS risk scores increase after the model calibration year due to coding and population changes, CMS applies a normalization factor to adjust beneficiaries' risk scores so that the average risk score is 1.0 in subsequent years.

The normalization factor is calculated by first using the model to predict risk scores for the FFS population over a number of years. Next, CMS estimates the annual average trend in the risk scores over these years. This annual trend is then compounded by the number of years between the model denominator year and the payment year to produce the normalization factor for the payment year.

CMS uses a standard of five years of data in the normalization trend. Each year, CMS drops the earliest year and adds a new year of risk scores to the trend data to create the five-year dataset. By using a standard number of years, CMS calculates risk score trends based on recent trends in coding, while maintaining stability in the year-to-year trends used.

Normalization factors are downward adjustments to risk scores and are applied to risk scores when they are calculated (prior to 2007, CMS applied the normalization factor to the ratebook). Risk scores on the Monthly Membership Report (MMR) are always normalized. Each year's normalization factors are announced in that year's Rate

Announcement, published in April prior to the payment year. Table 11 supplies the normalization factor by payment year.

Table 11. Normalization factors used in payment years

	CMS-HCC	RxHCC	Dialysis/Transplant	Functioning Graft
2007	1.029	NA	NA	1.029
2008	1.040	1.065	1.010	1.040
2009	1.030	1.085	1.019	1.058
2010	1.041	1.146	1.039	1.072
2011	1.058	1.029	1.060	1.088

100 - MA Coding Adjustment

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Because CMS calibrates the CMS-HCC model using FFS data, the relative factors reflect the FFS pattern of coding. CMS adjusts for the trend in the rate of increase of diagnosis codes submitted by FFS providers with the application of a normalization factor that is updated annually and that reduces risk scores with the goal that the average remains 1.0 in each payment year. Because MA coding patterns differ from those in FFS, MA risk scores increase more quickly and are, therefore, higher than they would be if MA plans coded in the same manner as FFS providers.

Beginning in 2010, CMS instituted a separate adjustment to the Part C risk scores to account for differential coding patterns between MA and FFS. The adjustment for 2010 of 3.41% was based on our estimate of how much lower plans' 2010 risk scores would have been if the disease scores (the portion of the risk score attributable to diagnostic coding) for MA enrollees who stayed in an MA plan during the period 2007 to 2010 ("MA stayers") had grown at the same rate as FFS beneficiaries' risk scores during this period. In calculating the adjustment for MA coding differences, CMS removed the impact of differences in rising risk scores that are attributed to enrollment into and disenrollment out of MA plans, aging and other demographic changes, and adjusted for age and sex effects on disease coding changes. For a description of the coding adjustment for 2011-2013 please see the 2010 Rate Announcement.

110 - Risk Adjustment Process and Payment

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The risk adjustment process incorporates demographic and diagnostic data.

Demographic data includes:

- HICN, age, original reason for entitlement (e.g., disability), and Medicaid status
- Long Term Institutional status
- Primary payer information

- ESRD status

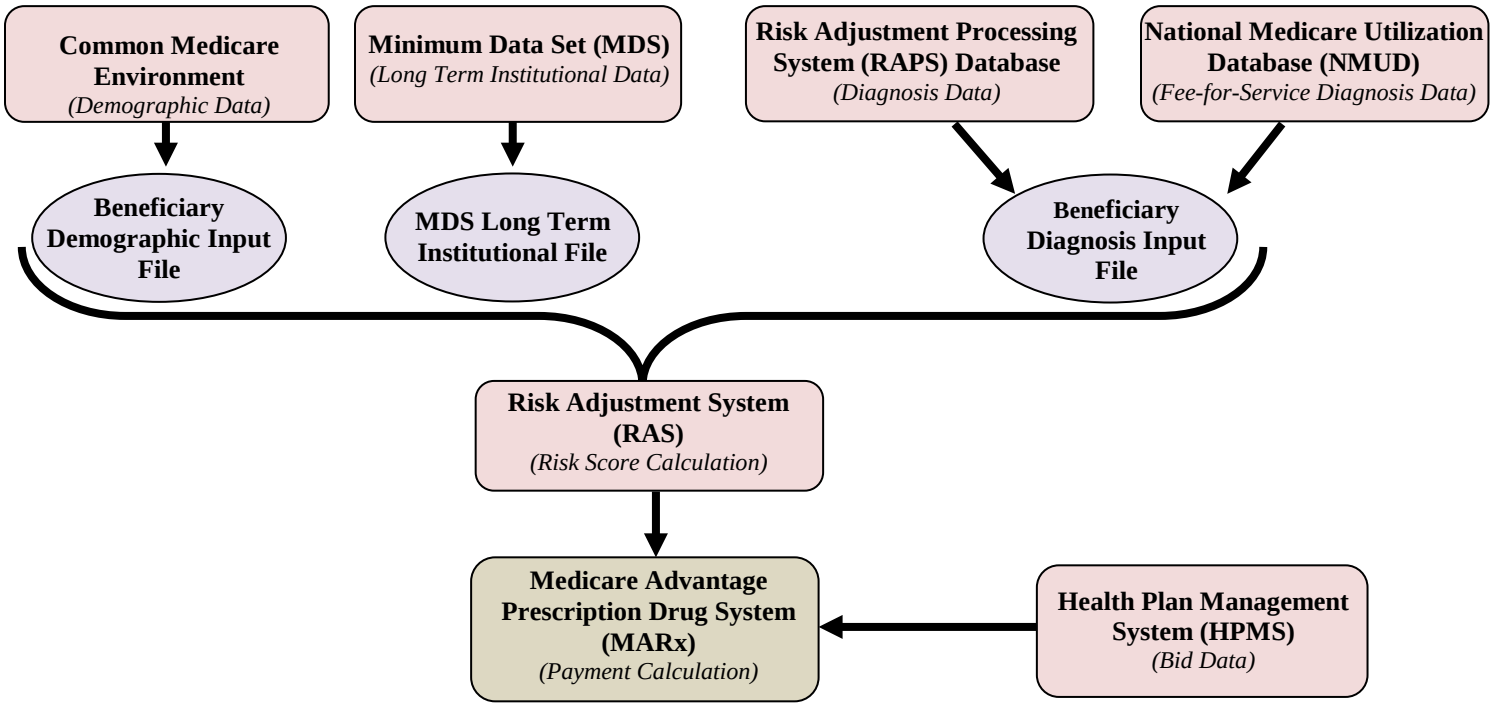
Diagnostic Data is used in risk score calculations and is obtained from both plans and FFS providers.

- The **Risk Adjustment Processing System (RAPS) Database** contains the diagnostic data submitted by Medicare Advantage plans, PACE organizations, and cost plans.
- The **National Medicare Utilization Database (NMUD)** contains the diagnostic data submitted by fee-for-service providers.

The Risk Adjustment System (RAS) calculates risk scores for all Medicare beneficiaries, which are sent to the payment system for use in calculating payment.

Figure 1 illustrates the systems and databases that provide data used in risk score calculations and ultimately in payment calculations in MARx. The components of the process are described in further detail throughout the chapter.

Figure 1. Risk Adjustment Payment Process



120 - Operations

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS requires Medicare Advantage plans to collect hospital inpatient, hospital outpatient, and physician risk adjustment data and submit the data to CMS at least quarterly for calculation of the risk score for use in the payment calculation and payment reconciliation. Each quarterly submission should represent approximately one-fourth of the data a plan submits during a data collection year.

Once plans have collected the data and verified the data came from an acceptable data source, the plans submit the data using the Risk Adjustment Processing System (RAPS) format and provide the five required data elements in the cluster. Table 12 lists the five required elements and a description for each.

Table 12. Five Required Data Elements/Descriptions

Required Data Element	Description
Health Insurance Claim (HIC) Number	Beneficiary identification number issued by the Railroad Retirement Board (RRB) or the Social Security Administration (SSA).
Diagnosis code	*International Classification of Diseases (ICD)* codes are used to describe the clinical reason for a patient's treatment.
Service from date	The dates of service define when a beneficiary received medical treatment from a physician or medical facility. For outpatient and physician services, the From Date and Through Date may be identical. For inpatient services, these dates are usually different from each other, and reflect the dates of admission to and discharge from a facility.
Service through date	
Provider type	The types of providers, for the purpose of risk adjustment, MA organizations must collect data from are: • Hospital Inpatient facilities • Hospital outpatient facilities • Physicians

Plans submit the five data elements in the RAPS format (or the Direct Data Entry, an online data entry application for the RAPS format) to the Front End Risk Adjustment System (FERAS) for initial edit checks. FERAS transmits files successfully passing the initial edit checks to RAPS for detailed editing and processing.

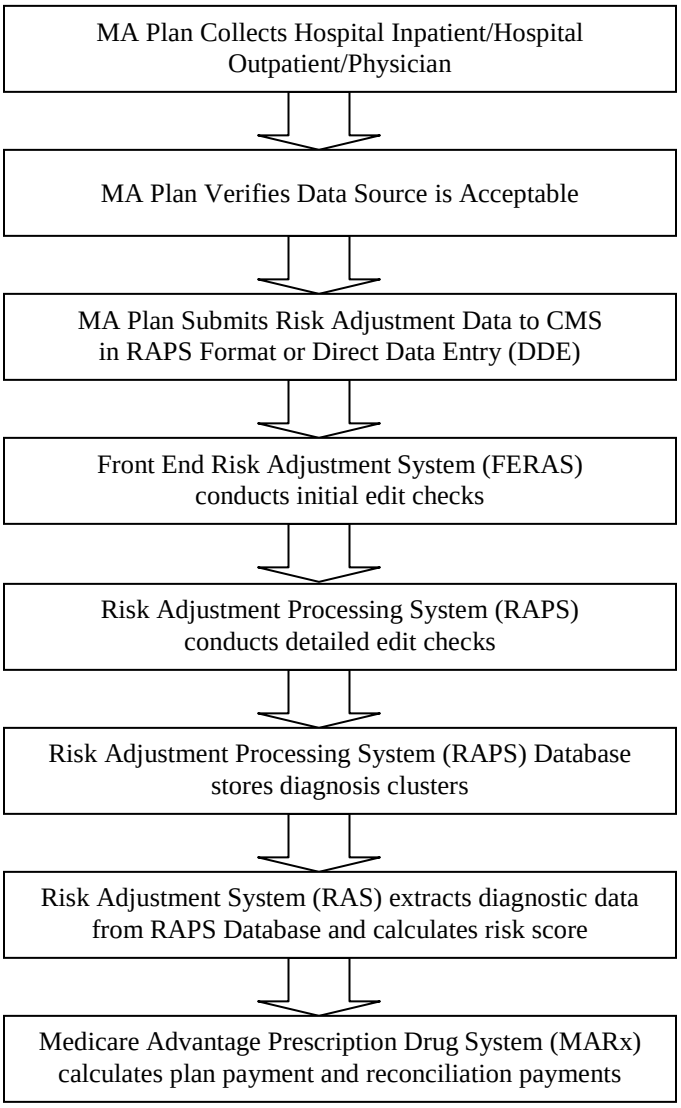
The FERAS and RAPS systems generate Transaction Reports describing the status of the transaction and any errors that occurred during processing. RAPS also provides Management Reports that identify the disposition of the submitted data so plans can verify their data and project their payment.

Finalized diagnosis clusters are stored in the RAPS database and used for calculation of risk scores. The Risk Adjustment System (RAS) extracts the diagnostic data from the RAPS database to calculate risk scores by executing the CMS-HCC payment model.

RAS sends the risk scores to the Medicare Advantage Prescription Drug System (MARx) for use in calculation of plan payments and payment reconciliation.

Figure 2 illustrates the risk adjustment collection, submission, and payment process.

Figure 2. Operations Overview



120.1 - Data Collection to Support Risk Adjustment
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

According to 42 CFR 422, MA organizations must collect and submit to CMS the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

120.1.1 - Sources of Data
(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS requires that MA organizations collect data for the purposes of risk adjustment from the following provider types:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians

Unacceptable Data Sources

It is important for MA organizations to note that regardless of the type of diagnostic radiology bill (outpatient department or physician component), the diagnostic data associated with these services are not acceptable for risk adjustment. Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and is, therefore, not assigned in the medical record documentation from diagnostic radiology services alone.

Excluded Providers

Medicare will not pay for items or services rendered to beneficiaries and recipients by an excluded provider or by entities owned or managed by an excluded provider. Therefore, MA organizations should not submit risk adjustment data if it was submitted by an excluded provider. Providers are excluded for the following reasons: a program related crime, patient abuse or neglect, health care fraud in any health care program, and convictions relating to controlled substances.

The HHS monthly exclusion notification can be found at http://oig.hhs.gov/fraud/exclusions.asp.

Hospital Inpatient

A hospital inpatient service is one provided by a hospital during which a patient is admitted to the facility for at least one overnight stay. Table 13 identifies covered and non-covered facilities with regard to risk adjustment diagnoses data collection.

Table 13. Hospital Inpatient Sources of Diagnostic Data

RAPS Provider Type	Covered Facilities	Non-Covered Facilities*
Hospital Inpatient	Short-term (general and specialty) Hospitals Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) Long-term Hospitals Rehabilitation Hospitals Children's Hospitals Psychiatric Hospitals Medical Assistance Facilities/ Critical Access Hospitals	Skilled Nursing Facilities (SNFs) Hospital Inpatient Swing Bed Components Intermediate Care Facilities Respite Care Hospice

*These are examples of non-covered facilities and not a comprehensive list.

NOTE: When submitting hospital inpatient data, MA organizations must make a distinction between the principal diagnosis and other diagnoses. Section 120.2 Submission and Flow of Risk Adjustment Data covers the details of submitting data.

Hospital Outpatient

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization.

Table 14 identifies covered and non-covered hospital outpatient facilities. MA organizations should refer to this table with regard to risk adjustment data collection.

Table 14. Outpatient Sources of Diagnostic Data

RAPS Provider Type	Covered Facilities	Non-Covered Facilities*

<table>
<tr><th>RAPS Provider Type</th><th>Covered Facilities</th><th>Non-Covered Facilities*</th></tr>
<tr><td rowspan="3">Hospital Outpatient</td><td>Short-term (general and specialty) Hospitals
Medical Assistance Facilities/Critical Access Hospitals
Community Mental Health Centers 1**
Federally Qualified Health Centers 2/ Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) **
Long-term Hospitals
Rehabilitation Hospitals
Children’s Hospitals
Psychiatric Hospitals
Rural Health Clinic (Free-standing and Provider-Based) 3**</td><td>Free-standing Ambulatory Surgical Centers (ASCs)
Home Health Care
Free-standing Renal Dialysis Facilities</td></tr>
<tr><td colspan="2">Non-Covered Services</td></tr>
<tr><td>Laboratory Services
Ambulance
Durable Medical Equipment
Prosthetics</td><td>Orthotics
Supplies
Radiology Services</td></tr>
</table>

* These are examples of non-covered facilities and are not to be considered a comprehensive list.

** Facilities use a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

1. Community Mental Health Centers (CMHCs) provide outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC’s mental health services area who have been discharged from inpatient treatment at an inpatient facility.

2. Federally Qualified Health Centers (FQHCs) are facilities located in a medically underserved area that provide Medicare beneficiaries with preventive primary medical care under the general direction of a physician.

3. Rural Health Clinics (RHCs) are Medicare certified facilities that are located in a rural, medically underserved area that provide ambulatory primary medical care under the general direction of a physician.

Determining Whether Facilities Are Acceptable for Risk Adjustment – MA organizations are responsible for ensuring that data collected and submitted to CMS are acceptable for the risk adjustment process. However, the NPI does not convey information regarding the type of facility or provider specialty, so a new code called the "taxonomy code" can be used to help identify types of providers. Both the legacy provider number and the taxonomy code can be used in determining the appropriateness of the covered hospital entities for the purposes of risk adjustment data collection. Table 15 illustrates the steps MA organizations may use to identify the provider numbers or taxonomy codes for facilities.

Table 15. Determining Covered Hospital Entity Provider Numbers

Situation	Issue	Action
Situation 1	The CCN or taxonomy code is identified.	Determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data.
Situation 2	An in-network provider submitted a claim but did not include any provider number or taxonomy code.	Obtain the provider number or taxonomy code and then determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data. NOTE: All network providers are required to have provider numbers or taxonomy codes; therefore, do not submit risk adjustment data for this provider until these numbers are obtained.
Situation 3	An out-of-network provider submits a claim without a provider number.	Plans must obtain a provider number or taxonomy code.

National Provider Identifier – MA organizations should verify that diagnoses are collected from Medicare certified hospitals/facilities and that data from all Medicare certified network hospital/facilities include the associated Medicare provider identifiers (NPI and taxonomy code; or the legacy provider number). They should also verify that the Medicare certified hospitals/facilities providing the data are from acceptable facilities and services. As stated above, plans may use either the Medicare provider numbers or the taxonomy code to determine if facilities and services are acceptable for risk adjustment.

Plan sponsors may wish to create a system for checking if the data are from acceptable facilities and for acceptable services. They may check the legacy provider number

against the provider number ranges or check the taxonomy code against the taxonomy code ranges, both of which identify what type of service has been rendered.

- If using the legacy provider number, please note that it has six characters.
    - The first two characters are numerals and represent the state/territory as illustrated in Table 16.

Table 16. Provider Number State Assignments

State	Code	State	Code	State	Code
Alabama	01	Kentucky	18	Oklahoma	37
Alaska	02	Louisiana	19	Oregon	38
American Samoa	64	Maine	20	Palau	N/A
Arizona	03	Maryland	21	Pennsylvania	39
Arkansas	04	Massachusetts	22	Puerto Rico	40
California	05	Michigan	23	Rhode Island	41
Colorado	06	Minnesota	24	South Carolina	42
Connecticut	07	Mississippi	25	South Dakota	43
Delaware	08	Missouri	26	Tennessee	44
District of Columbia	09	Montana	27	Texas	45
Florida	10	Nebraska	28	Utah	46
Georgia	11	Nevada	29	Vermont	47
Guam	65	New Hampshire	30	Virgin Islands	48
Hawaii	12	New Jersey	31	Virginia	49
Idaho	13	New Mexico	32	Washington	50
Illinois	14	New York	33	West Virginia	51
Indiana	15	North Carolina	34	Wisconsin	52
Iowa	16	North Dakota	35	Wyoming	53
Kansas	17	Ohio	36		

    - The third character may be a numeral or a letter. Provider numbers with a **U, W, Y, Z, 5,** or **6** in the third character indicate that the service was provided in a swing bed component of a hospital or a skilled nursing facility, which, are not covered entities. The last three characters are numerals unique to the facility.

- If using the taxonomy code, the bill type will be needed to identify if the service was provided by a non-covered entity such as a swing bed component of a hospital or a skilled nursing facility.

As an additional check, refer to Tables 17 and 18, which provide the only acceptable ranges for hospital facilities. The tables reflect the range of legacy provider numbers for

risk adjustment covered hospital entities. Risk adjustment data are not acceptable when received from facilities with numbers outside the ranges.

NOTE: Skilled nursing facilities, home health care, and hospital inpatient swing bed components are not covered entities for risk adjustment data.

Table 17. Hospital Inpatient Covered Entities

Type Of Hospital Inpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Religious Non-Medical Health Care Institutions	XX1990-XX1999	TOB 4XX
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

Table 18. Hospital Outpatient Covered Entities

Type Of Hospital Outpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Community Mental Health Centers	XX1400-XX1499 XX4600-XX4799 XX4900-XX4999	TOB 76X
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions	XX1800-XX1999	TOB 73X for FQHC TOB 4XX for RNHCI
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X

Type Of Hospital Outpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
Rural Health Clinics, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999	TOB 71X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

The implementation of the NPI did not change the valid Hospital Inpatient and Outpatient facilities for submission of risk adjustment data nor eliminate the process for receiving and verifying information from Medicare health care providers that are in network. Institutional providers that currently bill Medicare using more than one legacy identifier in order to identify subparts of their facility are required to submit a taxonomy code on all of the claims they submit to Medicare.

The Health Care Provider Taxonomy Code Set website, http://www.wpc-edi.com/codes/taxonomy, serves as a reference to types of facilities and taxonomy codes.

The American Hospital Directory website, http://www.ahd.com/freesearch.php3, serves as a reference for hospital provider numbers.

Physician

The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all diagnoses that are in the risk adjustment model and rendered as a result of a physician visit must be collected by the MA organization. This includes data collected from non-network as well as network physicians.

Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).

Only those physician specialties and other clinical specialists identified in Table 19 are acceptable for risk adjustment.

Table 19. Acceptable Physician Specialty Types
Payment Year 2011 (dates of services 2010)

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	26	Psychiatry	67	Occupational Therapist
2	General Surgery	27**	Geriatric Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	28	Colorectal Surgery	72*	Pain Management
4	Otolaryngology	29	Pulmonary Disease	76*	Peripheral Vascular Disease
5	Anesthesiology	33*	Thoracic Surgery	77	Vascular Surgery
6	Cardiology	34	Urology	78	Cardiac Surgery
7	Dermatology	35	Chiropractic	79	Addiction Medicine
8	Family Practice	36	Nuclear Medicine	80	Licensed Clinical Social Worker
9**	Interventional Pain Management (IPM)	37	Pediatric Medicine	81	Critical care (intensivists)
10	Gastroenterology	38	Geriatric Medicine	82	Hematology
11	Internal Medicine	39	Nephrology	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	40	Hand Surgery	84	Preventive Medicine
13	Neurology	41	Optometry	85	Maxillofacial Surgery
14	Neurosurgery	42	Certified Nurse Midwife	86	Neuropsychiatry
15	Speech Language Pathologist	43	Certified Registered Nurse Anesthetist	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	44	Infectious Disease	90	Medical Oncology
17**	Hospice And Palliative Care	46*	Endocrinology	91	Surgical Oncology
18	Ophthalmology	48*	Podiatry	92	Radiation Oncology
19	Oral Surgery	50*	Nurse Practitioner	93	Emergency Medicine
20	Orthopedic Surgery	62*	Psychologist	94	Interventional Radiology
22*	Pathology	64*	Audiologist	97*	Physician Assistant
24*	Plastic And Reconstructive Surgery	65	Physical Therapist	98	Gynecologist/Oncologist
25	Physical Medicine And Rehabilitation	66	Rheumatology	99	Unknown Physician Specialty

* Indicates that a number has been skipped.
** Added effective January 1, 2010 dates of service

120.2 - Submission and Flow of Risk Adjustment Data
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The following outlines the flow of risk adjustment data:

- Hospital/Physician submits data to MA organization using standard claims formats, or through review of medical records.
- The MA organization submits required data at least quarterly to FERAS via Direct Data Entry (DDE) or RAPS format.
- FERAS checks the file-level data, batch-level data, and first and last detail records on each Batch Record within the file.
- If any data are rejected, the rejections are reported on the FERAS Response Report.
- After passing the FERAS checks, the file is submitted to RAPS where detail editing is performed and applicable reports are generated.
- The RAPS Return File contains the entire submitted transaction and identifies errors.
- The RAPS Transaction Error Report communicates errors found in CCC records during processing.
- The RAPS Transaction Summary Report summarizes the disposition of the diagnosis clusters.
- The Duplicate Diagnosis Cluster Report identifies diagnosis clusters with the 502- error message. Duplicate clusters are accepted but not stored.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report provides a summary of the status of submissions by submitter ID and plan number.
- Distributed monthly and quarterly, the Error Frequency Report provides an overview of all errors associated with files submitted in test and productions.
- RAPS database stores all finalized diagnosis clusters.
- RAS calculates the Risk Adjuster Factors by executing the CMS-HCC model.
- MARx is used in the calculation of payments and determination of plan payments.

120.2.1 - Data Exchange Requirements
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

Prior to submitting risk adjustment data to CMS, CMS requires MAOs to:

- Complete and submit an Electronic Data Interchange (EDI) Agreement to the Customer Service and Support Center (CSSC) within 1 month of their contract's HPMS effective date.
    - The EDI Agreement is a contract between the MAO and CMS attesting to the accuracy of the data submitted.
    - An officer (e.g., CEO) that represents the MAO must sign the EDI Agreement
- Submit test data within three months of the HPMS effective date.
- Submit production files within four months of the HPMS effective date and continue to submit at least one time per quarter.

If the MAO uses a third party submitter:

- A Letter of Authorization on company letterhead from the plan is required indicating that the third party vendor is going to submit on their behalf.
- The MAO must complete the EDI Agreement.
- The third party submitter must complete the Submitter ID Application Form.

If the MAO establishes a new contract number, the MAO must submit a new EDI agreement. If the submitter's system successfully submitted test data previously, CMS does not require additional testing.

Note: CMS holds the MA organization accountable for the content of submissions regardless of who submits the data.

120.2.2 - Format

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

In accordance with CMS' 2008 Call Letter, MA organizations must submit risk adjustment data electronically using one of two formats to enable CMS to more efficiently process the data at CSSC and ensure appropriate payment under the risk adjustment payment models. MA organizations must submit data electronically using either the RAPS format or the Direct Data Entry (DDE) option. Both of these formats are used for all provider types.

Table 20 describes each field of the current RAPS file layout.

- The shaded fields in the table represent where the RAPS Return File provides new information after data processes through RAPS.

There are two diagnosis cluster error fields because MA organizations can receive up to two errors on any diagnosis cluster.

Table 20. RAPS File Layout

RAPS RECORD AAA – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	File-level information that identifies the submitter. This field should always be populated with "AAA."
2	4-9	Required	Submitter ID	Identifies the submitter and should be populated with the six-digit alphanumeric SH# assigned by CSSC.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. This file name may not be repeated within a 12-month period.
4	20-27	Required	Transaction Date	Specifies the date that the file was submitted to Palmetto and formatted as CCYYMMDD.
5	28-31	Required	Production Test Indicator	Must be populated with "PROD" or "TEST." Submission test data proceeds through the entire process.
6	32-512	Spaces	Filler	Must be populated with 481 spaces. The "Filler" field allows for additional fields in the future.

RAPS RECORD BBB – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Batch-level information that identifies the MA organization is populated with "BBB."
2	4-10	Required	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one. This is a numeric field.
3	11-15	Required	Plan Number	Identifies the MA organization and should be populated with the five-digit

RAPS RECORD BBB – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
				alphanumeric contract assigned by CMS. (H#, R#, etc.).
4	16-512	Spaces	Filler	Must be populated with 497 spaces. The "Filler" field allows for additional fields in the future.

Table 20. RAPS File Layout (Continued)

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Detail-level information that identifies the beneficiary information. This field should always be populated with "CCC."
2	4-10	Required	Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field. Limited to 1,000,000 per day.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the sequence number, or will remain blank if no errors were detected in the sequence number.
4	14-53	Optional	Patient Control Number	This optional field may be used by the MA organization to identify the claim submitted. The field allows up to 40 alphanumeric characters.
5	54-78	Required	HIC	The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces, not zeros, in unused spaces.
6	79-81	RAPS RETURN	HIC Error Code	This should be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the HIC number, or remains blank if no errors were detected in the HIC number.
7	82-89	Optional	Patient DOB	This optional field may be populated with the patient's date of birth and is used to verify that the correct beneficiary identification was submitted. If the field is populated, it must be formatted as CCYYMMDD, and CMS edits this field against the information on file at the MBD. If no DOB is submitted, fill with spaces.
8	90-92	RAPS RETURN	DOB Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error with DOB, or remains blank if no errors were detected in the DOB.

Table 20. RAPS File Layout (Continued)

RAPS RECORD CCC – DETAIL LEVEL (CONTINUED)				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
9	93-412	DIAGNOSIS-CLUSTER (10 occurrences)		The following 8 fields (9.0-9.7) may be repeated 10 times in the same "CCC" record with one diagnosis per cluster. Each diagnosis cluster must contain 32 characters or spaces. Plans must not skip clusters when submitting active diagnosis codes. If there are less than 10 diagnosis clusters the remaining clusters are space filled. If there are more than 10 diagnoses, a new "CCC" record must be established.
9.0		Required	Provider Type	This 2-digit alphanumeric field identifies the site of service provided (01,02,10,20).
9.1		Required	From Date	For hospital inpatient this describes the admission date. For physician and hospital outpatient this describes the date of service. Must be formatted as CCYYMMDD.
9.2		Required	Through Date	For hospital inpatient this describes the discharge date. For physician and hospital outpatient this may be left blank and the system will fill with the "From Date." Must be formatted as CCYYMMDD.
9.3		Conditional	Delete Indicator	This field allows the MA organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. Enter a "D" or space.
9.4		Required *when ICD-9-CM is used*	Diagnosis *Code or Filler*	This field is populated with the three-to five-digit ICD-9-CM diagnosis code. The decimal is implied and should not be included (e.g., 42732). *Fill with spaces when ICD-9-CM is not used. Left justify.*
9.5		*Required when ICD-10-CM is used*	Diagnosis Code *or* Filler	*This field is populated with the three-to seven-digit ICD-10-CM diagnosis code. The decimal is implied and should not be included (e.g., 4273432).* *Fill with spaces when ICD-10-CM is not used. Left justify*
9.6		RAPS RETURN	Diagnosis Cluster Error 1	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
9.7		RAPS RETURN	Diagnosis Cluster Error 2	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
19	413-437	RAPS RETURN	Corrected HIC number	This field must be submitted with spaces. If the MA organization has submitted an outdated HIC, upon return, this field is populated with the most current HIC number and the "HIC Error" field contains an information error code.

RAPS RECORD CCC – DETAIL LEVEL (CONTINUED)				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
20	438-512	Spaces	Filler	Must be populated with 75 spaces. The "Filler" field allows for additional fields in the future.

Table 20. RAPS File Layout (Continued)

RAPS RECORD YYY – BATCH TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
1	1-3	Required	Record ID	Batch trailer information should be populated with "YYY."
2	4-10	Required	Sequence Number	A 7-digit numeric character identifying the batch submitted. Must match the "BBB" record.
3	11-15	Required	"H" Number	"H" number assigned by CMS to identify the MA organization. Must match the "H" number in the corresponding "BBB" record (i.e., the "BBB" record with the same sequence number).
4	16-22	Required	CCC Record Total	This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001). Limited to 1,000,000 per day.
5	23-512	Spaces	Filler	Must be populated with 490 spaces. The "Filler" field allows for additional fields in the future.

RAPS RECORD ZZZ – FILE TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
1	1-3	Required	Record ID	File Trailer Information should be populated with "ZZZ."
2	4-9	Required	Submitter ID	Identifies the submitter and must match the 6-digit alphanumeric SH# in the AAA record.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. Must match the File ID in the "AAA" record.
4	20-26	Required	BBB Record Total	This field should total the number of batches in the file. This field is

RAPS RECORD ZZZ – FILE TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
				numeric and should be filled with leading zeros (e.g., 0000001).
5	27-512	Required	Filler	Must be populated with 486 spaces. The "Filler" field allows for additional fields in the future.

Data must be submitted as described in the tables above. When data is entered improperly, the plan receives errors as the data is processed through FERAS or RAPS. If errors are discovered in FERAS, the file will be returned to the plan. Job aids with list of FERAS and RAPS error codes are available at http://www.csscoperations.com. Once at the web site, select "Training Information," then select the latest "Risk Adjustment Training Information" link, and then select "Job Aides."

120.2.3 - Diagnosis Cluster

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The diagnosis cluster contains the core information regarding each diagnosis submitted by an MA organization. The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- Delete Indicator
- Diagnosis Code

A maximum of 10 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above. If any of these attributes are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur.

ICD-9-CM Diagnosis Codes - International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment *for inpatient discharges before the ICD-10 implementation date and for outpatient and physician services before that date*. Diagnosis codes describe the patient's medical condition, not the service performed. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations.

ICD-10-CM will be used for inpatient discharges and for outpatient and physician services on or after the ICD-10 implementation date. ICD-10-CM codes are 3-7 digit codes.

Service From and Through Dates – Defines the start and end dates for a provided service. The correct submission format for the "From" and "Through" dates of service is CCYYMMDD. The "Through Date" defines the data used in the data collection year for risk adjustment purposes. Table 21 describes the "From" and "Through" dates.

Table 21. From and Through Dates

PROVIDER TYPE	FROM DATE	THROUGH DATE
Hospital Inpatient	Admission Date	Must have a through date and must be the discharge date
Hospital Outpatient	Exact date of patient visit or the first date service began for a series of services	Exact date of patient visit or the last date of service for a series of services
Physician		

Hospital Inpatient dates of service must reflect the final bill. Interim bills are not acceptable for risk adjustment data.

MA organizations may submit several occurrences of the same diagnosis in one cluster with a 31-date span. The "From" date will reflect the first occurrence and the "Through" date will reflect the final occurrence within the 31 days.

Delete Indicator – To delete a diagnosis, for correction purposes, that has been stored in the RAPS database, a "D" is entered. If not correcting a diagnosis, then a space is entered.

Provider Type – For risk adjustment purposes, MA organizations are responsible for collecting data from the acceptable data sources (hospital inpatient, hospital outpatient, and physician) and determining the provider type based on the source of data.

Type of Bill (TOB), which is coded on *the encounter record* during the collection of hospital data, may be used to assist in translating the correct provider type.

Table 22 lists the acceptable sources of data, provider types, provider type codes, TOB.

Table 22. Provider Type and Code

Source of Data	Provider Type	Provider Type Code	Type of Bill
Hospital Inpatient	Hospital Inpatient Principle Diagnosis	01	111 or 11Z
Hospital Inpatient	Hospital Inpatient Other Diagnosis	02	111 or 11Z
Hospital Outpatient	Hospital Outpatient	10	131, 13Z, 141 or 14Z
Physician	Physician	20	N/A

120.2.4 - Valid Diagnosis Codes

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Valid diagnosis codes are those that are published for the fiscal years pertaining to the CMS-HCC risk adjustment model in use for a particular payment year. Current model diagnosis codes are codes that CMS accepts as valid, and are also included in the current version of the CMS-HCC model; only these diagnosis codes affect the risk score in a particular payment year. Future model diagnosis codes are codes that are currently valid, but are not included in the current version of the CMS-HCC model and, therefore, do not count toward the risk score.

A current model diagnosis code must meet the following criteria:

1. The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC), Prescription Drug (CMS-RxHCC) or End Stage Renal Disease (CMS-HCC ESRD) risk adjustment models.

2. The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.

3. The diagnosis must be collected according to the risk adjustment data collection instructions.

A list of current and future *diagnosis* codes for the CMS-HCC, ESRD, and RxHCC risk adjustment models for any given payment year includes published National Center for Health Statistics (NCHS)/CMS codes that are valid for the payment year. The list is posted on the CMS website at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage

Figure 3 provides a snapshot of the required diagnoses for a given payment year.

Figure 3. Example of Required Current and Future Model Diagnoses

Revised September 30, 2008

ICD-9-CM Codes, CMS-HCC and RxHCC models

ICD-9-CM Code	ICD9_Description	Diagnosis Code Effective Date	CMS-HCC Model Category	RxHCC Model Category	CMS-HCC Model Calendar Year 2004 Payment	CMS-HCC Model Calendar Year 2005 Payment	CMS-HCC Model Calendar Year 2006 Payment	CMS-HCC Model Calendar Year 2007 Payment	CMS-HCC Model Calendar Year 2008 Payment	CMS-HCC Model Calendar Year 2009 Payment	RxHCC Model Calendar Year 2006 Payment	RxHCC Model Calendar Year 2007 Payment	RxHCC Model Calendar Year 2008 Payment	RxHCC Model Calendar Year 2009 Payment
0031	Salmonella Septicemia	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
00322	Salmonella Pneumonia	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
00323	Salmonella Arthritis	1/1/1991	37	39	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
00324	Salmonella Osteomyelitis	1/1/1991	37	39	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0064	Amebic Lung Abscess	1/1/1991	112	112	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0066	Amebic Skin Ulceration	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0074	Cryptosporidiosis	10/1/1998	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0201	Cellulocutaneous Plague	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0202	Septicemic Plague	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0203	Primary Pneumonic Plague	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0204	Secondary Pneumon Plague	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0205	Pneumonic Plague Nos	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0212	Pulmonary Tularemia	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0220	Cutaneous Anthrax	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0221	Pulmonary Anthrax	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0223	Anthrax Septicemia	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0310	Pulmonary Mycobacteria	1/1/1991	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0311	Cutaneous Mycobacteria	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0312	Dmac Bacteremia	10/1/1998	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
03283	Diphtheritic Peritonitis	1/1/1991	31		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No

ICD-9-CM Codes, Future models only

ICD-9-CM Code	ICD9_Description	Diagnosis Code Effective Date
003	OTH SALMONELLA INFECTION*	1/1/1991
0030	SALMONELLA ENTERITIS	1/1/1991
0032	LOCAL SALMONELLA INFECT*	1/1/1991
00320	LOCAL SALMONELLA INF NOS	1/1/1991
00321	SALMONELLA MENINGITIS	1/1/1991
00329	LOCAL SALMONELLA INF NEC	1/1/1991
0038	SALMONELLA INFECTION NEC	1/1/1991
0039	SALMONELLA INFECTION NOS	1/1/1991
004	SHIGELLOSIS*	1/1/1991
0040	SHIGELLA DYSENTERIAE	1/1/1991
0041	SHIGELLA FLEXNERI	1/1/1991
0042	SHIGELLA BOYDII	1/1/1991
0043	SHIGELLA SONNEI	1/1/1991
0048	SHIGELLA INFECTION NEC	1/1/1991
0049	SHIGELLOSIS NOS	1/1/1991
0065	AMEBIC BRAIN ABSCESS	1/1/1991
008	INTESTINAL INFECTION NEC*	1/1/1991
0080	E. COLI ENTERITIS*	1/1/1991
00800	INTEST INFEC E COLI NOS	1/1/1991

120.2.5 - Tips for Reducing Duplicate Diagnosis Cluster Errors
(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

As part of the requirement that plans submit accurate risk adjustment data, CMS requires that plans work to minimize the submission of duplicate diagnosis clusters. CMS considers a plan submission that contains 5% or greater duplicate diagnosis clusters to be a high level of duplicate submissions and to be in violation of the requirement to submit accurate data.

Failure to submit accurate and timely risk adjustment production files may result in: 1) incorrect payments to your MA organization; 2) loss of monthly prospective revenue relating to beneficiary-health status; 3) payment recovery through a lump-sum recovery; 4) cessation of monthly payments throughout the remainder of a coverage year; and/or 5) adjusting payments in a subsequent year. Non-compliance with these requirements may result in CMS restricting future risk adjustment submissions by your MA organization.

Table 23, below, provides tips to assist plan sponsors in tracking diagnosis clusters so that they can be compliant with the guidance on the 5 percent benchmark for duplicate diagnosis cluster errors. CMS communicates to submitters a 502-error code for each diagnosis cluster that shares the same attributes as one previously submitted and stored in the RAPS database. CMS reviews files weekly and identifies diagnosis clusters; each 502-error code counts toward the 5 percent benchmark. If the submitter is a third party and the file contains records for multiple plans, the review will occur at the plan level within the file.

Table 23. Tips for Ensuring Compliance with the 5 Percent Benchmark for Duplicate Diagnosis Cluster Error Guidance

Tips	Description
Identify a Duplicate Diagnosis Cluster	CMS defines a Duplicate Diagnosis Cluster as one that shares all of the same attributes (HIC Number, Provider Type, From and Through Dates and Diagnosis) as one previously submitted and stored in the RAPS database.
Review Reports	Review current and previous RAPS Return Files to determine which clusters RAPS stored. If RAPS stored the cluster, MA organizations should not resubmit.
Understand Error Resolution	300-Level Errors Resubmit all clusters associated with the record, this would not create a duplicate diagnosis because none of the records were previously stored. 400-Level Errors Only resubmit the specific cluster that resulted in the 400-level error

	message. Do not resubmit all clusters within the record, only the clusters that contain errors.
Understanding Modifying Data	MA organizations should only resubmit the diagnosis clusters that require a modification. For example, an MA organization submits eight clusters, and the following week the organization notices the date of service submitted was incorrect in one of the clusters, the organization must submit that specific cluster with a "D" in the delete indicator field, and submit a new cluster with the correct date. Resubmitting all of the remaining seven clusters would create seven duplicates.

120.2.6 - Health Insurance Portability and Accountability Act (HIPAA)

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Effective October 16, 2003, when HIPAA transaction standards became mandatory, all electronic claims/encounters sent from providers/physicians to MA organizations (health plans) constitute a HIPAA covered transaction. Any MA organization that receives an electronic claim/encounter from a provider/physician must use the *current applicable ASC* X12 837 format.

MA organizations cannot request that a physician resubmit data previously submitted (same patient, same diagnosis) using a different format (e.g., HCFA 1500) if the physician initially submits data in *ASC X12 professional* format for purposes of risk adjustment data collection.

In accordance with Final Rule 45 CFR Part 152, effective March 17, 2009, CMS adopted X12 Version 5010 for HIPAA transactions. The final rule mandates covered entities MA organizations (health plans) comply no later than January 1, 2012.

120.2.7 - Submission Timeline

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

MA organizations must submit data at least quarterly to CMS. Each quarterly submission should represent approximately one-fourth of the data that the MA organization will submit during a data collection year. MA organizations will be monitored to ensure compliance. Table 24 provides the submission schedule for all diagnosis data submitted

for all risk adjustment models. This includes data for both the Part C CMS-HCC and ESRD models and the Part D Drug risk adjuster.

Table 24. Risk Adjustment Implementation Calendar

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
2009	01/01/08 - 12/ 31/08	03/06/09	07/01/09	01/31/10
2010	07/ 01/08 - 06/30/09	09/04/09	01/01/10	N/A
2010	01/01/09 - 12/31/09	3/05/10	07/01/10	01/31/11
2011	07/01/09 - 06/30/10	09/03/10	01/01/11	N/A
2011	01/01/10 - 12/31/10	03/04/11	07/01/11	01/31/12

120.2.8 - Status Reports of Risk Adjustment Submissions

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

CMS communicates the status of risk adjustment submissions via reports delivered to submitters' mailbox. The reports remain in the submitters' mailbox for 14 days. MA organizations may access reports through CSSC. Table 25 provides an overview of the Risk Adjustment reports received from the Front End Risk Adjustment System (FERAS) and the Risk Adjustment Processing System (RAPS).

Table 25. Reports Overview

Report	Description	Frequency
FERAS Response Report	• Indicates file is accepted or rejected • Identifies reasons for rejection • Report layout format	Same business day for Secure Website and FTP users Next business day for Connect:Direct and Gentran users
RAPS Return File	• Contains the entire submitted transaction • Identifies 300-, 400-, and 500-level errors • Flat file layout	Next business day after submission
RAPS Transaction Error Report	• Communicates errors found in CCC records during processing	Next business day after submission

	• Displays only 300-, 400-, and 500-level error codes • Report layout	
RAPS Transaction Summary Report	• Summarizes the disposition of diagnosis clusters • Report layout	Next business day after submission
RAPS Duplicate Diagnosis Cluster Report	• Identifies diagnosis clusters with 502-error message • Clusters accepted, but not stored • Report layout	Next business day after submission
RAPS Monthly Plan Activity Report	• Provides monthly summary of the status of submissions by submitter ID and Plan Number • Report layout	Available for download the second business day of the month
RAPS Cumulative Plan Activity Report	• Provides cumulative summary of the status of submissions by submitter ID and Plan Number • Report layout	Available for download the second business day of the month
RAPS Monthly Error Frequency Reports	• Provides a monthly summary of all errors associated with files submitted in test and production • Report layout	Available for download the second business day of the month
RAPS Quarterly Error Frequency Reports	• Provides a quarterly summary of all errors on all file submissions within the 3-month quarter • Report layout	Available for download the second business day of the month following each quarter

Examples of risk adjustment reports are available in the Edits and Reports module of the Risk Adjustment Training Participant Guide at http://www.csscoperations.com. Once at the web site, select "Training Information," then select that latest "Risk Adjustment Training Information" link, and then select "Participant Guides."

120.3 - Risk Score Verification Tools

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

MA organizations can use a variety of tools to ensure that the risk score reported by CMS is in close alignment with the score that the organization expects to receive. Table 26 identifies the tools, method of access, and availability. Sections 120.3.1 through 120.3.3 provide information on how an organization can use the tool to increase the accuracy of payment projections.

Table 26. Risk Score Verification Tools

Report Name	Access	Availability
RAPS Return File/RAPS Transaction Error Report	RAPS Mailbox RPT####.RPT.RAPS_RETURN_FLAT RPT####.RPT.RAPS_RETURN_FLAT (zip	Next business day following data submission

	format) RPT#####.RPT.RAPS_ERROR_RPT RPT#####.RPT.RAPS_ERROR_RPT (zip format)	
RAPS Monthly and Cumulative Plan Activity Reports	RAPS Mailbox RPT####.RPT.RAPS_MONTHLY RPT####.RPT.RAPS_MONTHLY (zip format) RPT####.RPT.RAPS_CUMULATIVE RPT####.RPT.RAPS_CUMULATIVE (zip format)	Second business day of the month
Monthly Membership Report (MMR) • MMR Non-Drug • Drug Reports	Through MARx	Monthly
Model Output Report (MOR) • Part C HCC MOR • RAS RxHCC MOR	Through MARx	Monthly
Risk Adjustment SAS Programs	http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats Medicare Rates & Statistics – Risk Adjustment Downloads for CMS-HCC, ESRD, RxHCC	2006-present

120.3.1 - RAPS Reports

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

MA organizations can use the RAPS Transaction and Management Reports Return to verify the diagnostic data stored in the model. Table 27 describes the RAPS Reports used as verification tools.

Table 27. RAPS Reports as Verification Tools

Report	Description
RAPS Return File	• Contains all transactions submitted by the MA organization. • Errors identified during the RAPS process appear next to the field in which the error occurred, which indicates the diagnosis did not store. • File delivered in the same flat file format used for the RAPS input. • Unique diagnosis clusters returned without an error are stored in the RAPS database at CMS. • CMS uses the diagnosis clusters that contain relevant diagnosis codes to calculate risk adjustment factors when running the CMS-HCC model or ESRD model. • MA organizations may download the file into a Microsoft Access or Excel database since the report is a flat file. • MA organizations should establish a record of each diagnosis that was stored in the CMS-HCC model for each enrollee. • Larger organizations also use the file in mainframe databases. • Organizations that employ automated update processes for their databases typically use the Return File.
RAPS Transaction Error Report	• Contains only the records that contain errors, causing one or more diagnosis clusters to reject. • Organizations that employ non-automated update processes when maintaining diagnosis files typically use the Transaction Error Report. • An individual at the health plan generally downloads the report, prints it, and manually updates the diagnosis records to indicate which diagnoses were rejected.
RAPS Monthly and Cumulative Plan Activity Reports	• Confirms the total number of diagnoses stored in the CMS-HCC model.

Creating a database with the diagnoses will serve several purposes:

The MA organization will have a history of all diagnosis clusters submitted and stored, which can be used to prevent future submissions of duplicate diagnosis clusters.

The MA organization will have the data required to determine which diagnoses were stored for each beneficiary for the payment period.

MA organizations can compare their internal database developed from the RAPS Return File to the number of diagnoses stored on the Monthly and Cumulative reports. The cumulative report reflects the total number of diagnoses stored to date for the contract number (e.g., H number). The database should reflect all diagnosis clusters stored for the plan sponsor for the data collection period.

120.3.2 - MARx Reports

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

MARx generates several monthly reports that provide information for verifying diagnostic and demographic data used in the payment model calculations. Table 28 describes the Monthly Membership Report (MMR).

Table 28. Monthly Membership Report

Description

• Provides information to reconcile the Medicare membership and payment record to the records maintained by CMS.
• Available in two formats – report and data file, both containing drug and non-drug data.
• The report and data file formats provide summary and detail-level information on beneficiaries belonging to the MA organization.
• Summary
  o Payments and adjustments applicable to the organization's Medicare membership, shows total number of payments for beneficiaries receiving hospice, ESRD or institutionalized status.
• Detail
  o Detailed list of beneficiaries for who payment was made for a month (prospective for that month or an adjustment payment for a previous month).
  o Allows for comparison of organization's beneficiary records with CMS' records.
• Non-Drug MMR
  o Contains information such as rebates, payments and adjustments, Part A and Part B information, risk adjustment factors for Part A and Part B, and other detailed beneficiary information.
• Drug MMR
  o Contains information such as basic premiums, estimated reinsurance, payments and adjustments, low-income cost sharing percentage, low-income cost sharing subsidy, risk adjustment factors, and other detailed beneficiary information.

Figures 4 and 5 highlight the location of key information on the formatted MMRs for reconciling reports with enrollee information.

At the top of the report, the name of the report appears along with whether the report is for drug or non-drug data. The plan number, Plan Benefit Package (PBP), and Segment along with the plan name appear under the report name.

At the top left of the report is the group number and contract number. The run date appears as year/month/date with the payment month in the top left of the report. The page number is to the right.

There are two lines of information for each beneficiary in the detail report and that information is staggered. For example, the HICN appears on one line and beneath that line appears the surname of the beneficiary.

The MMR for Non-Drugs reports on flags for Health Status and the Drug reports on the LIS or LTI multiplier for calculation in the beneficiary risk factor.

If a beneficiary has one of the flags for a Health Status, which is sometimes called "special status," this is identified with a "Y" on the report.

Figure 4. Sample Drug MMR – Key Fields

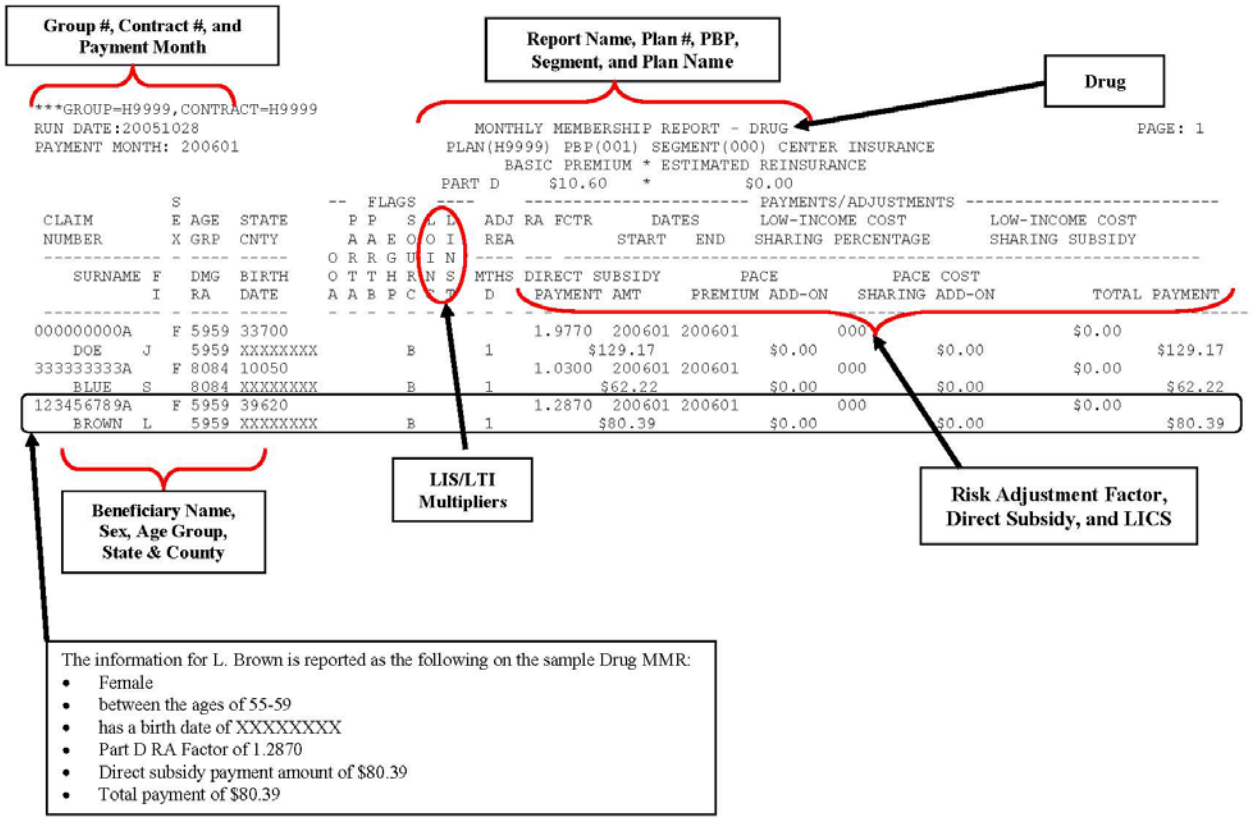
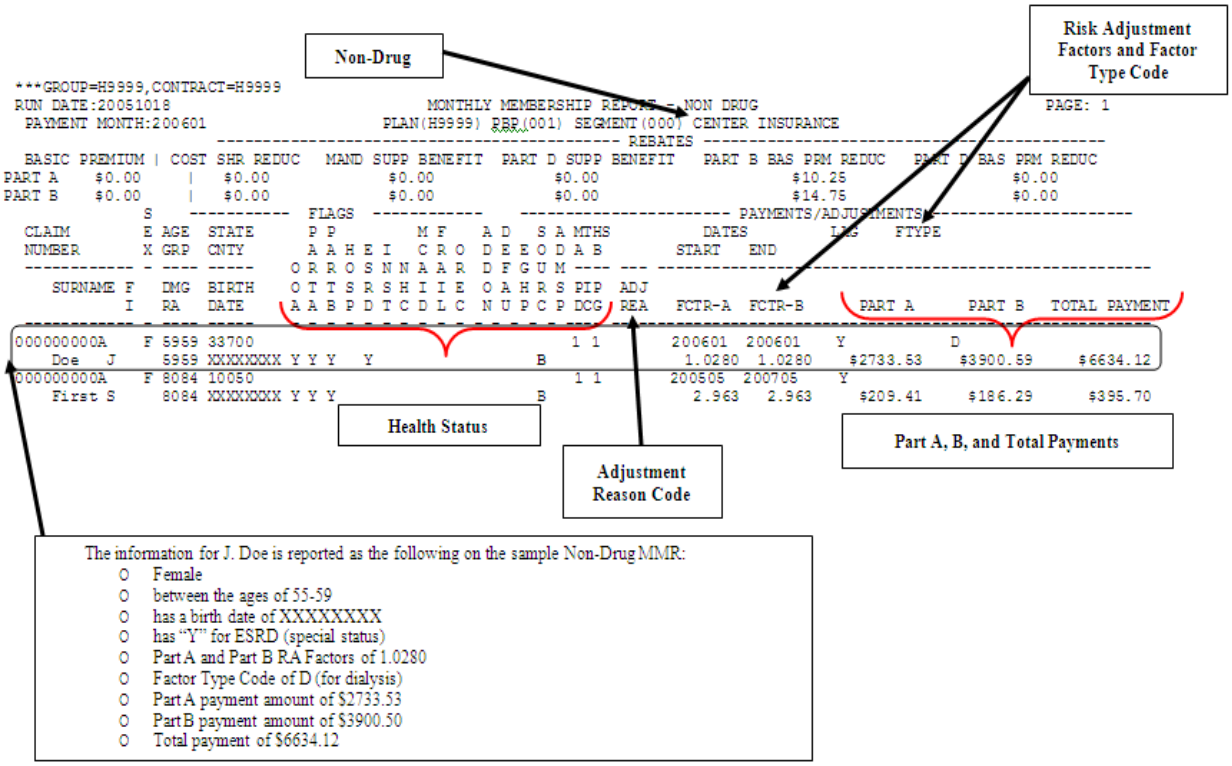


Figure 5. Sample Non-Drug MMR - Key Fields



The information for J. Doe is reported as the following on the sample Non-Drug MMR:

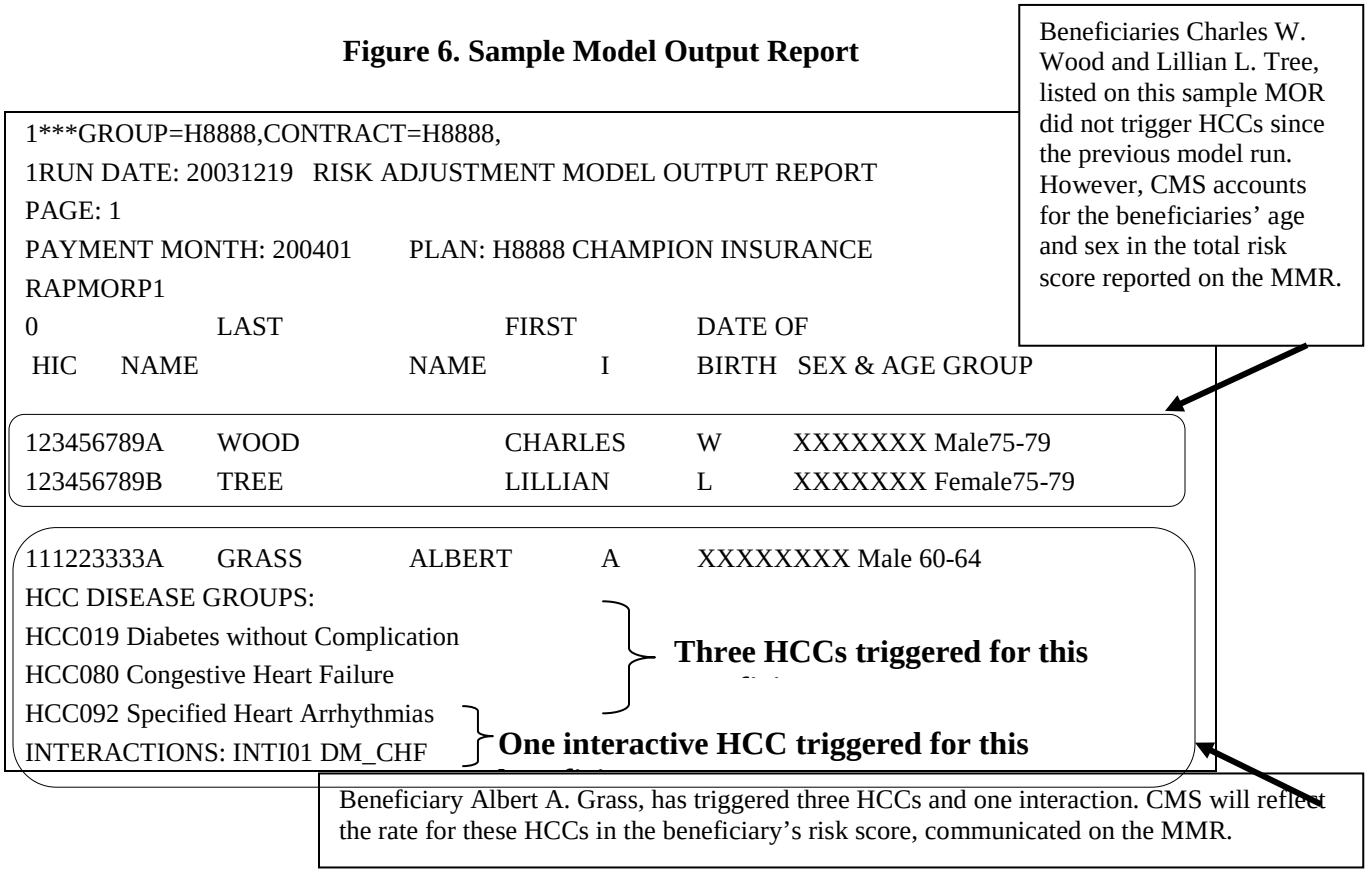
- Female
- between the ages of 55-59
- has a birth date of XXXXXXXX
- has "Y" for ESRD (special status)
- Part A and Part B RA Factors of 1.0280
- Factor Type Code of D (for dialysis)
- Part A payment amount of $2733.53
- Part B payment amount of $3900.50
- Total payment of $6634.12

Table 29 describes the Model Output Report (MOR) and Figure 6 highlights the location of key information on the formatted MOR

Table 29. Model Output Report

Description
• Used in conjunction with the MMR and beneficiary-specific information (residence-community vs. institution, Medicaid status, disability, etc.) to verify risk scores. • Part C Risk Adjustment MOR o Displays HCCs used by RAS to calculate risk adjustment factors for each beneficiary. o Displays the HCC Disease Groups used by the CMS-HCC model and disease and demographic interactions. o Provides detailed beneficiary level information on: • Enrollee identifiers (HICs, name, date of birth). • Appropriate sex and age group, as well as other demographic factors for an individual (if applicable). • Provides detailed information on the specific disease groups and disease interactions triggered for an enrollee. • Disease hierarchies are not identified separately. If a hierarchy exists, only the most severe manifestation in the hierarchy is displayed on the report. For organization receiving frailty payments: Organizations receiving frailty adjustment should review their overall risk score, which represents the output of the CMS-HCC model and the frailty score. Beneficiaries under the age of 55 and beneficiaries who have an institutional factor do not receive frailty scores. Organizations receiving frailty adjustment can find their contract-level frailty score on HPMS. A final reconciliation of HCCs may prove to be a useful analysis for plan sponsors. • RAS RxHCC MOR • Displays the RxHCCs for each beneficiary used by RAS to calculate risk adjustment factors for each beneficiary. • RxHCCs can be used by plans to verify a beneficiary's risk score provided on the MMR. • Summing the risk factors for an individual beneficiary yields a total risk adjustment score.

Figure 6. Sample Model Output Report



The flat file layouts and sample formatted MMR and MOR reports are located in the Medicare Advantage and Prescription Drug Plans - Plan Communications User Guide Appendices at: http://www.cms.gov/MAPDHelpDesk/02_Plan_Communications_User_Guide.asp#TopOfPage.

120.3.3 - Risk Adjustment Model Software

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

CMS provides a SAS software program for each of the CMS-HCC risk adjustment models that allows organizations to verify and predict risk scores. Users must have a SAS license to use the SAS program.

MA organizations may access the risk adjustment Risk Model software at: http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

The software includes an HCCSOFT SAS program that uses several SAS Macros to create HCC, RxHCC, and ESRD HCC risk score variables using coefficients from the following regression models:

- Community
- Institutional

- New enrollee

The HCCSOFT software supplies user parameters to the main SAS Macro program MACROSFT. This macro program takes user-provided files and assigns HCCs or RxHCCs for each beneficiary. The program follows five major steps when calculating risk scores:

1. Assigns each beneficiary to an appropriate age/sex grouping, and adds in the interactions for Medicaid, disabled, and previously disabled

2. Crosswalks diagnoses to Condition Categories using SAS formats that were previously stored in the FORMAT library

3. Creates HCCs by imposing hierarchies on the Condition Categories

4. Creates the interactions

5. Computes three scores for each beneficiary: community, institutional, and new enrollee

Note: For beneficiaries without relevant diagnoses from RAPS or FFS claims data, zeros are assigned to all HCCs and RxHCCs.

130 - Glossary of Terms

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Beneficiary Demographic Input File - Contains beneficiary demographic data captured from Common Medicare Environment. The demographic data is used by the Risk Adjustment System (RAS) to calculate a beneficiary's risk score and to determine payment.

Beneficiary Diagnosis Input File - Contains beneficiary diagnosis data captured from Risk Adjustment Processing System (RAPS) and National Medicare Utilization Database (NMUD). The diagnosis data is used by the Risk Adjustment System to calculate a beneficiary's risk score and to determine payment.

Common Medicare Environment (CME) – Tables sourced from the Medicare Beneficiary Database (MBD) and the Enrollment Database (EDB) that provide beneficiary demographic and enrollment data.

Connect: Direct - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. This connection involves mainframe-to-mainframe connection with a submission response from FERAS.

Data Collection Period - The 12 month period from which CMS uses diagnoses submitted by MA organizations to calculate a beneficiary's risk score.

Data Submission - The process in which MA organizations submit required data elements to CMS for risk adjustment purposes.

Data Validation - The process of validating that enrollee diagnosis codes submitted for payment by MA organizations are supported by the medical record documentation.

Diagnosis Cluster - Core information submitted by MA organizations for each diagnoses submitted. The following are included: provider type, from date of service, through date of service, delete indicator, and diagnosis code.

Dialysis Status - CMS risk adjusts payments for a beneficiary using the CMS-HCC dialysis model when we are notified that the beneficiary is receiving dialysis.

Direct Data Entry (DDE) - An electronic data exchange between providers and health plans where health plans enter RAPS data directly into an online screen for processing.

Disabled Status - Demographic factor for beneficiaries who became eligible for Medicare based on a disability.

Disease Hierarchy - *International Classification of Diseases Clinical Modification (ICD-9-*CM *or ICD-10 CM as applicable)* diagnosis codes that address multiple levels of severity for a disease with varying levels of associated medical costs.

Dual Eligible - An MA eligible individual who is also entitled to Medical Assistance under a State Plan under Title XIX (Medicaid). A chart describing the various categories of individuals who are collectively known as dual-eligibles can be found at: https://www.cms.gov/MedicareEnRpts/Downloads/Buy-InDefinitions.pdf.

Electronic Data Interchange (EDI) Agreement - An agreement MA organizations have with CMS to follow provisions for submitting risk adjustment data through one of CMS' accepted types of electronic connections.

End Stage Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Enrollment Database (EDB) – A data repository that contains Medicare entitlement information for beneficiaries entitled to Medicare.

File Transfer Protocol (FTP) - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. The connection uses modem-to-modem (i.e., dial up) or lease line connection with a submission response from FERAS.

Frailty Adjuster - Predicts Medicare expenditures of community populations with functional impairments that are unexplained by the risk adjustment methodology alone. The frailty adjuster is included as part of risk adjusted payments for PACE organizations and, through 2011, for certain demonstration organizations. Beginning in 2012, certain Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are eligible to receive frailty adjustment.

Front End Risk Adjustment (FERAS) - Performs the initial file editing for risk adjustment data submitted by Medicare Advantage and Medicare Advantage-Prescription Drug plans and transmits files to the Risk Adjustment Processing System (RAPS).

Full Risk - Medicare beneficiaries that have 12 months of Part B coverage during the data collection period.

Gentran - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. Gentran users are issued a mailbox and it is used as a vehicle to transmit and receive reports on RAPS data sent to CMS.

Health Plan Management System (HPMS) - CMS information system used by Medicare Advantage and Prescription Drug plans to upload bid, Plan Benefit Package, and marketing information, and is used by CMS to send information to plans.

Hierarchical Condition Category (HCC) - Groupings of clinically similar diagnoses in each risk adjustment model. Conditions are categorized hierarchically and the highest severity takes precedence over other conditions in a hierarchy. Each HCC is assigned a relative factor which is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.

Health Insurance Portability and Accountability Act (HIPAA) - Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data and contained health insurance reforms intended to promote access and portability of insurance coverage. The implementation of HIPPA improved the use of electronic data exchange in the national health care system.

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) Codes - 3 to 5-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. *ICD-9-CM codes are used for inpatient discharges before the implementation date of ICD-10, and for outpatient and physician services before that date.*

***International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) Codes** - 3- to 7-digit codes used to describe the clinical reason for a patient's*

treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. ICD-10-CM codes are used for inpatient discharges on and after the implementation date of ICD-10, and for outpatient and physician services on and after that date.

Long-term Institutionalized (LTI) Status - CMS identifies whether a Medicare beneficiary is in a long term institution for both model development and risk score calculation purposes. CMS considers a beneficiary as having long term institutional status if they have been in an institution for 90 days or more. CMS obtains this information from the Minimum Data Set (MDS), which stores dates of 90-day assessments reported by nursing homes.

Low-income Subsidy (LIS) - Provides financial assistance for beneficiaries who have limited income and resources; individuals eligible for this low-income subsidy will receive assistance with paying for their monthly premium, yearly deductible, prescription coinsurance and copayments and coverage in the gap.

Medicaid - Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.

Medicare Advantage Prescription Drug (MARx) System - Receives beneficiary level risk adjustment factors from RAS for use in Part C and Part D payment calculations.

Medicare Beneficiary Database (MBD) – A data repository that contains eligibility and enrollment data for Medicare beneficiaries.

Minimum Data Set (MDS) - A part of the Resident Assessment Instrument (RAI) developed by CMS to assist Medicare/Medicaid certified nursing homes in developing a comprehensive care plan for each resident.

Minimum Data Set (MDS) Long Term Institutional File - Identifies beneficiaries that resided in a long term institution for 90 days or more, which classifies them as long term institutional (LTI) beneficiaries. The file is used to identify Medicare beneficiaries that reside in LTI for risk adjustment purposes.

National Medicare Utilization Database (NMUD) - Contains Medicare claims data, including diagnostic data submitted by fee-for-service providers for beneficiaries new to Medicare Advantage with less than 12 months of risk adjustment data. The diagnostic data stored in NMUD is translated to the risk adjustment format.

National Provider Identifier (NPI) - The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization.

New Enrollee - A Medicare beneficiary who has less than 12 months of Part B entitlement during the data collection period.

Normalization Factor - Factor used to correct population and coding changes between the data years used in model calibration and the payment year.

Original Reason for Entitlement Code (OREC) - A demographic factor added to the risk score for beneficiaries 65 years of age or older who were originally entitled to Medicare due to disability. The factor varies based on the age and sex of the beneficiary.

Post-Graft (Functioning Graft) - A beneficiary is in post-graft status when they have received a kidney transplant or kidney/pancreas transplant at least three months ago and did not return to dialysis status since the transplant. There is a separate segment of the CMS-HCC ESRD model for people who have functioning kidney grafts.

Principal Inpatient Diagnostic Cost Group (PIP-DCG) - The PIP-DCG model was a precursor to the CMS-HCC risk adjustment model CMS used the PIP-DCG model from 2000-2003. In this model, CMS used diagnoses from hospitalizations to identify a particularly ill and high cost subset of beneficiaries for whom CMS will make higher payments in the next year. The system recognized admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

Program of All-Inclusive Care for the Elderly (PACE) - A unique capitated managed care benefit for frail and elderly individuals provided by a public entity or private entity. PACE features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Reconciliation - The CMS process of updating beneficiaries' statuses and processing the resulting payment adjustments.

Risk Adjustment Processing System (RAPS) – An application that stores diagnoses data submitted by MA Organizations. Upon completion of the initial file processing, FERAS sends the risk adjustment data to RAPS to perform low level edits to the file header and record.

Risk Adjustment System (RAS) – A system used to calculate a beneficiary's risk score from enrollment and diagnosis data received from Common Medicare Environment (CME), National Medicare Utilization Database (NMUD) system and Risk Adjustment Processing System (RAPS). After the risk scores are calculated in RAS, they are sent to MARx to use in calculating beneficiary level prospective payments.

Special Needs Plan (SNP) - An MA coordinated plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more

severe or disabling chronic conditions, as set forth at 42 CFR 422.4(a)(1)(iv) of the MA regulation, and provides Part D benefits under 42 CFR Part 423.

Taxonomy Code - An external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute, Accredited Standards Committee health care transaction.

Transplant Status - A Medicare beneficiary is in Transplant Status for the three months commencing with a kidney transplant.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R118MCM	09/19/2014	Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010	Upon Implementation of ICD-10	N/A
R116MCM	02/28/2014	Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010 – Rescinded and replaced by Transmittal 118	10/012014	N/A
R114MCM	06/07/2013	Chapter 7 – Risk Adjustment	06/07/2013	N/A
R57MCM	08/13/2004	Coverage of Clinical Trials, Hospital Inpatient Data, Diagnostic Coding, and Collection of Data	N/A	N/A
R47MCM	02/20/2004	Miscellaneous Changes	N/A	N/A
R02MCM	10/01/2001	Miscellaneous Changes	N/A	N/A
R01MCM	07/02/2001	Initial Issuance of Chapter	N/A	N/A

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RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help Medicare Advantage (MA) organizations, providers, physicians, and third party submitters locate information specific to risk adjustment.

The purpose of this Resource Guide is to identify and supply resources that will simplify and clarify both the terminology and the processes employed in the submission of risk adjustment data. An emphasis is given to recent, policy-relevant material.

This Resource Guide is a helpful tool for those who need a quick reference for technical concepts, or for those who need to provide employees with an introductory presentation to the risk adjustment data process. Where possible and appropriate, "screen shots" of important resources on the Internet have been included. These pages may also be utilized as a suitable visual aid for risk adjustment data instructors to enhance their presentation.

The information listed in the Resource Guide is arranged in seven sections:

- RISK ADJUSTMENT ACRONYMS AND TERMS
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- CSSC WEB RESOURCES
- CSSC REFERENCE DOCUMENTS
- APPLICATION FOR ACCESS

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Henry Thomas: henry.thomas@cms.hhs.gov
Stephen Calfo: stephen.calfo@cms.hhs.gov
Sean Creighton: sean.creighton@cms.hhs.gov

CUSTOMER SERVICE AND SUPPORT CENTER (CSSC) – http://www.csscoperations.com
The CSSC website provides "one-stop shopping" for MA organizations regarding risk adjustment data submission needs. Visit www.csscoperations.com to register for email updates from the CSSC. The updates will serve as notification that new or updated information has been added to the website.

CSSC Contact Information
877-534-2772 (toll-free)
csscoperations@palmettogba.com

LEADING THROUGH CHANGE, INC. (LTC, INC.)
For general questions about training and Risk Adjustment User Groups, please email Leading Through Change, Inc. at TARegistration@tarsc.info.

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RISK ADJUSTMENT ACRONYMS AND TERMS

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RISK ADJUSTMENT ACRONYMS AND TERMS

ACRONYM	TERM
AAPC	American Academy of Professional Coders
ACR	Adjusted Community Rates
ACRP	Adjusted Community Rate Proposal
ADS	Alternative Data Sources
ADL	Activities of Daily Living
AGNS	AT&T Global Network Services
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI X12 837	Variable Length File Format for Electronic Submission of Encounter Data
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act 1999
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement and Protection Act of 2000
CAD	Coronary Artery Disease
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Refined Hierarchical Condition Category Risk Adjustment Model
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSSC	Customer Service and Support Center
CVD	Cerebrovascular Disease
CWF	Common Working File
CY	Calendar Year
DCP	Data Collection Period
DDE	Direct Data Entry
DHHS	Department of Health & Human Services
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DOB	Date of Birth
DoD	Department of Defense
DOS	Dates of Service
DRG	Diagnosis Related Group
DX	Diagnosis
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
ET	Eastern Time
FERAS	Front-End Risk Adjustment System
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
GUI	Graphical User Interface
H#	MA Organization CMS Contract Number
HCC	Hierarchical Condition Category
HCFA 1500	Medicare Part B Claim Filing Form
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set

ACRONYM	TERM
HHS	Department of Health and Human Services
HIC#	Health Insurance Claim Number (Beneficiary Medicare ID#)
HICN	Health Insurance Claim Number (Beneficiary Medicare ID#)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICN	Internal Claim Number
IP	Internet Protocol
IVC	Initial Validation Contractor
JCAHO	Joint Commission on Accreditation of Health Care Organizations
LTC	Leading Through Change, Inc.
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
M+C organization	Medicare+Choice Organization
MCCOY	Managed Care Option Information System
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug Modernization Act of 2003
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MnDHO	Minnesota Disability Health Options
MOR	Model Output Report
MSA	Medical Savings Account
MSG	Message
MSHO	Minnesota Senior Health Options
NCH	National Claims History
NCHS	National Center for Health Statistics
NCPDP	National Council on Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDM	Network Data Mover
NES	Not elsewhere classified
NMUD	National Medicare Utilization Database
NOS	Not otherwise specified
NPI	National Provider Identifier
NSF	National Standard Format
OIG	Office of Inspector General
OREC	Original Reason for Entitlement Code
Palmetto GBA	Palmetto Government Benefits Administrators
PACE	Program of All-Inclusive Care for the Elderly
PCN	Patient Control Number
PHS	PACE Health Survey
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
RAPS	Risk Adjustment Processing System
RAPS Database	Risk Adjustment Processing System Database
RAS	Risk Adjustment System

ACRONYM	TERM
RHC	Rural Health Clinic
RPT	Report
RRB	Railroad Retirement Board
RT	Record Type
RxHCC	Prescription Drug Hierarchical Condition Category
SAS	Statistical Analysis Software
SCO	MassHealth Senior Care Option
SH#	Submitter CMS Contract Number
S/HMO	Social Health Maintenance Organizations
SNF	Skilled Nursing Facility
SSD	Selected Significant Disease Model
SSN	Social Security Number
SUB ID	Submitter ID
SVC	Second Validation Contractor
TOB	Type of Bill
UB-04	Uniform Billing Form 04
VA	Veterans Administration
WPP	Wisconsin Partnership Program

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CMS WEB RESOURCES

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CMS Main Page
http://www.cms.hhs.gov

Advance Notice of Methodological Changes for Calendar Year (CY) 2004 (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf

Announcement of Calendar Year (CY) 2004 Medicare+Choice Payment Rates (May 12, 2003)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004.pdf

Cover Letter Regarding Revised Medicare Advantage Rates for Calendar Year (CY) 2004 (January 16, 2004)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004b.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf

Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates (April 4, 2005)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2006.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2007 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf

Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates (April 3, 2006)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2008 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2008.pdf

Announcement of Calendar Year (CY) 2008 Medicare Advantage Payment Rates (April 2, 2007)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2009 for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2009.pdf

Announcement of Calendar Year (CY) 2009 Medicare Advantage Payment Rates (April 7, 2008)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf

Medicare Managed Care Manual
http://www.cms.hhs.gov/manuals
(select Internet-Only Manuals, then select 100-16 Medicare Managed Care Manual)

Rate Book Information
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

Healthplans Page
http://www.cms.hhs.gov/HealthPlansGenInfo/

Risk Adjustment Page
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_Adjustment.asp

Health Insurance Portability and Accountability Act (HIPAA) Page
http://www.cms.hhs.gov/HIPAAGenInfo/

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates/

Official Coding Guidelines on Centers for Disease Control & Prevention Website
http://www.cdc.gov/nchs/data/icd9/icdguide.pdf

Risk Adjustment Model Output Report Letter
http://csscoperations.com/new/references/cmsinstructions.html

Medicare Advantage (MA) Prescription Drug Plans Plan Communications User's Guide
http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage

Individuals with Access to CMS Systems (IACS) User Guide and Website
http://www.cms.hhs.gov/MMAHelp/07_IACS.asp#TopOfPage

Reference to Types of Facilities and Taxonomy Codes
http://www.wpc-edi.com/codes/taxonomy

CMS Call Letters (Finals)

2005:
http://www.cms.hhs.gov/ACR/Downloads/CallLetter.pdf

Overview 2006 & 2007:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/01Overview.asp#TopOfPage

2006:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/02Bid2006.asp#TopOfPage

2007:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/03Bid2007.asp#TopOfPage

2008:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf

2009:
http://www.cms.hhs.gov/prescriptionDrugCocContra/Downloads/CallLetter.pdf

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CMS REFERENCE DOCUMENTS

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Health Plan Management System (HPMS)

HPMS is a CMS information system created specifically for the Medicare Advantage program that provides MA organization level information.

Accessing HPMS

- Access to HPMS is accomplished via the Medicare Data Communications Network (MDCN).
- A User ID is required for HPMS access. If you do not currently have access, complete the "Access to CMS Computer Systems" form available at www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf or at the end of this Resource Guide.

If MA organizations experience difficulty logging into HPMS, please contact Don Freeburger (don.freeburger@cms.hhs.gov) 410-786-4586 or Neetu Jhagwani (neetu.jhagwani@cms.hhs.gov) 410-786-2548.

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Risk Adjustment Implementation

(Attachment A – Risk Adjustment Implementation excerpt from 2009 Final Call Letter – March 17 2008, http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf)

1. Risk Adjustment Data Submission Schedule

Table 1. Risk Adjustment Implementation Calendar (below) provides the updated submission schedule for all diagnosis data submitted for all risk adjustment models. This includes data for both the Part C CMS-HCC and ESRD models and the Part D Drug risk adjustment model.

Table 1. Risk Adjustment Implementation Calendar

CY	Dates of Service	Initial Submission Deadline*	First Payment Date	Final Submission Deadline
2008	July 1, 2006 through June 30, 2007	September 7, 2007	January 1, 2008	N/A**
2008	January 1, 2007 through December 31, 2007	March 7, 2008	July 1, 2008	January 31, 2009
2009	July 1, 2007 through June 30, 2008	September 5, 2008	January 1, 2009	N/A**
2009	January 1, 2008 through December 31, 2008	March 6, 2009	July 1, 2009	January 31, 2010
2010	July 1, 2008 through June 30, 2009	September 4, 2009	January 1, 2010	N/A**
2010	January 1, 2009 through December 31, 2009	March 5, 2010	July 1, 2010	January 31, 2011
2011	July 1, 2009 through June 30, 2010	September 3, 2010	January 1, 2011	N/A**
2011	January 1, 2010 through December 31, 2010	March 4, 2011	July 1, 2011	January 31, 2012

*March and September dates reflect the first Friday of the respective month.
**All risk adjustment data for a given payment year (CY) must be submitted by January 31st of the subsequent year.

Changes in payment methodology for 2009, including Part C and Part D payment and risk adjustment, are described in the February 22, 2009, *Advance Notice of Methodological Changes for Calendar Year (CY) 2009 Medicare Advantage Payment Rates* and the April 7, 2009, *Announcement of Calendar Year (CY) 2009 Medicare Advantage Payment Rates* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

2. Part A Risk Adjustment Factor Options

- ***Determinations of Risk Status***

As stated in the April 3, 2006 *Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/), plans subject to risk adjusted payments have an option for how to treat beneficiaries with 12 months of Part A data but less than 12 months of Part B enrollment in a data collection year.

Table 2. Which Risk Adjustment Factors to Apply to Payment*

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	Time Period Beneficiary Has Been Entitled to Benefits under Part A Medicare**	
	0 - 11 months	≥ 12 months
0 – 11 months	New enrollee factors	Plan's option: New enrollee or full risk adjustment factors
≥ 12 months	Full risk adjustment factors	Full risk adjustment factors

*Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled to benefits under Part A and enrolled in Part B.
**During data collection period (previous calendar year).

Table 2. Which Risk Adjustment Factors to Apply to Payment (above) illustrates that beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less than 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees, as they are now.

Currently beneficiaries with 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS has created an option for how the risk adjustment payments for this category of enrollees are determined. Effective as of 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision will be applied to all "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.

- ***Option to Elect Full Risk Option for "Part A-only" Enrollees***

Effective as of 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. If an organization elects to have CMS determine payment factors (i.e., new enrollee factors or full risk adjustment factors) for all "Part-A only" enrollees, then -

- The decision will be applied to all "Part-A" only enrollees in the plan;
- The option elected will remain turned "on" until CMS is otherwise notified prior to August 31st of any successive year.

Plans interested in electing this option for 2009 must contact: Henry Thomas, CMS, at henry.thomas@cms.hhs.gov by August 31, 2008.

3. Risk Adjustment Implementation

MA organizations must review the following:

- Changes in payment methodology for 2009, including Part C and Part D payment and risk adjustment, are described in the February 22, 2009, *Advance Notice of Methodological Changes for Calendar Year (CY) 2009 Medicare Advantage Payment Rates and Part D Payment Policies* and the April 7, 2009, *Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Payment Policies and CY 2009 Part D Payment Notification* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

- Two important risk adjustment memoranda dated November 27, 2007, which were published via HPMS on November 28, 2007 -
  - o CMS implementation of ICD-9 diagnosis codes for 2009 CMS implementation of ICD-9 diagnosis codes for 2009
  - o Medicaid status for Part C and D risk adjustment and Part D cost sharing; and

For additional information on risk adjustment, see 42 CFR §422.310.

4. Impact of Hospital Acquired Conditions under the Inpatient Prospective Payment System on Diagnoses Reporting for Risk Adjustment

For purposes of risk adjustment, MA organizations are required to submit discharge diagnoses from hospital inpatient settings. To the extent that any ICD-9 codes attributable to the eight selected hospital acquired conditions (surgical site infections, blood incompatibility, air embolism, object left in surgery, catheter associated urinary tract infections, pressure ulcers, hospital acquired injuries, or vascular catheter associated infection) appear in the discharge diagnoses, these codes may be submitted for risk adjustment payment.

5. National Provider Identifier (NPI)

The January 23, 2004 final rule (69 FR 3434*), HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers*, established the standard for a unique identifier for health care providers and adopted the National Provider Identifier (NPI) number as that standard. The National Provider System (NPS) was established to assign unique NPI numbers to health care providers. The NPS was designed to be used by other Federal and state Agencies as well as by private health plans, if deemed appropriate, to enumerate their health care providers that did not participate in Medicare. Consequently, the NPI can not be used to determine whether a provider is a Medicare certified provider.

On May 23, 2007, the CMS implemented the use of the NPI, for claims submitted to Fee-For-Service (Original) Medicare and discontinued issuing the Medicare Provider Identifier Numbers (legacy or OSCAR numbers). In the past, Medicare plans could use the legacy number to verify that a provider was a Medicare provider and that the provider was an acceptable source for diagnosis data for the CMS risk adjustment process.

Implementation of the NPI necessitates that Medicare plans that had been using the legacy Medicare provider numbers to verify the source of diagnoses submitted for risk adjustment purposes establish new methodologies for determining: 1) that providers are Medicare certified and 2) that diagnosis sources are acceptable. Implementation of the NPI does not change the requirement for Medicare plans to verify that the diagnosis data submitted to the CMS for risk adjustment are from Medicare certified providers and from acceptable data sources.

6. Testing Requirements

Submitter testing is required to ensure the proper flow of data from the Submitter to the Risk Adjustment Processing System (RAPS). Testing also ensures the data submitted is valid and formatted correctly.

If you would like to send data in a test format, please contact the Customer Service and Support Center (CSSC) Help Line at (877) 534-2772. By calling the CSSC Help Line prior to transmission of your first production or test file, a CSSC representative will be able to give you information on how to properly submit a test and/or production file. Information regarding the CSSC and the Risk Adjustment Processing System (RAPS) is available on the CSSC web site at http://www.csscoperations.com/.

7. Acceptable Provider Types and Physician Data Sources

For purposes of risk adjustment, MA organizations must collect data from the following provider types:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physician.

In addition, only those physician specialties and other clinical specialists identified in Table 3 – Acceptable Physician Data Sources of the Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions (dated April 4, 2006) are acceptable for risk adjustment. To obtain a copy of this document, please visit the CMS web site at http://www.cms.hhs.gov/healthplansgeninfo/downloads/Rev%20MA-MAPD%20call%20letter%20final.pdf. Note that registered nurses, licensed practical nurses, and nursing assistants are not included in Table 3 – Acceptable Physician Data Sources as they are unacceptable physician data sources.

MA organizations are responsible for ensuring that the data they collect and submit to CMS for payment comes from acceptable provider types and physician data sources. The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all ICD-9-CM diagnoses that are in the risk adjustment model and rendered as a result of a visit to a physician must be collected by the MA organization. This includes data collected from non-network as well as network providers. Therefore, CMS requires MA organizations to filter and submit risk adjustment data in accordance with the appropriate provider types and acceptable physician data sources as approved by CMS.

8. Integrity of RAPS Submissions

Although a plan may designate another entity to submit claims on its behalf to CMS, the plan remains responsible for data submission, accuracy and content. If your MA organization needs assistance or is experiencing data submission issues, please contact our Customer Service and Support Center (CSSC) at 1-877-534-2772 or http://www.csscoperations.com/.

9. IT Technical Assistance Outreach

The purpose of the IT Technical Assistance Outreach program is to provide Part C and Part D contracted organizations with the IT support to perform the required Risk Adjustment, Prescription Data Event and Enrollment/Payment data submissions skills and to understand the roles data play in relationship to enrollment and payment. This outreach will enable these organizations to collect and submit the appropriate data in accordance with CMS requirements; thereby, this assistance's expected outcome seeks to provide a positive impact on "the correct payment." CMS offers Monthly Risk Adjustment and Enrollment/Payment outreach sessions at its Baltimore headquarters. We anticipate conducting our regional outreach sessions in August and September of 2008.

The specific dates for the monthly and regional outreach sessions will be announced during the Risk Adjustment (i.e., Part C) User Group sessions, and will be listed on our contractor's web site. For additional information or to register for the outreach sessions and the User Group sessions, please visit our contractor's web site at http://www.TARSC.info.

10. Risk Adjustment Data Validation

42 CFR §422.310(e) requires MA organizations and their providers and practitioners to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. CMS will increase emphasis on MA organization compliance with the medical record submission guidelines.

The Centers for Medicare & Medicaid Services (CMS) conducts medical record reviews to validate the accuracy and integrity of the risk adjustment data submitted by the Medicare Advantage (MA) for payments. CMS selects MA organizations to participate in the medical record review based on a number of criteria. For example, some organizations are randomly selected while others are targeted; thus, every MA organization has a chance of being selected for validation.

Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the MA organization are supported by medical record documentation for an enrollee. The primary goals of risk adjustment data validation are to:

- Identify
  - Confirmed risk adjustment discrepancies
  - MA organizations in need of technical assistance to improve risk adjustment data quality
- Measure
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- Improve/Inform
  - Quality of risk adjustment data
  - The CMS-Hierarchical Condition Category (CMS-HCC) model.

a. Missing Medical Records

If your MA organization is selected for inclusion in the data validation, your MA organization would be required to submit all necessary medical record documentation as requested within the allotted timeframe. Medical records not submitted to CMS within the required timeframe will be identified as "missing medical records." A missing medical record is a risk adjustment discrepancy. Risk adjustment data characterized as "discrepant" are used to evaluate the accuracy of payments to your MA organization. The results of the risk adjustment data validation will be used to develop an estimated payment error rate for your MA organization.

b. Guiding Principle & Guidelines

Since implementation of the CMS-HCC model in 2004, we have included hospital inpatient, hospital outpatient, and physician medical records in our risk adjustment data validation. Additionally, we modified our Guiding Principle to account for acceptable provider types and physician data sources for medical record documentation. Our Guiding Principle now states:

The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, or physician) and an acceptable physician data source as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting*.

MA organizations are allowed flexibility to select and submit supporting medical record documentation when responding to a medical record request. Since plans are not required to submit multiple occurrences of a unique diagnosis for a given enrollee, a medical record from any risk adjustment data source would be acceptable. This means that the medical record submitted for validation could be based on an encounter other than the one for which the data were submitted.

According to the risk adjustment data validation guidelines:

- Enrollee risk adjustment records are selected for validation based on risk adjustment diagnoses submitted to the Risk Adjustment Processing System (RAPS).
- Since CMS does not collect provider identifiers for risk adjustment, MA organizations must be able to track and locate supporting medical record documentation for its providers.
- MA organizations must select the "one best medical record" to support each HCC identified for validation. This means the MA organizations decide whether to submit a hospital inpatient, hospital outpatient, or physician medical record when more than one type of record is available.
- The medical record documentation must support an HCC.
- Once a MA organization selects its "one best medical record," a date of service must be identified to facilitate the medical record review process. CMS coders who review medical records will not search beyond the date of service identified in the medical record by the MA organization for review.
- Payment adjustments are based on confirmed risk adjustment discrepancies.
- An appeals process is in place to address a MA organization's disagreement with a payment adjustment based on a confirmed risk adjustment discrepancy.

c. Acceptable Risk Adjustment Data Sources

CMS has provided a list of ambulatory services that are "non-covered services" and, therefore, are unacceptable for risk adjustment. (To obtain a copy of *Table 3C – Hospital Outpatient*, please visit the *2007 Risk Adjustment Data Training For Medicare Advantage Organizations, Participant Guide* available on our contractor's web site at http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf. However, we continue to receive inquiries about the use of two specific "non-covered services"—laboratory and diagnostic radiology—and their potential use in risk adjustment payment and data validation. Therefore, we would like to clarify the importance of associating risk adjustment data submission with valid clinical documentation for physician specialties.

MA organizations must not submit documentation from laboratory and diagnostic radiology services as a standalone medical record for data validation. This type of medical documentation is insufficient for coding purposes. The following ICD-9-CM guideline updated November 2006 (available on the CDC web site at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf) clarifies the appropriate use of documentation from "non-covered source" providers for determining clinical significance:

> Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

The previous version from October 2002 included the above statement along with further clarification and examples:

The coder should not arbitrarily add an additional diagnosis to the final diagnostic statement on the basis of an abnormal laboratory finding alone. To make a diagnosis on the basis of a single lab value or abnormal diagnostic finding is risky and carries the possibility of error.

It is important to remember that a value reported either lower or higher than the normal range does not necessarily indicate a disorder. Many factors influence the value of a lab sample. These include the method used to obtain the sample (for example, a constricting tourniquet left in place for over a minute prior to collecting the sample will cause an elevated hematocrit and potassium level), the collection device, the method used to transport the sample to the lab, the calibration of the machine that reads the values, and the condition of the patient. An example is a patient who because of dehydration may show an elevated hemoglobin due to increased viscosity of the blood.

As stated above, it is inappropriate for MA organizations to submit a risk adjustment diagnosis and medical documentation on the sole basis of a "non-covered service." Thus, we will identify documentation from "non-covered services" as "invalid" and, therefore, deem such documentation as a risk adjustment discrepancy.

Note that we will accept documentation from "non-covered services" provided the documentation is reviewed by the physician and the outcome of the physician's review (i.e., diagnosis) is appropriately documented by the physician in the medical record. However, we will not accept for data validation documentation whereby a MA organization submits a diagnosis based on a laboratory service within the data collection period and physician medical record documentation that is outside of the data collection period.

For additional information on data validation, please visit the *2007 Risk Adjustment Data Training For Medicare Advantage Organizations, Participant Guide* available on our contractor's web site at http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf.

d. Signatures and Credentials

For purposes of risk adjustment data submission and validation, the MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. (Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.) This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. In these instances, the coders are able to determine that the beneficiary was evaluated by a physician or an acceptable physician data source. (For additional information on acceptable physician data sources, see the above section titled *Filtering for Acceptable Provider Types and Physician Data Sources*.)

We have identified medical records where it is unclear if the beneficiary is actually evaluated by a physician, physician extender, or other. In several cases, we have found encounters that are documented on physician's stationery but appear to be signed by a non-physician provider. For example, a medical record appears on group stationery for a given date of service. The medical record is signed but the

provider's name and credentials are not furnished on the stationery. Thus, the coders are unable to determine whether the beneficiary was evaluated by a physician, medical student, nurse practitioner, registered nurse, or other provider. This type of medical record documentation is incomplete and unacceptable for risk adjustment and, therefore, will be counted as a risk adjustment discrepancy.

CSSC WEB RESOURCES

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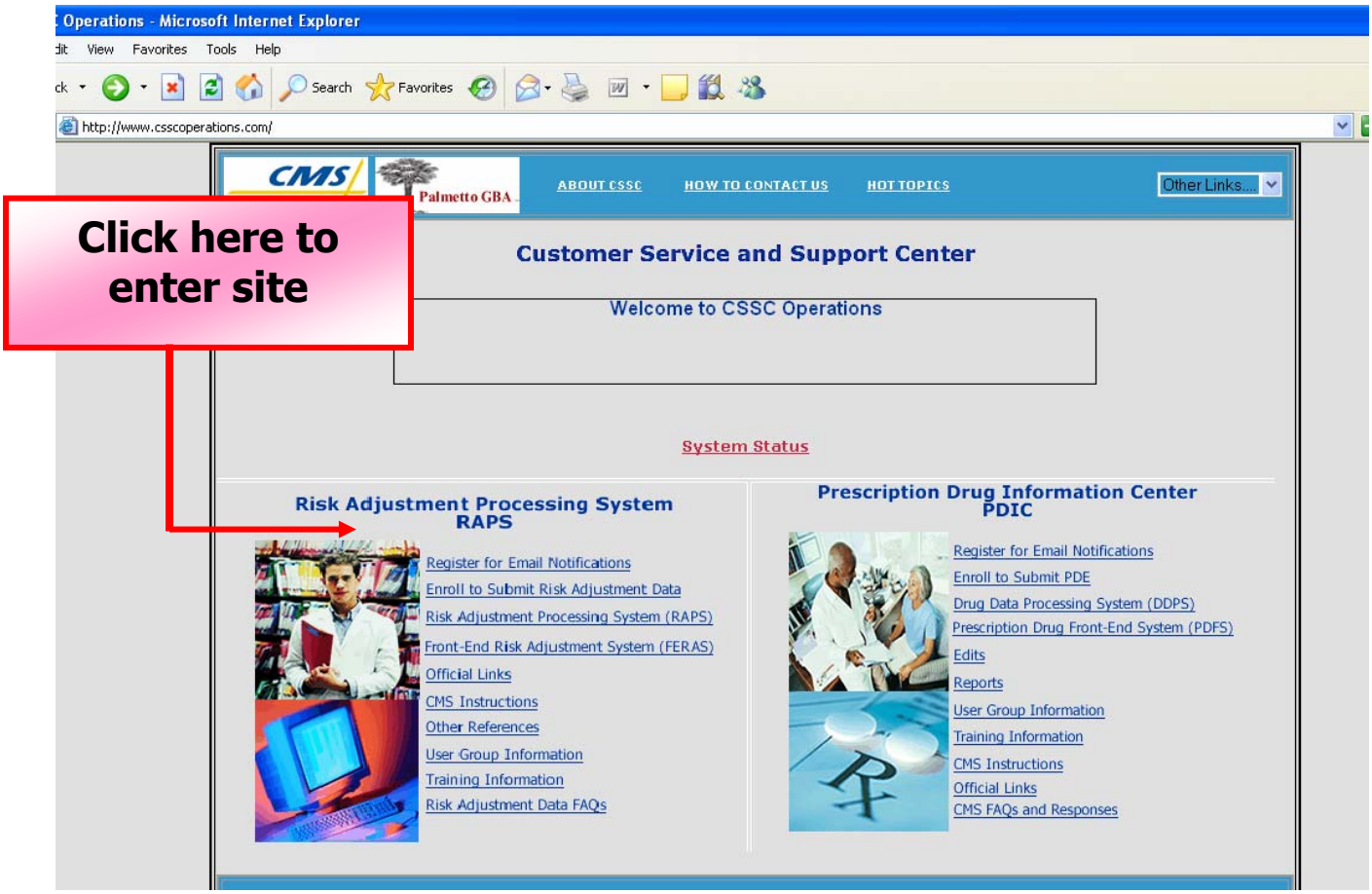
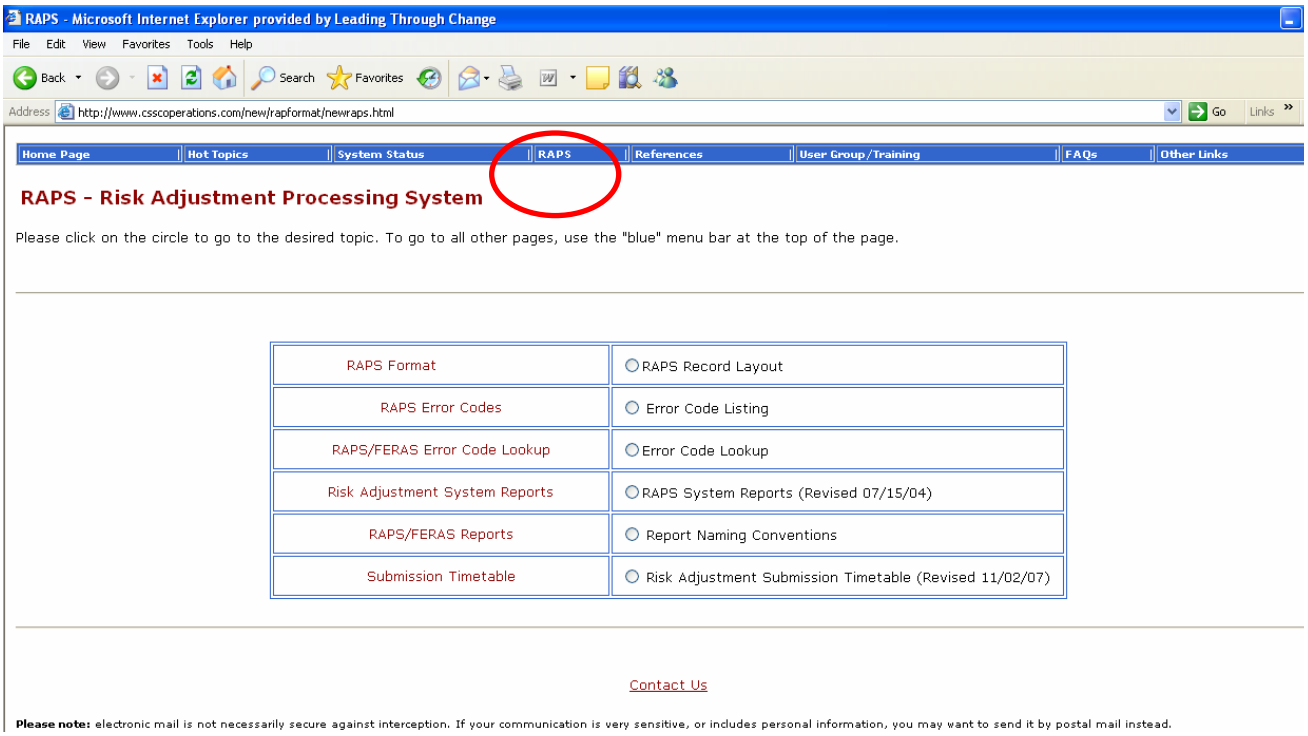
WWW.CSSCOPERATIONS.COM

http://www.csscoperations.com



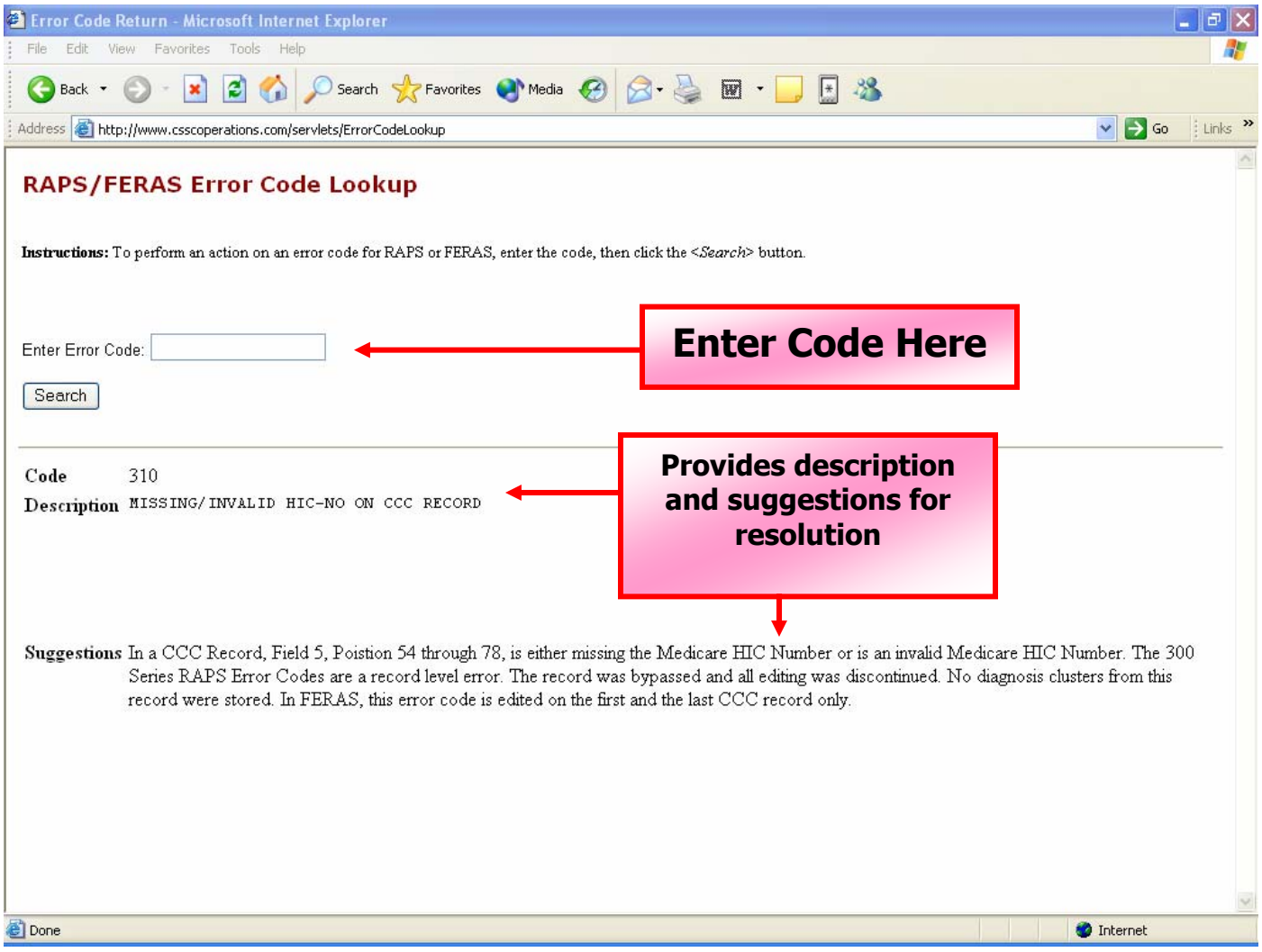
RAPS Resources

http://csscoperations.com/new/rapformat/newraps.html



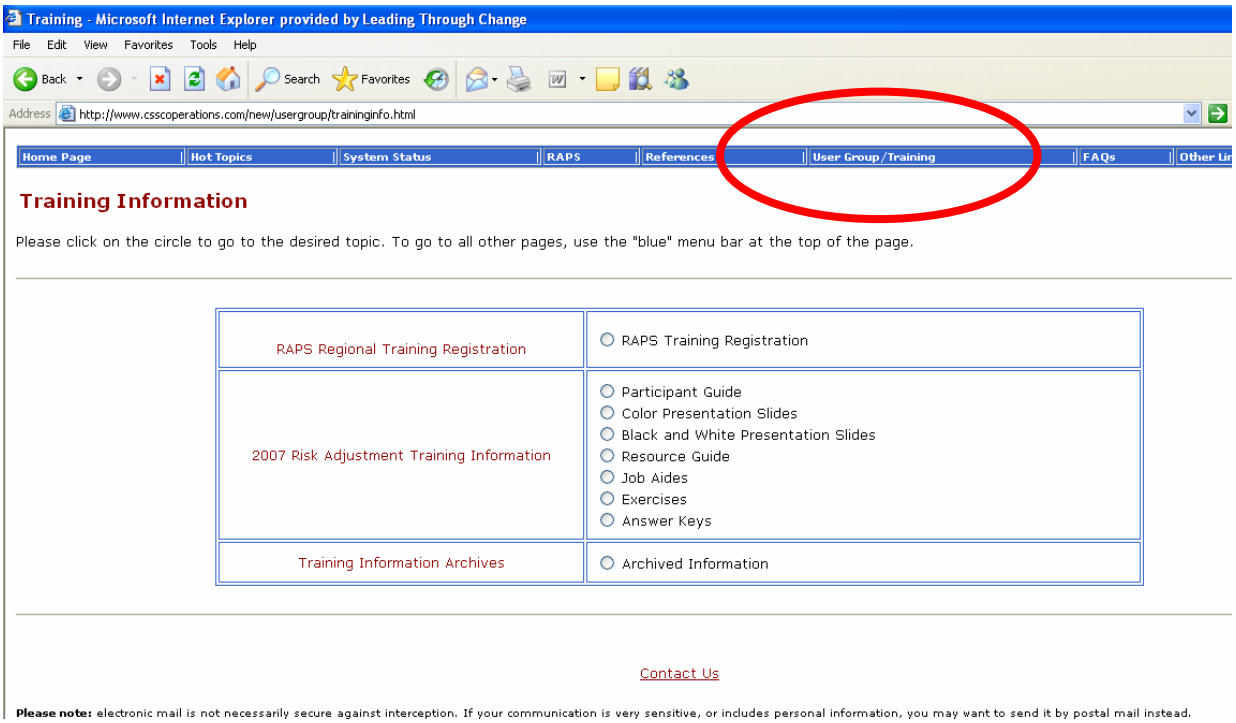
RAPS/FERAS Error Code Lookup

http://www.mcoservice.com/new/errorcodelookup_052505.htm



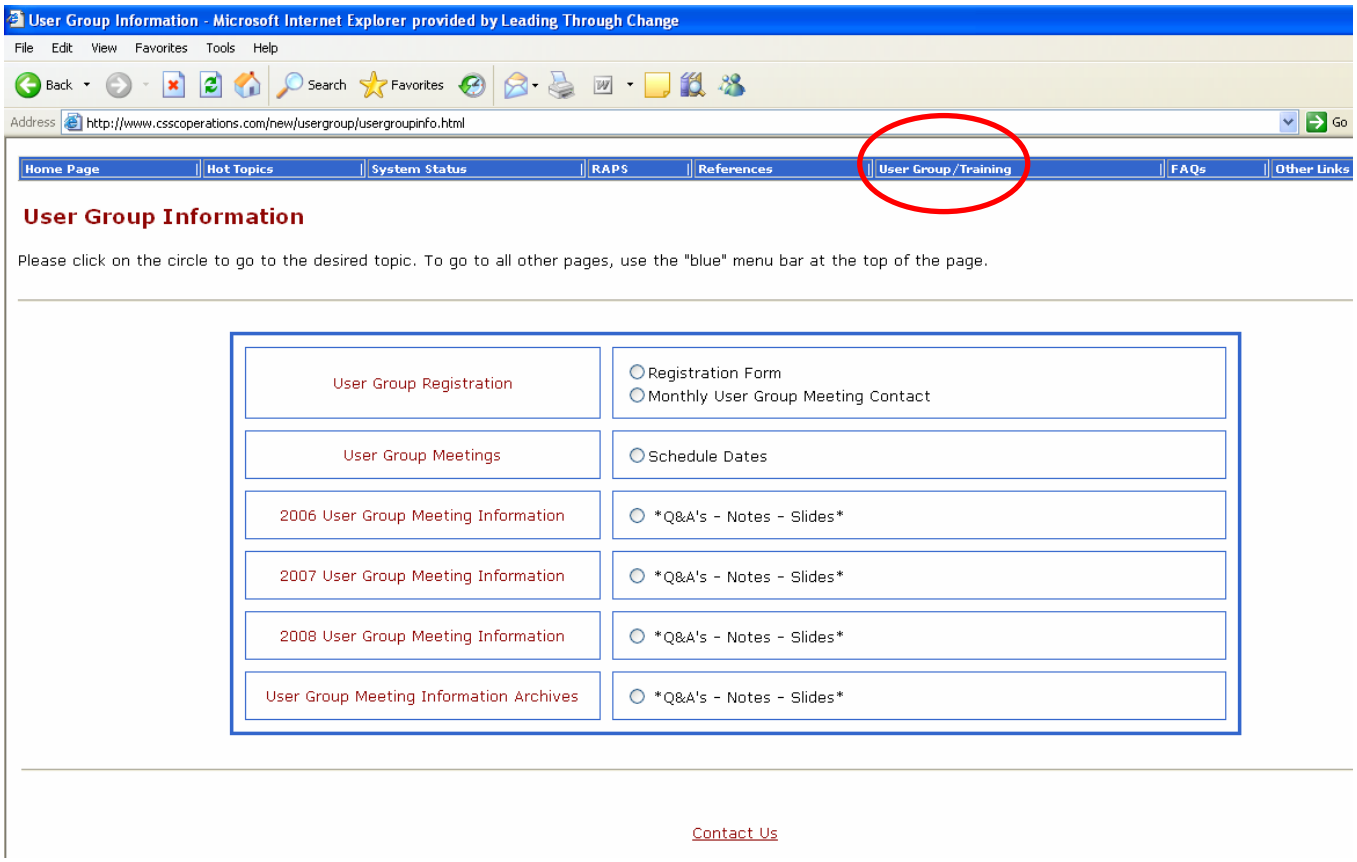
Training Guides and Updates

http://csscoperations.com/new/usergroup/traininginfo.html



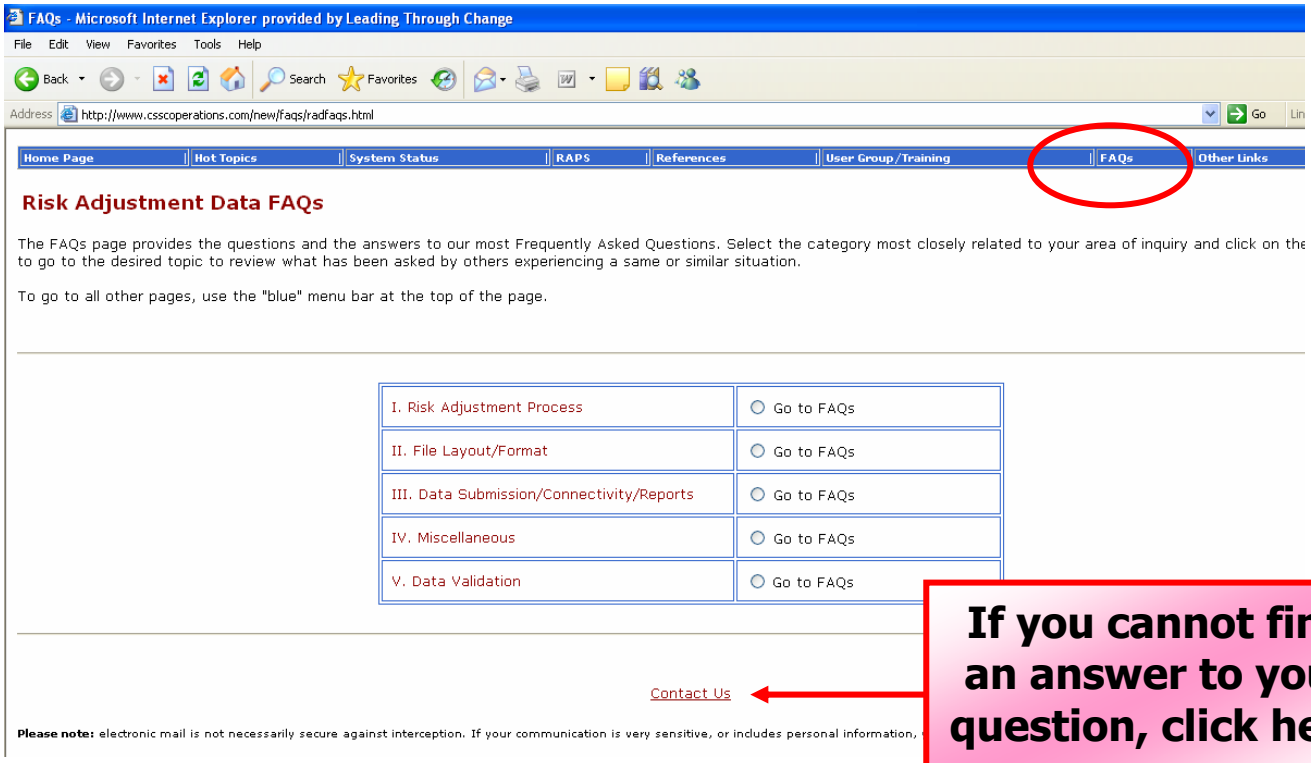
User Group Information

http://www.csscoperations.com/new/usergroup/usergroupinfo.html



Frequently Asked Questions (FAQs)

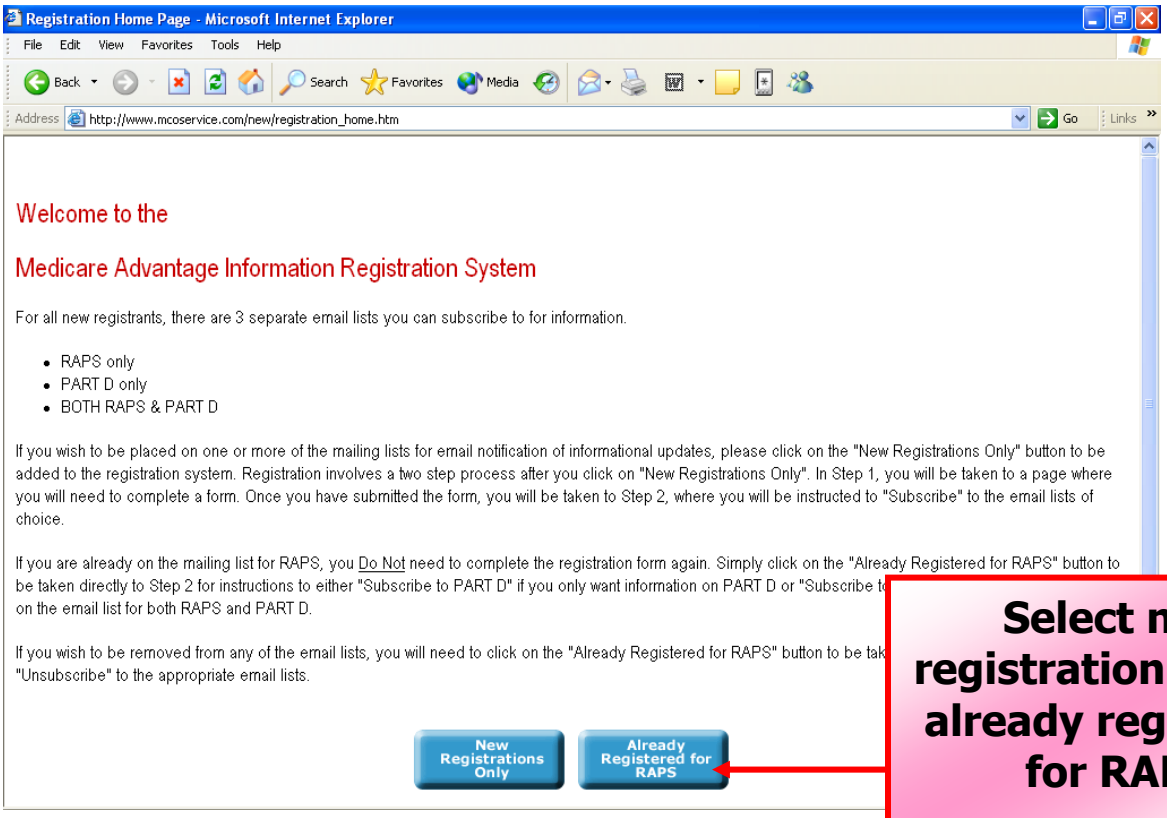
http://www.csscoperations.com/new/faqs/radfaqs.html



If you cannot find an answer to your question, click here

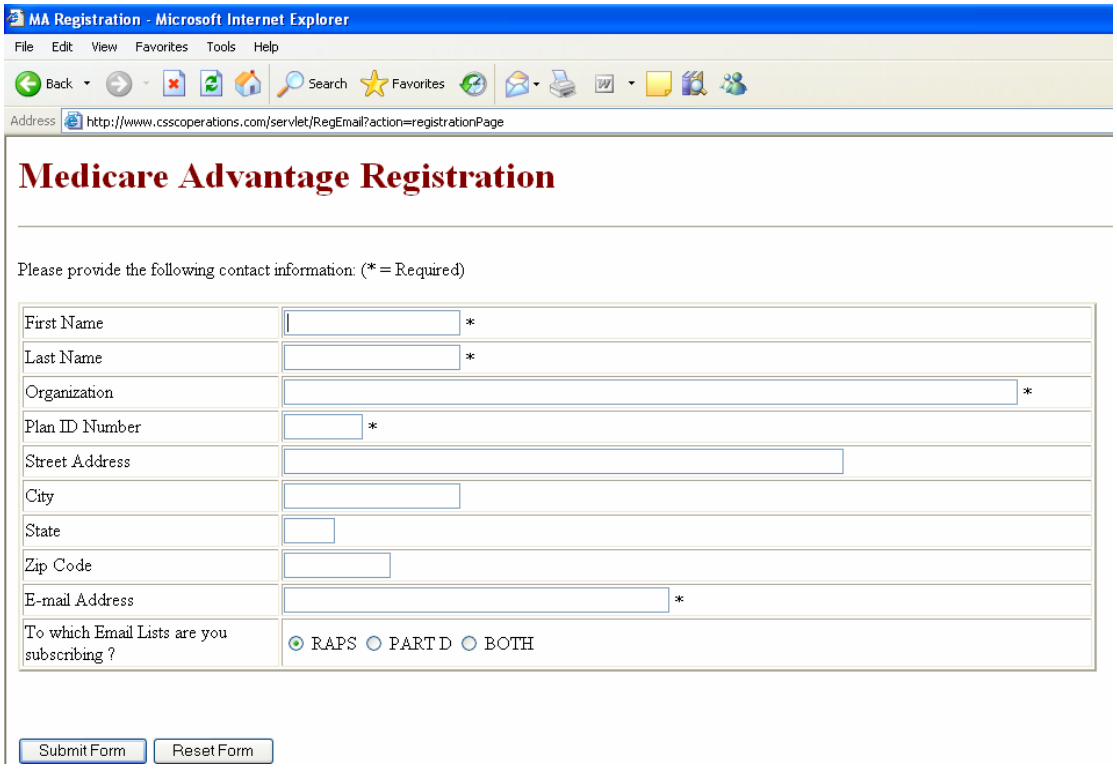
Register for Email Service

http://www.mcoservice.com/new/registration_home.htm



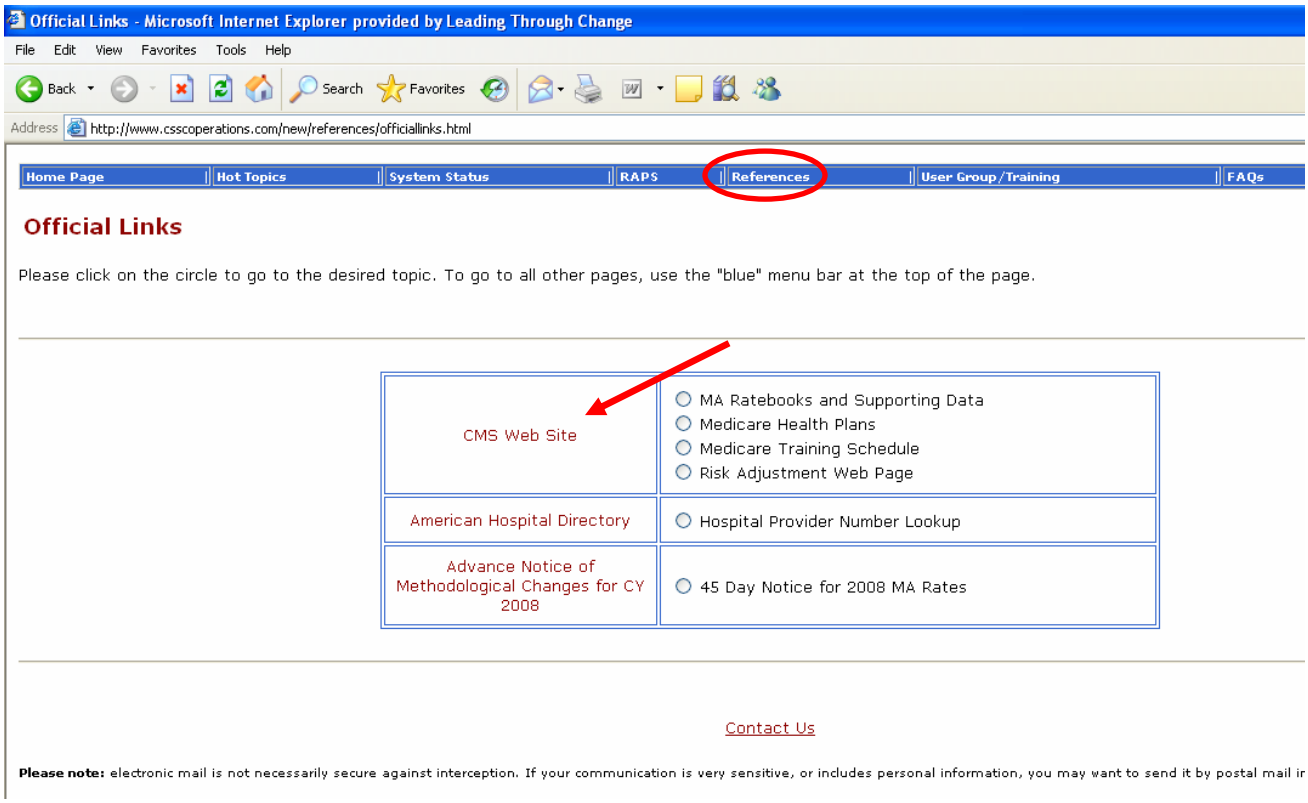
Medicare Advantage Registration

http://www.csscoperations.com/servlet/RegEmail?action=registrationPage



Link to CMS Website

http://csscoperations.com/new/references/officiallinks.html



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CSSC REFERENCE DOCUMENTS

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TO: Medicare Advantage Organizations Submitting Risk Adjustment Data

RE: EDI Enrollment and Submitter Application for Risk Adjustment Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Advantage (MA) Organizations submitting Risk Adjustment Data. The CSSC and the Front-End Risk Adjustment System (FERAS) look forward to working with you in all aspects of the submission of risk adjustment data.

The following information must be completed and sent to the CSSC for enrollment for the submission of data for Risk Adjustment:

- EDI Agreement for Risk Adjustment Data collection
- Submitter Application
- Risk Adjustment Connect:Direct Specifications (For Connect:Direct users only)

Please note the following for submitting Risk Adjustment Data:

- A CMS Risk Adjustment Data EDI Agreement must be completed for each contract number and on file with CSSC prior to submitting Risk Adjustment Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** If the submitter will be an entity other than an MA organization, the Submitter must complete the Submitter ID Application form and the EDI Agreement form. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. Regardless who submits the data, CMS holds the MA organization accountable for the content of the submission.

- A Submitter ID (SHnnnn) will be assigned to you by the CSSC and will remain effective for ongoing submission of risk adjustment data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application return it to CSSC Operations with the completed EDI Agreement.

- You will be submitting all Risk Adjustment Data to the FERAS. Data can only be submitted in the RAPS format. All data submitted to the front-end will be sent to the Risk Adjustment Processing System (RAPS) in the risk adjustment data layout.

- Datasets are required to be set up for Connect:Direct users. The Risk Adjustment Connect:Direct Specifications form should be completed and returned to the CSSC with the Submitter Application and the EDI Agreement.

- Technical Specifications are available based on the communication medium that is currently in use. Connect:Direct instructions and the FERAS User Guide are available on the csscoperations.com web site. Testing instructions for each medium are included within the document.

- On-Line transaction data entry is available through the secure MDCN FERAS web site. This option allows the user to key risk adjustment data directly into the front-end, creating the file for direct data submission.

- Reports are returned on all data submitted. The following report files are available for data submitted:

Response report generated by FERAS - per file submission

FERAS Response Report	RSP#####.RSP.FERAS_RESP
	RSP#####.ZIP.FERAS_RESP (zip format)

RAPS – CMS generated reports per file submission

RAPS Return File	RPT#####.RPT.RAPS_RETURN_FLAT
	RPT#####.ZIP.RAPS_RETURN_FLAT (zip format)
RAPS Error Report	RPT#####.RPT.RAPS_ERROR_RPT
	RPT#####.ZIP.RAPS_ERROR_RPT (zip format)
RAPS Duplicate Diagnosis Cluster Report	
	RPT#####.RPT.RAPS_DUPDX_RPT
	RPT#####.ZIP.RAPS_DUPDX_RPT (zip format)
RAPS Transaction Summary Report	
	RPT#####.RPT.RAPS_SUMMARY
	RPT#####.ZIP.RAPS_SUMMARY_RPT (zip)

RAPS - CMS generated reports monthly

RAPS Monthly Plan Activity Report	
	RPT#####.RPT.RAPS_MONTHLY
	RPT#####.ZIP.RAPS_MONTHLY (zip format)
RAPS Cumulative Plan Activity Report	
	RPT#####.RPT.RAPS_CUMULATIVE
	RPT#####.ZIP.RAPS_CUMULATIVE (zip format)
RAPS Monthly Error Frequency Report	
	RPT#####.RPT.RAPS_ERRFREQ_MNTH
	RPT#####.ZIP.RAPS_ERRFREQ_MNTH (zip)
Quarterly Error Frequency Report	
	RPT#####.RPT.RAPS_ERRFREQ_QRT
	RPT#####.ZIP.RAPS_ERRFREQ_QRT (zip)

All reference material is available on the **www.csscoperations.com** web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the information provided.

Palmetto GBA
CSSC Operations, AG-570
2300 Springdale Drive, Bldg. One
Camden, SC 29020-1728
1-877-534-2772
www.csscoperations.com
FAX: 1-803-935-0171

Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees**:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct risk adjustment data discrepancies.

12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To**:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name: _____

_____

Contract Number:_____

Signature:_____

Name: _____

Title: _____

Address:_____

_____

City/State/ZIP: _____

Phone: _____

Email: _____

Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

MA EDI Enrollment
CSSC Operations AG-570
Columbia, SC 29202-3275
Phone (877) 534-2772
www.csscoperations.com

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CSSC Risk Adjustment Data Submitter Application

New Submitter ID:	☐ Yes ☐ No
If no, please provide your existing submitter number:	
If yes, please indicate who will submit your data:	☐ Self ☐ Third Party Submitter
If Third Party Submitter is selected, please provide the Third Party's name:	
Plan Name:	
Address:	
Fax Number :	
Operations Contact Person:	
E-Mail address:	
Phone Number:	
Technical Contact Person:	
E-Mail address:	
Phone Number:	

Please list any additional Plan numbers your organization will submit data for:

Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:

**If more space is needed to list additional Plan numbers, please make a copy of this page, list the Plan numbers, and attach with the application.

What Connection Type is established via the Medicare Data Communications Network (MDCN)?

Lease Line	☐
Direct Connect	☐
Dial up / Modem	☐
GENTRAN	☐

Please return the completed submitter application, EDI Agreement and NDM dataset specifications, if applicable, to CSSC Operations at the address below.

Palmetto GBA
CSSC Operations
Post Office Box 100275, AG-570 • Columbia, South Carolina • 29202-3275
www.csscoperations.com

Risk Adjustment Connect:Direct Specifications

The CONNECT:DIRECT Node connection is defined as follows:

NET ID: **SCA**
NODE ID: **A70NDM.MC**
APPLID: A70NDMMC
AGNS ID: PGBA

PLEASE ENTER YOUR Connect:Direct INFORMATION (Required):

NET ID: _____
NODE ID: _____
APPLID: ____ **_____**
AGNS ID: **_____**
Your Connect:Direct User ID and password (if datasets are racf protected)
User ID: **_____**
Password: **_____**

RAPS Transaction Submission

DSN: **MAB.PROD.NDM.RAPS.PROD.submitter id(+1)**
DISP: (NE W,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RE CFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.RAPS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, AAA 6, must also indicate "TEST" or "PROD", depending on the type of file being submitted.

Report Retrieval (enter names)

We will return reports to you in the following DSN's. These datasets need to be GDGs to allow multiple files to be sent without manual intervention or overwriting of existing files.

Front End (FERAS) Response Report

Frequency: Daily
Report **DSN**:
DCB=(DS _____ ORG=PS,LRECL=80,RECFM=FB,BLKSIZE=27920)

RAPS Return File

Frequency: Daily
Flat **DSN**:
DCB=(DS _____ ORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

RAPS Error Report
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Summary Report
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Duplicate Diagnosis Cluster Report (502 Error Report)
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Summary Report
Frequency: Monthly
Report **DSN**:_____
DCB =(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Cumulative Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Error Frequency Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Quarterly Error Frequency Report
Frequency: Quarterly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

Date: May 2006

To: Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PD) Contracts

Regarding: Submitting and / or Retrieving, Risk Adjustment (RA) and / or Prescription Drug Event (PDE) Data Directly to CMS Enterprise File Transfer (GENTRAN)

Plans / Contracts submitting directly to the GENTRAN application need to submit an EDI agreement and Submitter application to the Customer Service and Support Center (CSSC), 877-534-2772, www.csscoperations.com.

- **EDI Agreement:** A CMS EDI Agreement must be completed for the specific data type, RA / PDE, by each contract and on file with CSSC, prior to submitting Test or Production Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations.

- **Submitter ID Assignment:** A Submitter ID will be assigned to you by the CSSC and will remain effective for ongoing submission of RA and/or PDE data. This is the unique ID assigned to the contract that will allow data submission and report retrieval. Complete the Submitter Application and return it to CSSC Operations with the completed EDI Agreement.

The GENTRAN mailbox(s) for any PDE or RA data must be established and access granted by contacting the Customer Support for Medicare Modernization (CSMM) technical help desk at 800-927-8069 or through the website at www.mmahelp.cms.hhs.gov or e-mail at mmahelp@cms.hhs.gov.

- Contracts using GENTRAN may not have more than 100,000 enrollees.

- The files submitted may not be over 1.5 g in size for any one submission.

- A mailbox must be established for each Plan / Contract number and type of data, i.e. RA and PDE that will be submitted through GENTRAN. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Third Party Submitters submitting RA and / or PDE data through GENTRAN would have to have mailboxes created for each of the contracts for which they are submitting. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Contracts / Plans using Third Party Submitters should request through the CSMM, that a GENTRAN mailbox be established for the Plan to receive reports / files.

Contracts / Plans considering using the GENTRAN application at CMS will work closely with the CSSC and the CSMM to complete the appropriate paperwork and establish the necessary connectivity.

GENTRAN File and Report Naming Conventions

PDE Production

Plan to CMS GENTRAN Name

guid.racf.PDE.freq.ccccc.FUTURE.P guid.r

GENTRAN Report Name

RSP.PDFS_RESP_ssssss T
RPT.DDPS_TRANS_VALIDATION_ssssss T
RPT.DDPS_ERROR_SUMMARY_ssssss T
RPT.DDPS_CUM_BENE_ACT_COV_ssssss T
RPT.DDPS_CUM_BENE_ACT_ENH_ssssss T
RPT.DDPS_CUM_BENE_ACT_OTC_ssssss T

PDE Test

Plan to CMS GENTRAN Name

acf.PDE.freq.ccccc.FUTURE.T

GENTRAN Report Name

EST.RSP.PDFS_RESP_ssssss
EST.RPT.DDPS_TRANS_VALIDATION_ssssss
EST.RPT.DDPS_ERROR_SUMMARY_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_COV_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_ENH_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_OTC_ssssss

RAPS Production

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.P

GENTRAN Report Name

RSP.FERAS_RESP_ssssss T
RPT.RAPS_RETURN_FLAT_ssssss TEST
RPT.RAPS_ERRORRPT_ssssss TEST
RPT.RAPS_SUMMARY_ssssss TEST
RPT.RAPS_DUPDX_RPT_ssssss TEST
RPT.RAPS_MONTHLY_ssssss TEST
RPT.RAPS_CUMULATIVE_ssssss TEST
RAPS_ERRORFREQ_MNTH_ssssss T
RAPS_ERRORFREQ_QTR_ssssss T

RAPS Test

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.T

GENTRAN Report Name

EST.RSP.FERAS_RESP_ssssss
.RPT.RAPS_RETURN_FLAT_ssssss
.RPT.RAPS_ERRORRPT_ssssss
.RPT.RAPS_SUMMARY_ssssss
.RPT.RAPS_DUPDX_RPT_ssssss
.RPT.RAPS_MONTHLY_ssssss
.RPT.RAPS_CUMULATIVE_ssssss
EST.RAPS_ERRORFREQ_MNTH_ssssss
EST.RAPS_ERRORFREQ_QTR_ssssss

CONTACTING CSSC OPERATIONS:

When a contract has established a mailbox at CMS, the following steps must be taken to make sure the connection from FERAS/PDFS to CMS GENTRAN mailbox has been generated:

- Check enrollment in HPMS
- Distinguish RAPS and/or PDE mailbox needs to be established
- Send email to CSSC technician to set up GDG Base to send either RAPS and/or PDE data and reports
- Once the above steps have been completed, EPClaims is updated for PDE contracts only (RAPS requires no additional updates in EPClaims)
- Customer is notified
- GENT RAN spreadsheet on the “U” Drive is updated
- Enter information into the INFO System

APPLICATION FOR ACCESS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

EUA WorkFlow Request No.

APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

1. TYPE OF REQUEST *(Check only one)*:

❑ NEW *(Issue a CMS UserID)*
❑ CONNECT/DISCONNECT *(Add/remove access authorities)*
❑ CERTIFY *(Due date: _____/_____ mo yr)*
❑ CHANGE USER INFORMATION *(Note new info)*
❑ DELETE *(Remove CMS UserID from all CMS systems)*

USERID
(Capital Letters)

2. USER INFORMATION

❑ CMS Employee
❑ Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only
❑ Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using Other Systems
❑ CITIC Contractor
❑ Program Safeguard Contractor
❑ Medicare Contractor/Intermediary/Carrier
❑ Contractor (non-Medicare contract with CMS)
❑ Researcher
❑ Quality Improvement Organization
❑ End-Stage Renal Disease Network
❑ State Agency (State of _____)
❑ Federal Govt – Baltimore HR Center
❑ Federal Govt – Centers for Disease Control & Prevention
❑ Federal Govt – Commission Corps
❑ Federal Govt – Dept of Health & Human Services
❑ Federal Govt – HHS – OMHA
❑ Federal Govt – Dept of Justice
❑ Federal Govt – Dept of Veterans Affairs
❑ Federal Govt – Government Accountability Office
❑ Federal Govt – General Services Administration
❑ Federal Govt – Internal Revenue Service
❑ Federal Govt – Office of General Counsel
❑ Federal Govt – Office of Inspector General
❑ Federal Govt – Railroad Retirement Board
❑ Federal Govt – Social Security Administration
❑ Federal Govt – Other: _____
❑ Other: _____

First Name *(As you want it published)*	MI	Last Name *(As you want it published)*

Company/Organization/Department Name

Mailing Address *(Include Suite/Mailstop)*

City	State	ZIP Code

Office Telephone *(Include Extension)*	Company Telephone *(If different)*	E-Mail Address

IF CMS EMPLOYEE Org Name/Admin Code

Are you a Manager?
❑ Yes ❑ No

IF ONSITE AT CMS LOCATION CMS Region/Facility (Check One)

❑ R4 (AFC) Atlanta
❑ R10 (BLNCH) Seattle
❑ CO (CENTRAL) Central Office
❑ R5 (CHIICB) Chicago
❑ DC (COHEN) DC
❑ R6 (DAL1301) Dallas
❑ R8 (DENCSB) Denver
❑ R7 (FOBKAN) Kansas City
❑ DC (HHH) DC
❑ R9 (HWTHRN) San Francisco
❑ R1 (JFKBOS) Boston
❑ R2 (JKJNYC) New York
❑ CO (LBDCO) Central Office
❑ CO (NORTH) Central Office
❑ R3 (PHIPLB) Philadelphia
❑ CO (SOUTH) Central Office
❑ Other _____

Mail Stop	Desk Location

3. WORKLOAD INFORMATION

Contract Number(s) *(for Medicare Advantage/Medicare Advantage with Prescription Drug/Prescription Drug Plan/Cost Contracts — Hxxxx, Sxxxx, etc.)*

Carrier Number(s) *(for Medicare Contractors/Intermediaries/Carriers — 12345)*

Contract and Task Number *(for Contractors — CMS-05-0001 : 0001)*

Grant Number *(for Researchers)*

Inter-Agency Agreement Number

4. REQUIRED ACCESSES *(See http://www.cms.hhs.gov/mdcn/bmcjcreport.asp for list of available jobcodes)*

❑ Connect	❑ Disconnect	❑ Keep	Default CMS Employee (standard desktop & network with CMS e-mail acct)	❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	Default Non-CMS Employee (standard network access)	❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____

5. JUSTIFICATION *(If name change, show Old Name =, New Name =)*

6. APPROVALS: *(See http://www.cms.hhs.gov/mdcn/reqsigchart.pdf for approval info)*

PROVIDE SIGNATURES BELOW OR APPROVE ONLINE EUA WORKFLOW REQUEST NUMBER REFERENCED ON PAGE 1.

Authorization: We acknowledge that our Organization is responsible for all resources to be used by the person identified above and that requested accesses are required to perform their duties. We have reviewed and verified the workload information supplied is accurate and appropriate. We understand that any change in employment status or access needs are to be reported immediately via submittal of this form or EUA WorkFlow request.

1st APPROVER *(CMS Project Officer, CMS Contact, CMS Supervisor, MCIC Contact, etc.)*

Printed Name		Telephone Number
CMS UserID	Signature	Date

2nd APPROVER *(Not required for CMS employees, BHRC or Commissioned Corps)*

Printed Name		Telephone Number
CMS UserID	Signature	Date

APPLICANT: Read, complete and sign next page.

EUA WorkFlow Request No.

APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

Printed Name *(As you want it published)*

Social Security Number

CMS USERID

PRIVACY ACT STATEMENT

The information on page 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10) (The Privacy Act of 1974). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on this form will be maintained in the Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Data Center Systems of Records and may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED.REG.41329 (08-11-94) and as CMS may establish in the future by publication in the Federal Register.

The Social Security Number (SSN) is used as an identifier in the Federal Service because of the large number of present and former Federal employees and applicants whose identity can only be distinguished by use of the SSN. Collection of the SSN is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary. However, if you do not provide this information, you will not be granted access to CMS computer systems.

SECURITY REQUIREMENTS FOR USERS OF CMS COMPUTER SYSTEMS

CMS uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of Federal programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in Federal computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. CMS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. CMS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to CMS Computer Systems containing sensitive information must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Do not browse or use CMS data files for unauthorized or illegal purposes.
- Do not use CMS data files for private gain or to misrepresent yourself or CMS.
- Do not make any disclosure of CMS data that is not specifically authorized.
- Do not duplicate CMS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter CMS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of CMS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from Federal Service, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

Applicant's Signature	Date

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ICD-9-CM Official Guidelines for Coding and Reporting

Effective October 1, 2011
Narrative changes appear in bold text
Items underlined have been moved within the guidelines since October 1, 2010

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-9-CM

The conventions for the ICD-9-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the index and tabular of the ICD-9-CM as instructional notes. The conventions are as follows:

1. Format:

The ICD-9-CM uses an indented format for ease in reference

2. Abbreviations

a. Index abbreviations

NEC "Not elsewhere classifiable"
This abbreviation in the index represents "other specified" when a specific code is not available for a condition the index directs the coder to the "other specified" code in the tabular.

b. Tabular abbreviations

NEC "Not elsewhere classifiable"
This abbreviation in the tabular represents "other specified". When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the "other specified" code.
(See Section I.A.5.a. "Other" codes").

NOS "Not otherwise specified"
This abbreviation is the equivalent of unspecified.
(See Section I.A.5.b., "Unspecified" codes)

3. Punctuation

[ ] Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the index to identify manifestation codes.
(See Section I.A.6. "Etiology/manifestations")

( ) Parentheses are used in both the index and tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is

assigned. The terms within the parentheses are referred to as nonessential modifiers.

: Colons are used in the Tabular list after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

4. Includes and Excludes Notes and Inclusion terms

Includes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Excludes: An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

Inclusion terms: List of terms is included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

5. Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" (usually a code with a 4th digit 8 or fifth-digit 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate "other" codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

6. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.

In addition to the notes in the tabular, these conditions also have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

The most commonly used etiology/manifestation combinations are the codes for Diabetes mellitus, category 250. For each code under category 250 there is a use additional code note for the manifestation that is specific for that particular diabetic manifestation. Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition. The category 250 diabetes codes should be sequenced first, followed by the manifestation codes.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
See - Section I.B.9. "Multiple coding for a single condition".

7. "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

8. "With"

The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

The word "with" in the alphabetic index is sequenced immediately following the main term, not in alphabetical order.

9. "See" and "See Also"

The "see" instruction following a main term in the index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

B. General Coding Guidelines

1. Use of Both Alphabetic Index and Tabular List

Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.

2. Locate each term in the Alphabetic Index

Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

3. Level of Detail in Coding

Diagnosis and procedure codes are to be used at their highest number of digits available.

ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. For example, Acute myocardial infarction, code 410, has fourth digits that describe the location of the infarction (e.g., 410.2, Of inferolateral wall), and fifth digits that identify the episode of care. It would be incorrect to report a code in category 410 without a fourth and fifth digit.

ICD-9-CM Volume 3 procedure codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of third and/or fourth digits, which provide greater detail.

4. Code or codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

5. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the admission/encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

6. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

7. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

8. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

9. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. "Use additional code" notes are found in the tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair - "use additional code" indicates that a secondary code should be added.

For example, for infections that are not included in chapter 1, a secondary code from category 041, Bacterial infection in conditions classified elsewhere and of unspecified site, may be required to identify the bacterial organism causing the infection. A "use additional code" note will normally be found at

the infectious disease code, indicating a need for the organism code to be added as a secondary code.

"Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a "code first" note is present and an underlying condition is present the underlying condition should be sequenced first.

"Code, if applicable, any causal condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

10. Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

11. Combination Code

A combination code is a single code used to classify:
Two diagnoses, or
A diagnosis with an associated secondary process (manifestation)
A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

12. Late Effects

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two

codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

Exceptions to the above guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) **or the classification instructs otherwise.** The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

13. Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.
If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened."
If the subterms are listed, assign the given code.
If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

14. Reporting Same Diagnosis Code More than Once

Each unique ICD-9-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.

15. Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.

Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.

16. Documentation for BMI and Pressure Ulcer Stages

For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient's

provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI and pressure ulcer stage codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

17. Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome.

18. Documentation of Complications of care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

C. Chapter-Specific Coding Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.

1. Chapter 1: Infectious and Parasitic Diseases (001-139)

a. Human Immunodeficiency Virus (HIV) Infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's

diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2) Selection and sequencing of HIV codes

(a) **Patient admitted for HIV-related condition**

If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

(b) **Patient with HIV disease admitted for unrelated condition**

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

(c) **Whether the patient is newly diagnosed**

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d) **Asymptomatic human immunodeficiency virus**

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

(e) **Patients with inconclusive HIV serology**

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code 795.71, Inconclusive serologic test for Human Immunodeficiency Virus [HIV].

(f) **Previously diagnosed HIV-related illness**

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient has developed an HIV-related illness, the patient

should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

(g) **HIV Infection in Pregnancy, Childbirth and the Puerperium**

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

(h) **Encounters for testing for HIV**

If a patient is being seen to determine his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high risk group for HIV. Should a patient with signs or symptoms or illness, or a confirmed HIV related diagnosis be tested for HIV, code the signs and symptoms or the diagnosis. An additional counseling code V65.44 may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results use code V65.44, HIV counseling, if the results of the test are negative.

If the results are positive but the patient is asymptomatic use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic use code 042, HIV infection, with codes for the HIV related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

b. Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

1) SIRS, Septicemia, and Sepsis

(a) The terms *septicemia* and *sepsis* are often used interchangeably by providers, however they are not considered synonymous terms. The following descriptions are provided for reference but do not preclude querying the provider for clarification about terms used in the documentation:

(i) Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.

(ii) Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis.

(iii) Sepsis generally refers to SIRS due to infection.

(iv) Severe sepsis generally refers to sepsis with associated acute organ dysfunction.

(b) **The Coding of SIRS, sepsis and severe sepsis**

The coding of SIRS, sepsis and severe sepsis requires a minimum of 2 codes: a code for the underlying cause (such as infection or trauma) and a code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(i) The code for the underlying cause (such as infection or trauma) must be sequenced before the code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(ii) Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, Unspecified septicemia.

(iii) Severe sepsis requires additional code(s) for the associated acute organ dysfunction(s).

(iv) If a patient has sepsis with multiple organ dysfunctions, follow the instructions for coding severe sepsis.

(v) Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9.

(vi) See Section I.C.17.g), Injury and poisoning, for information regarding systemic inflammatory response syndrome (SIRS) due to trauma/burns and other non-infectious processes.

(c) Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Sequencing sepsis and severe sepsis

(a) **Sepsis and severe sepsis as principal diagnosis**

If sepsis or severe sepsis is present on admission, and meets the definition of principal diagnosis, the systemic infection code (e.g., 038.xx, 112.5, etc) should be assigned as the principal diagnosis, followed by code 995.91, Sepsis, or 995.92, Severe sepsis, as required by the sequencing rules in the Tabular List. Codes from subcategory 995.9 can never be assigned as a principal diagnosis. A code should also be assigned for any localized infection, if present.

If the sepsis or severe sepsis is due to a postprocedural infection, see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.

(b) **Sepsis and severe sepsis as secondary diagnoses**

When sepsis or severe sepsis develops during the encounter (it was not present on admission), the systemic infection code and code 995.91 or 995.92 should be assigned as secondary diagnoses.

(c) **Documentation unclear as to whether sepsis or severe sepsis is present on admission**

Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear

whether the sepsis or severe sepsis was present on admission, the provider should be queried.

3) Sepsis/SIRS with Localized Infection

If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS doesn't develop until after admission, see guideline I.C.1.b.2.b).

If the localized infection is postprocedural, *see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.*

Note: The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.

4) Bacterial Sepsis and Septicemia

In most cases, it will be a code from category 038, Septicemia, that will be used in conjunction with a code from subcategory 995.9 such as the following:

(a) **Streptococcal sepsis**

If the documentation in the record states streptococcal sepsis, codes 038.0, Streptococcal septicemia, and code 995.91 should be used, in that sequence.

(b) **Streptococcal septicemia**

If the documentation states streptococcal septicemia, only code 038.0 should be assigned, however, the provider should be queried whether the patient has sepsis, an infection with SIRS.

5) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not

clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

6) Septic shock

(a) **Sequencing of septic shock and postprocedural septic shock**

Septic shock generally refers to circulatory failure associated with severe sepsis, and, therefore, it represents a type of acute organ dysfunction.

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92, **Severe sepsis** and 785.52**, Septic shock or 998.02, Postoperative septic shock**. Any additional codes for other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

(b) **Septic shock and postprocedural septic shock without documentation of severe sepsis**

Since septic shock indicates the presence of severe sepsis, **c**ode 995.92, Severe sepsis, **can be** assigned with code 785.52, Septic shock, **or code 998.02 Postoperative shock, septic,** even if the term severe sepsis is not documented in the record.

7) Sepsis and septic shock complicating abortion and pregnancy

Sepsis and septic shock complicating abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).
See section I.C.11.i.7. for information on the coding of puerperal sepsis.

8) Negative or inconclusive blood cultures

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

9) Newborn sepsis

See Section I.C.15.j for information on the coding of newborn sepsis.

10) Sepsis due to a Postprocedural Infection

(a) **Documentation of causal relationship**

As with all postprocedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

(b) **Sepsis due to postprocedural infection**

In cases of postprocedural sepsis, the complication code, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and either code 995.91or 995.92). An additional code(s) for any acute organ dysfunction should also be assigned for cases of severe sepsis.

See Section see Section I.C.1.b.6 if the sepsis or severe sepsis results in postprocedural septic shock.

(c) **Postprocedural infection and postprocedural septic shock**

In cases where a postprocedural infection has occurred and has resulted in severe sepsis and postprocedural septic shock, the code for the precipitating complication such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and code 995.92). Code 998.02, Postoperative septic shock, should be assigned as an additional code. In cases of severe sepsis, an additional code(s) for any acute organ dysfunction should also be assigned.

11) External cause of injury codes with SIRS

Refer to Section I.C.19.a.7 for instruction on the use of external cause of injury codes with codes for SIRS resulting from trauma.

12) Sepsis and Severe Sepsis Associated with Non-infectious Process

In some cases, a non-infectious process, such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a

non-infectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the non-infectious condition should be sequenced first, followed by the code for the systemic infection and either code 995.91, Sepsis, or 995.92, Severe sepsis. Additional codes for any associated acute organ dysfunction(s) should also be assigned for cases of severe sepsis. If the sepsis or severe sepsis meets the definition of principal diagnosis, the systemic infection and sepsis codes should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the sepsis or severe sepsis meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

See Section I.C.1.b.2.a. for guidelines pertaining to sepsis or severe sepsis as the principal diagnosis.

Only one code from subcategory 995.9 should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in sepsis or severe sepsis, assign either code 995.91 or 995.92. Do not additionally assign code 995.93, Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome with acute organ dysfunction.

See Section I.C.17.g for information on the coding of SIRS due to trauma/burns or other non-infectious disease processes.

c. Methicillin Resistant *Staphylococcus aureus* (MRSA) Conditions

1) Selection and sequencing of MRSA codes

(a) **Combination codes for MRSA infection**

When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., septicemia, pneumonia) assign the appropriate code for the condition (e.g., code 038.12, Methicillin resistant Staphylococcus aureus septicemia or code 482.42, Methicillin resistant pneumonia due to Staphylococcus aureus). Do not assign code 041.12, Methicillin resistant Staphylococcus aureus, as an additional code because the code includes the type of infection and the

MRSA organism. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins, as an additional diagnosis.

See Section C.1.b.1 for instructions on coding and sequencing of septicemia.

(b) **Other codes for MRSA infection**

When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, select the appropriate code to identify the condition along with code 041.12, Methicillin resistant Staphylococcus aureus, for the MRSA infection. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins.

(c) **Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization**

The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier. Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as “MRSA screen positive” or “MRSA nasal swab positive”.

Assign code V02.54, Carrier or suspected carrier, Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code V02.53, Carrier or suspected carrier, Methicillin susceptible Staphylococcus aureus, for patient documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

Code V02.59, Other specified bacterial diseases, should be assigned for other types of staphylococcal colonization (e.g., S. *epidermidis, S. saprophyticus).* Code V02.59 should not be assigned for colonization with any type of *Staphylococcus aureus* (MRSA, MSSA).

(d) **MRSA colonization and infection**

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code V02.54, Carrier or suspected carrier, Methicillin resistant *Staphylococcus aureus*, and a code for the MRSA infection may both be assigned.

2. Chapter 2: Neoplasms (140-239)

General guidelines

Chapter 2 of the ICD-9-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The tabular should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist. *See Section I. C. 18.d.4. for information regarding V codes for genetic susceptibility to cancer.*

a. Treatment directed at the malignancy

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate V58.x code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. Treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.

If anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented**, assign codes for both conditions.**

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first. The appropriate neoplasm code should be assigned as an additional code.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4) Treatment of a complication resulting from a surgical procedure

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and

there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.

e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy

1) Episode of care involves surgical removal of neoplasm

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.

2) Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code V58.0, Encounter for radiation therapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

3) Patient admitted for radiotherapy/chemotherapy and immunotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

f. Admission/encounter to determine extent of malignancy

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

g. Symptoms, signs, and ill-defined conditions listed in Chapter 16 associated with neoplasms

Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

h. Admission/encounter for pain control/management

See Section I.C.6.a.5 for information on coding admission/encounter for pain control/management.

i. Malignant neoplasm associated with transplanted organ

A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from subcategory 996.8, Complications of transplanted organ, followed by code 199.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

3. Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)

a. Diabetes mellitus

Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of diabetes mellitus and whether the diabetes is controlled or uncontrolled.

See I.C.3.a.7 for secondary diabetes

1) Fifth-digits for category 250:

The following are the fifth-digits for the codes under category 250:

0 type II or unspecified type, not stated as uncontrolled
1 type I, [juvenile type], not stated as uncontrolled
2 type II or unspecified type, uncontrolled

3 type I, [juvenile type], uncontrolled

The age of a patient is not the sole determining factor, though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is type II.

3) Diabetes mellitus and the use of insulin

All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic. Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, the appropriate fifth-digit for type II must be used. For type II patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient's blood sugar under control during an encounter.

4) Assigning and sequencing diabetes codes and associated conditions

When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification *(See Section I.A.6., Etiology/manifestation convention).* Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has. The corresponding secondary codes are listed under each of the diabetes codes.

(a) **Diabetic retinopathy/diabetic macular edema**

Diabetic macular edema, code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0, Diabetic retinopathy, must be used with code 362.07. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code.

5) Diabetes mellitus in pregnancy and gestational diabetes

(a) For diabetes mellitus complicating pregnancy, see Section I.C.11.f., Diabetes mellitus in pregnancy.

(b) For gestational diabetes, see Section I.C.11, g., Gestational diabetes.

6) Insulin pump malfunction

(a) **Underdose of insulin due insulin pump failure**

An underdose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal or first listed code, followed by the appropriate diabetes mellitus code based on documentation.

(b) **Overdose of insulin due to insulin pump failure**

The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be 996.57, Mechanical complication due to insulin pump, followed by code 962.3, Poisoning by insulins and antidiabetic agents, and the appropriate diabetes mellitus code based on documentation.

7) Secondary Diabetes Mellitus

Codes under category 249, Secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) **Fifth-digits for category 249:**

A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled.

(b) **Secondary diabetes mellitus and the use of insulin**

For patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned. Code V58.67 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.

(c) **Assigning and sequencing secondary diabetes codes and associated conditions**

When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. The secondary diabetes codes and the diabetic manifestation codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes. For example, secondary diabetes with diabetic nephrosis is assigned to code 249.40, followed by 581.81.

(d) **Assigning and sequencing secondary diabetes codes and its causes**

The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the reason for the encounter, applicable ICD-9-CM sequencing conventions, and chapter-specific guidelines.

If a patient is seen for treatment of the secondary diabetes or one of its associated conditions, a code from category 249 is sequenced as the principal or first-listed diagnosis, with the cause of the secondary diabetes (e.g. cystic fibrosis) sequenced as an additional diagnosis.

If, however, the patient is seen for the treatment of the condition causing the secondary diabetes (e.g., malignant neoplasm of pancreas), the code for the cause of the secondary diabetes should be sequenced as the principal or first-listed diagnosis followed by a code from category 249.

(i) Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. Assign a code from subcategory 249**,** Secondary diabetes mellitus and a code from subcategory V88.1, Acquired absence of pancreas as additional

codes. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.
See section I.C.17.e for coding of adverse effects and poisoning, and section I.C.19 for E code reporting.

4. Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)

a. Anemia of chronic disease

Subcategory 285.2, Anemia in chronic illness, has codes for anemia in chronic kidney disease, code 285.21; anemia in neoplastic disease, code 285.22; and anemia in other chronic illness, code 285.29. These codes can be used as the principal/first listed code if the reason for the encounter is to treat the anemia. They may also be used as secondary codes if treatment of the anemia is a component of an encounter, but not the primary reason for the encounter. When using a code from subcategory 285 it is also necessary to use the code for the chronic condition causing the anemia.

1) Anemia in chronic kidney disease

When assigning code 285.21, Anemia in chronic kidney disease, it is also necessary to assign a code from category 585, Chronic kidney disease, to indicate the stage of chronic kidney disease.
See I.C.10.a. Chronic kidney disease (CKD).

2) Anemia in neoplastic disease

When assigning code 285.22, Anemia in neoplastic disease, it is also necessary to assign the neoplasm code that is responsible for the anemia. Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic chemotherapy drugs. Assign **the appropriate code** for anemia due to antineoplastic chemotherapy.
See I.C.2.c.1 Anemia associated with malignancy.
See I.C.2.c.2 Anemia associated with chemotherapy, immunotherapy and radiation therapy.

5. Chapter 5: Mental Disorders (290-319)

Reserved for future guideline expansion

6. Chapter 6: Diseases of Nervous System and Sense Organs (320-389)

a. Pain - Category 338

1) General coding information

Codes in category 338 may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome.

A code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

(a) **Category 338 Codes as Principal or First-Listed Diagnosis**

Category 338 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

- When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category 338 should be assigned.

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the

appropriate pain code as the principal or first listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

(b) **Use of Category 338 Codes in Conjunction with Site Specific Pain Codes**

(i) Assigning Category 338 Codes and Site-Specific Pain Codes

Codes from category 338 may be used in conjunction with codes that identify the site of pain (including codes from chapter 16) if the category 338 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) Sequencing of Category 338 Codes with Site-Specific Pain Codes

The sequencing of category 338 codes with site-specific pain codes (including chapter 16 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category 338 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code 338.11, Acute pain due to trauma, followed by code 723.1, Cervicalgia, to identify the site of pain).

- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category 338.

2) Pain due to devices, implants and grafts

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. Use additional code(s) from category 338 to identify acute or chronic pain due to presence of the device, implant or graft (338.18-338.19 or 338.28-338.29).

3) Postoperative Pain

Post-thoracotomy pain and other postoperative pain are classified to subcategories 338.1 and 338.2, depending on whether the pain is acute or chronic. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

(a) **Postoperative pain not associated with specific postoperative complication**

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category 338.

(b) **Postoperative pain associated with specific postoperative complication**

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. If appropriate, use additional code(s) from category 338 to identify acute or chronic pain (338.18 or 338.28). If pain control/management is the reason for the encounter, a code from category 338 should be assigned as the principal or first-listed diagnosis in accordance with *Section I.C.6.a.1.a above*.

(c) **Postoperative pain as principal or first-listed diagnosis**

Postoperative pain may be reported as the principal or first-listed diagnosis when the stated reason for the admission/encounter is documented as postoperative pain control/management.

(d) **Postoperative pain as secondary diagnosis**

Postoperative pain may be reported as a secondary diagnosis code when a patient presents for outpatient

surgery and develops an unusual or inordinate amount of postoperative pain.

The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.*

See Section II.I.2 for information on sequencing of diagnoses for patients admitted to hospital inpatient care following post-operative observation.

See Section II.J for information on sequencing of diagnoses for patients admitted to hospital inpatient care from outpatient surgery.

See Section IV.A.2 for information on sequencing of diagnoses for patients admitted for observation.

4) Chronic pain

Chronic pain is classified to subcategory 338.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

5) Neoplasm Related Pain

Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis.

See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).

6) Chronic pain syndrome

This condition is different than the term "chronic pain," and therefore this code should only be used when the provider has specifically documented this condition.

b. Glaucoma

1) Glaucoma

For types of glaucoma classified to subcategories 365.1-365.6, an additional code should be assigned from subcategory 365.7, Glaucoma stage, to identify the glaucoma stage. Codes from 365.7, Glaucoma stage, may not be assigned as a principal or first-listed diagnosis.

2) Bilateral glaucoma with same stage

When a patient has bilateral glaucoma and both are documented as being the same type and stage, report only the code for the type of glaucoma and one code for the stage.

3) Bilateral glaucoma stage with different stages

When a patient has bilateral glaucoma and each eye is documented as having a different stage, assign one code for the type of glaucoma and one code for the highest glaucoma stage.

4) Bilateral glaucoma with different types and different stages

When a patient has bilateral glaucoma and each eye is documented as having a different type and a different stage, assign one code for each type of glaucoma and one code for the highest glaucoma stage.

5) Patient admitted with glaucoma and stage evolves during the admission

If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.

6) Indeterminate stage glaucoma

Assignment of code 365.74, Indeterminate stage glaucoma, should be based on the clinical documentation. Code 365.74 is used for glaucomas whose stage cannot be clinically determined. This code should not be confused with code 365.70, Glaucoma stage, unspecified. Code

365.70 should be assigned when there is no documentation regarding the stage of the glaucoma.

7. Chapter 7: Diseases of Circulatory System (390-459)

a. Hypertension

Hypertension Table

The Hypertension Table, found under the main term, "Hypertension", in the Alphabetic Index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.

1) Hypertension, Essential, or NOS

Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

2) Hypertension with Heart Disease

Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

The same heart conditions (425.8, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive Chronic Kidney Disease

Assign codes from category 403, Hypertensive chronic kidney disease, when conditions classified to category 585 or code 587 are present with hypertension. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies chronic kidney disease (CKD) with hypertension as hypertensive chronic kidney disease.

Fifth digits for category 403 should be assigned as follows:

- 0 with CKD stage I through stage IV, or unspecified.
- 1 with CKD stage V or end stage renal disease.

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.

See Section I.C.10.a for information on the coding of chronic kidney disease.

4) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category 404, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. Assign an additional code from category 428, to identify the type of heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

Fifth digits for category 404 should be assigned as follows:

- 0 without heart failure and with chronic kidney disease (CKD) stage I through stage IV, or unspecified
- 1 with heart failure and with CKD stage I through stage IV, or unspecified
- 2 without heart failure and with CKD stage V or end stage renal disease
- 3 with heart failure and with CKD stage V or end stage renal disease

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 404 to identify the stage of kidney disease.
See Section I.C.10.a for information on the coding of chronic kidney disease.

5) Hypertensive Cerebrovascular Disease

First assign codes from 430-438, Cerebrovascular disease, then the appropriate hypertension code from categories 401-405.

6) Hypertensive Retinopathy

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension.

7) Hypertension, Secondary

Two codes are required: one to identify the underlying etiology and one from category 405 to identify the hypertension.

Sequencing of codes is determined by the reason for admission/encounter.

8) Hypertension, Transient

Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.

9) Hypertension, Controlled

Assign appropriate code from categories 401-405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

10) Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401-405 to designate the stage and type of hypertension. Code to the type of hypertension.

11) Elevated Blood Pressure

For a statement of elevated blood pressure without further specificity, assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

b. Cerebral infarction/stroke/cerebrovascular accident (CVA)

The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction.

Additional code(s) should be assigned for any neurologic deficits associated with the acute CVA, regardless of whether or not the neurologic deficit resolves prior to discharge.

See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

c. Postoperative cerebrovascular accident

A cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded to 997.02, Iatrogenic cerebrovascular infarction or hemorrhage. Medical record documentation should clearly specify the cause- and-effect relationship between the medical

intervention and the cerebrovascular accident in order to assign this code. A secondary code from the code range 430-432 or from a code from subcategories 433 or 434 with a fifth digit of "1" should also be used to identify the type of hemorrhage or infarct.

This guideline conforms to the use additional code note instruction at category 997. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used as a secondary code with code 997.02.

d. Late Effects of Cerebrovascular Disease

1) Category 438, Late Effects of Cerebrovascular disease

Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to 430-437.

Codes in category 438 are only for use for late effects of cerebrovascular disease, not for neurologic deficits associated with an acute CVA.

2) Codes from category 438 with codes from 430-437

Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

3) Code V12.54

Assign code V12.54, Transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

e. Acute myocardial infarction (AMI)

1) ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)

The ICD-9-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories 410.0-410.6 and 410.8 are used for ST elevation myocardial infarction (STEMI). Subcategory 410.7, Subendocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

2) Acute myocardial infarction, unspecified

Subcategory 410.9 is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign a code from subcategory 410.9.

3) AMI documented as nontransmural or subendocardial but site provided

If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

8. Chapter 8: Diseases of Respiratory System (460-519)

See I.C.17.f. for ventilator-associated pneumonia.

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

1) Conditions that comprise COPD and Asthma

The conditions that comprise COPD are obstructive chronic bronchitis, subcategory 491.2, and emphysema, category 492. All asthma codes are under category 493, Asthma. Code 496, Chronic airway obstruction, not elsewhere classified, is a nonspecific code that should only be used when the documentation in a medical record does not specify the type of COPD being treated.

2) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes for chronic obstructive bronchitis and asthma distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

3) Overlapping nature of the conditions that comprise COPD and asthma

Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented. Code selection must be based on the terms as documented. When selecting the correct code for the documented type of COPD and asthma, it is essential to first review the index, and then verify the code in the tabular list. There are many instructional notes under the different COPD subcategories and codes. It is important that all such notes be reviewed to assure correct code assignment.

4) Acute exacerbation of asthma and status asthmaticus

An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus should be sequenced first. It supersedes any type of COPD including that with acute exacerbation or acute bronchitis. It is inappropriate to assign an asthma code with 5th digit 2, with acute exacerbation, together with an asthma code with 5th digit 1, with status asthmatics. Only the 5th digit 1 should be assigned.

b. Chronic Obstructive Pulmonary Disease [COPD] and Bronchitis

1) Acute bronchitis with COPD

Acute bronchitis, code 466.0, is due to an infectious organism. When acute bronchitis is documented with COPD, code 491.22, Obstructive chronic bronchitis with acute bronchitis, should be assigned. It is not necessary to also assign code 466.0. If a medical record documents acute bronchitis with COPD with acute exacerbation, only code 491.22 should be assigned. The acute bronchitis included in code 491.22 supersedes the acute exacerbation. If a medical record documents COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned.

c. Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis

Acute respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

2) Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

3) Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis *(Section II, C.)* may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

d. Influenza due to certain identified viruses

Code only confirmed cases of avian influenza (code**s** 488.01-488.02, 488.09, Influenza due to identified avian influenza virus)**, 2009** H1N1 influenza virus (code**s** 488.11-488.12, 488.19)**, or novel influenza A (codes 488.81-488.82, 488.89, Influenza due to identified novel influenza A virus).** This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian**, 2009 H1N1** or novel influenza **A virus**. However, coding should be based on the provider's diagnostic statement that the patient has avian **influenza, 2009 H1N1 influenza,** or novel influenza **A.**

If the provider records "suspected**"** or "possible**"** or **"**probable**"** avian**, 2009 H1N1,** or novel influenza **A,** the appropriate influenza code from category 487**, Influenza** should be assigned. A code from category 488, Influenza due to certain identified influenza viruses, should not be assigned.

9. Chapter 9: Diseases of Digestive System (520-579)

Reserved for future guideline expansion

10. Chapter 10: Diseases of Genitourinary System (580-629)

a. Chronic kidney disease

1) Stages of chronic kidney disease (CKD)

The ICD-9-CM classifies CKD based on severity. The severity of CKD is designated by stages I-V. Stage II, code 585.2, equates to mild CKD; stage III, code 585.3, equates to moderate CKD; and stage IV, code 585.4, equates to severe CKD. Code 585.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code 585.6 only.

2) Chronic kidney disease and kidney transplant status

Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate 585 code for the patient's stage of CKD and code V42.0. If a transplant complication such as failure or rejection is documented, see section I.C.17.f.2.b for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

3) Chronic kidney disease with other conditions

Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the tabular list.
See I.C.3.a.4 for sequencing instructions for diabetes.

See I.C.4.a.1 for anemia in CKD.
See I.C.7.a.3 for hypertensive chronic kidney disease.
See I.C.17.f.2.b, Kidney transplant complications, for instructions on coding of documented rejection or failure.

11. Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-679)

a. General Rules for Obstetric Cases

1) Codes from chapter 11 and sequencing priority

Obstetric cases require codes from chapter 11, codes in the range 630-679, Complications of Pregnancy, Childbirth, and the Puerperium. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code V22.2 should be used in place of any chapter 11 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

2) Chapter 11 codes used only on the maternal record

Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.

3) Chapter 11 fifth-digits

Categories 640-64**9**, 651-676 have required fifth-digits, which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred.

4) Fifth-digits, appropriate for each code

The fifth-digits, which are appropriate for each code number, are listed in brackets under each code. The fifth-digits on each code should all be consistent with each other. That is, should a delivery occur all of the fifth-digits should indicate the delivery.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, should be used as the first-listed diagnoses. These codes should not be used in conjunction with chapter 11 codes.

2) Prenatal outpatient visits for high-risk patients

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate.

3) Episodes when no delivery occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy, which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

4) When a delivery occurs

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient's admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.

5) Outcome of delivery

An outcome of delivery code, V27.0-V27.9, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

c. Fetal Conditions Affecting the Management of the Mother

1) Codes from categories 655 and 656

Codes from categories 655, Known or suspected fetal abnormality affecting management of the mother, and 656, Other known or suspected fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of

pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

See I.C.18.d. for suspected maternal and fetal conditions not found

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category 655, Known or suspected fetal abnormalities affecting management of the mother, should be assigned identifying the fetal condition. Procedure code 75.36, Correction of fetal defect, should be assigned on the hospital inpatient record.

No code from Chapter 15, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

d. HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

e. Current Conditions Complicating Pregnancy

Assign a code from subcategory 648.x for patients that have current conditions when the condition affects the management of the pregnancy, childbirth, or the puerperium. Use additional secondary codes from other chapters to identify the conditions, as appropriate.

f. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code 648.0x, Diabetes mellitus complicating pregnancy, and a secondary code from category 250, Diabetes mellitus, or category 249, Secondary diabetes to identify the type of diabetes.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.

g. Gestational diabetes

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Gestational diabetes is coded to 648.8x, Abnormal glucose tolerance. Codes 648.0x and 648.8x should never be used together on the same record.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the gestational diabetes is being treated with insulin.

h. Normal Delivery, Code 650

1) Normal delivery

Code 650 is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code 650 is always a principal diagnosis. It is not to be used if any other code from chapter 11 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code 650 if they are not related to or are in any way complicating the pregnancy.

2) Normal delivery with resolved antepartum complication

Code 650 may be used if the patient had a complication at some point during her pregnancy, but the complication is not present at the time of the admission for delivery.

3) V27.0, Single liveborn, outcome of delivery

V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

i. The Postpartum and Peripartum Periods

1) Postpartum and peripartum periods

The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Postpartum complication

A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6 week period

Chapter 11 codes may also be used to describe pregnancy-related complications after the six-week period should the provider document that a condition is pregnancy related.

4) Postpartum complications occurring during the same admission as delivery

Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of "2." Subsequent admissions/encounters for postpartum complications should be identified with a fifth digit of "4."

5) Admission for routine postpartum care following delivery outside hospital

When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code V24.0, Postpartum care and examination immediately after delivery, should be assigned as the principal diagnosis.

6) Admission following delivery outside hospital with postpartum conditions

A delivery diagnosis code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum conditions and/or postpartum procedures should be coded.

7) Puerperal sepsis

Code 670.2x, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site). A code from category 038, Septicemia, should not be used for puerperal sepsis. Do not assign code 995.91, Sepsis, as code 670.2x describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

j. Code 677, Late effect of complication of pregnancy

1) Code 677

Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

2) After the initial postpartum period

This code may be used at any time after the initial postpartum period.

3) Sequencing of Code 677

This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

k. Abortions

1) Fifth-digits required for abortion categories

Fifth-digits are required for abortion categories 634-637. Fifth digit assignment is based on the status of the patient at the beginning (or start) of the encounter. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit 2, complete, indicates that all products of conception have been expelled from the uterus.

2) Code from categories 640-649 and 651-659

A code from categories 640-64**9** and 651-659 may be used as additional codes with an abortion code to indicate the complication leading to the abortion.

Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

3) Code 639 for complications

Code 639 is to be used for all complications following abortion. Code 639 cannot be assigned with codes from categories 634-638.

4) Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus assign code 644.21, Early onset of delivery, with an appropriate code from category V27, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.

5) Retained Products of Conception following an abortion

Subsequent admissions for retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, Spontaneous abortion, or 635 Legally induced abortion, with a fifth digit of "1" (incomplete). This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

12. Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages.

The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).

The ICD-9-CM classifies pressure ulcer stages based on severity, which is designated by stages I-IV and unstageable.

2) Unstageable pressure ulcers

Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

3) Documented pressure ulcer stage

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the

terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.

4) Bilateral pressure ulcers with same stage

When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

5) Bilateral pressure ulcers with different stages

When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.

6) Multiple pressure ulcers of different sites and stages

When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

7) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed.

8) Patients admitted with pressure ulcers documented as healing

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified.

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

9) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site.

13. Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)

a. Coding of Pathologic Fractures

1) Acute Fractures vs. Aftercare

Pathologic fractures are reported using subcategory 733.1, when the fracture is newly diagnosed. Subcategory 733.1 may be used while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.2, V54.8 or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

See Section I. C. 17.b for information on the coding of traumatic fractures.

14. Chapter 14: Congenital Anomalies (740-759)

a. Codes in categories 740-759, Congenital Anomalies

Assign an appropriate code(s) from categories 740-759, Congenital Anomalies, when an anomaly is documented. A congenital anomaly may be the principal/first listed diagnosis on a record or a secondary diagnosis.

When a congenital anomaly does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the congenital anomaly, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 14 may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly. Although present at birth, a congenital anomaly may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes 740-759.

For the birth admission, the appropriate code from category V30, Liveborn infants, according to type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 740-759.

15. Chapter 15: Newborn (Perinatal) Guidelines (760-779)

For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

a. General Perinatal Rules

1) Chapter 15 Codes

They are never for use on the maternal record. Codes from Chapter 11, the obstetric chapter, are never permitted on the newborn record. Chapter 15 code may be used throughout the life of the patient if the condition is still present.

2) Sequencing of perinatal codes

Generally, codes from Chapter 15 should be sequenced as the principal/first-listed diagnosis on the newborn record, with the exception of the appropriate V30 code for the birth episode, followed by codes from any other chapter that provide additional detail. The "use additional code" note at the beginning of the chapter supports this guideline. If the index does not provide a specific code for a perinatal condition, assign code 779.89, Other specified conditions originating in the perinatal period, followed by the code from another chapter that specifies the condition. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established.

3) Birth process or community acquired conditions

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 15 should be used. If the condition is community-acquired, a code from Chapter 15 should not be assigned.

4) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs

Note: The perinatal guidelines listed above are the same as the general coding guidelines for "additional diagnoses", except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs. Codes from the perinatal chapter should not be assigned unless the provider has established a definitive diagnosis.

b. Use of codes V30-V39

When coding the birth of an infant, assign a code from categories V30-V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

c. Newborn transfers

If the newborn is transferred to another institution, the V30 series is not used at the receiving hospital.

d. Use of category V29

1) Assigning a code from category V29

Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

A code from category V29 may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. Codes from category V29 are for use only for healthy newborns and infants for which no condition after study is found to be present.

2) V29 code on a birth record

A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code.

e. Use of other V codes on perinatal records

V codes other than V30 and V29 may be assigned on a perinatal or newborn record code. The codes may be used as a principal or first-listed diagnosis for specific types of encounters or for readmissions or encounters when the V30 code no longer applies.

See Section I.C.18 for information regarding the assignment of V codes.

f. Maternal Causes of Perinatal Morbidity

Codes from categories 760-763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor or delivery does not justify the routine assignment of codes from these categories to the newborn record.

g. Congenital Anomalies in Newborns

For the birth admission, the appropriate code from category V30, Liveborn infants according to type of birth, should be used, followed by any congenital anomaly codes, categories 740-759. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable.
Also, see Section I.C.14 for information on the coding of congenital anomalies.

h. Coding Additional Perinatal Diagnoses

1) Assigning codes for conditions that require treatment

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

2) Codes for conditions specified as having implications for future health care needs

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

Note: This guideline should not be used for adult patients.

3) Codes for newborn conditions originating in the perinatal period

Assign a code for newborn conditions originating in the perinatal period (categories 760-779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible provider at the time of transfer or discharge as having affected the fetus or newborn.

i. Prematurity and Fetal Growth Retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. The 5th digit assignment for codes from category 764 and subcategories 765.0 and 765.1 should be based on the recorded birth weight and estimated gestational age.

A code from subcategory 765.2, Weeks of gestation, should be assigned as an additional code with category 764 and codes from 765.0 and 765.1 to specify weeks of gestation as documented by the provider in the record.

j. Newborn sepsis

Code 771.81, Septicemia [sepsis] of newborn, should be assigned with a secondary code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site, to identify the organism. A code from category 038, Septicemia, should not be used on a newborn record. Do not assign code 995.91, Sepsis, as code 771.81 describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

16. Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)

Reserved for future guideline expansion

17. Chapter 17: Injury and Poisoning (800-999)

a. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available. These traumatic injury codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

b. Coding of Traumatic Fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More specific guidelines are as follows:

1) Acute Fractures vs. Aftercare

Traumatic fractures are coded using the acute fracture codes (800-829) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.1, V54.8, or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

Pathologic fractures are not coded in the 800-829 range, but instead are assigned to subcategory 733.1. *See Section I.C.13.a for additional information.*

2) Multiple fractures of same limb

Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.

3) Multiple unilateral or bilateral fractures of same bone

Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.

4) Multiple fracture categories 819 and 828

Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.

5) Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture. The provider should be asked to list the fracture diagnoses in the order of severity.

c. Coding of Burns

Current burns (940-948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

Classify burns of the same local site (three-digit category level, 940-947) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) Non-healing burns

Non-healing burns are coded as acute burns.
Necrosis of burned skin should be coded as a non-healed burn.

4) Code 958.3, Posttraumatic wound infection

Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category 946 Burns of Multiple specified sites, should only be used if the location of the burns are not documented. Category 949, Burn, unspecified, is extremely vague and should rarely be used.

6) Assign codes from category 948, Burns

Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

In assigning a code from category 948:

Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree).

Fifth-digits are assigned to identify the percentage of body surface involved in third-degree burn.

Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn.

Category 948 is based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns.

7) Encounters for treatment of late effects of burns

Encounters for the treatment of the late effects of burns (i.e., scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5-906.9). A late effect E code may also be used, if desired.

8) Sequelae with a late effect code and current burn

When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record (when both a current burn and sequelae of an old burn exist).

d. Coding of Debridement of Wound, Infection, or Burn

Excisional debridement involves surgical removal or cutting away, as opposed to a mechanical (brushing, scrubbing, washing) debridement.

For coding purposes, excisional debridement is assigned to code 86.22.

Nonexcisional debridement is assigned to code 86.28.

e. Adverse Effects, Poisoning and Toxic Effects

The properties of certain drugs, medicinal and biological substances or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

1) Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series. Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is

coded and followed by the appropriate code from the E930-E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

2) Poisoning

(a) **Error was made in drug prescription**

Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person, use the appropriate poisoning code from the 960-979 series.

(b) **Overdose of a drug intentionally taken**

If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960-979 series).

(c) **Nonprescribed drug taken with correctly prescribed and properly administered drug**

If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(d) **Interaction of drug(s) and alcohol**

When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

(e) **Sequencing of poisoning**

When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.
See Section I.C.3.a.6.b. if poisoning is the result of insulin pump malfunctions and Section I.C.19 for general use of E-codes.

3) Toxic Effects

(a) **Toxic effect codes**

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories 980-989.

(b) **Sequencing toxic effect codes**

A toxic effect code should be sequenced first, followed by the code(s) that identify the result of the toxic effect.

(c) **External cause codes for toxic effects**

An external cause code from categories E860-E869 for accidental exposure, codes E950.6 or E950.7 for intentional self-harm, category E962 for assault, or categories E980-E982, for undetermined, should also be assigned to indicate intent.

f. Complications of care

1) General guidelines for complications of care

(a) **Documentation of complications of care**

See Section I.B.18. for information on documentation of complications of care.

(b) **Use additional code to identify nature of complication**

An additional code identifying the complication should be assigned with codes in categories 996-999, Complications of Surgical and Medical Care NEC, when the additional code provides greater specificity as to the nature of the condition. If the complication code fully describes the condition, no additional code is necessary.

2) Transplant complications

(a) **Transplant complications other than kidney**

Codes under subcategory 996.8, Complications of transplanted organ, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication, the appropriate code from subcategory

996.8 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.

See I.C.18.d.3) for transplant organ removal status

See I.C.2.i for malignant neoplasm associated with transplanted organ.

(b) **Kidney transplant complications**

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code 996.81 should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code 996.81 should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned code 996.81, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.

For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, *see section I.C.10.a.2, Chronic kidney disease and kidney transplant status*.

3) Ventilator associated pneumonia

(a) **Documentation of Ventilator associated Pneumonia**

As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

Code 997.31, Ventilator associated pneumonia, should be assigned only when the provider has documented

ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code 041.7) should also be assigned. Do not assign an additional code from categories 480-484 to identify the type of pneumonia.

Code 997.31 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator but the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia.

If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

(b) **Patient admitted with pneumonia and develops VAP**

A patient may be admitted with one type of pneumonia (e.g., code 481, Pneumococcal pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories 480-484 for the pneumonia diagnosed at the time of admission. Code 997.31, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

g. SIRS due to Non-infectious Process

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code 995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction. If an acute organ dysfunction is documented, the appropriate code(s) for the associated acute organ dysfunction(s) should be assigned in addition to code 995.94. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

When the non-infectious condition has led to an infection that results in SIRS, *see Section I.C.1.b.12 for the guideline for sepsis and severe sepsis associated with a non-infectious process.*

18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V91)

Note: The chapter specific guidelines provide additional information about the use of V codes for specified encounters.

a. Introduction

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 - V91.99) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

There are four primary circumstances for the use of V codes:

1) A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issues.

2) A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.

3) Circumstances or problems influence a person's health status but are not in themselves a current illness or injury.

4) Newborns, to indicate birth status

b. V codes use in any healthcare setting

V codes are for use in any healthcare setting. V codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain V codes may only be used as first listed, others only as secondary codes.
See Section I.C.18.e, V Codes That May Only be Principal/First-Listed Diagnosis.

c. V Codes indicate a reason for an encounter

They are not procedure codes. A corresponding procedure code must accompany a V code to describe the procedure performed.

d. Categories of V Codes

1) Contact/Exposure

Category V01 indicates contact with or exposure to communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. These codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

Codes V15.84 – V15.86 describe contact with or (suspected) exposure to asbestos, potentially hazardous body fluids, and lead.

Subcategories V87.0 – V87.3 describe contact with or (suspected) exposure to hazardous metals, aromatic compounds, other potentially hazardous chemicals, and other potentially hazardous substances.

2) Inoculations and vaccinations

Categories V03-V06 are for encounters for inoculations and vaccinations. They indicate that a patient is being seen to receive a prophylactic inoculation against a disease. The injection itself must be represented by the appropriate procedure code. A code from V03-V06 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing a person's health status. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information. The

complication code indicates that the patient is a heart transplant patient.

The status V codes/categories are:

V02	Carrier or suspected carrier of infectious diseases Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.
V07.5X	Use of agents affecting estrogen receptors and estrogen level This code indicates when a patient is receiving a drug that affects estrogen receptors and estrogen levels for prevention of cancer.
V08	Asymptomatic HIV infection status This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.
V09	Infection with drug-resistant microorganisms This category indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.
V21	Constitutional states in development
V22.2	Pregnant state, incidental This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.
V26.5x	Sterilization status
V42	Organ or tissue replaced by transplant
V43	Organ or tissue replaced by other means
V44	Artificial opening status
V45	Other postsurgical states Assign code V45.87, Transplant organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter. *See section I.C17.f.2. for information on the coding of organ transplant complications.* Assign code V45.88, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to the current facility, as a secondary diagnosis when a patient is received by

transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility.

This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility.

The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

Code V45.88 is only applicable to the receiving facility record and not to the transferring facility record.

V46	Other dependence on machines
V49.6	Upper limb amputation status
V49.7	Lower limb amputation status **Note:** Categories V42-V46, and subcategories V49.6, V49.7 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.
V49.81	Asymptomatic postmenopausal status (age-related) (natural)
V49.82	Dental sealant status
V49.83	Awaiting organ transplant status
V49.86	Do not resuscitate status This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.
V49.87	Physical restraint status This code may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.
V58.6x	Long-term (current) drug use Codes from this subcategory indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of

medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

Assign a code from subcategory V58.6, Long-term (current) drug use, if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from subcategory V58.6 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

V83 Genetic carrier status

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

V84 Genetic susceptibility status

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category V84, Genetic susceptibility to disease, should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, a code from subcategory V26.3, Genetic counseling and testing, should be assigned as the first-listed code, followed by a code from category V84. Additional codes should be assigned for any applicable family or personal history.

See Section I.C. 18.d.14 for information on prophylactic organ removal due to a genetic susceptibility.

V85 Body Mass Index (BMI)
V86 Estrogen receptor status
V88 Acquired absence of other organs and tissue
V90 Retained foreign body

4) History (of)

There are two types of history V codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring. The exceptions to this general rule are category V14, Personal history of allergy to medicinal agents, and subcategory V15.0, Allergy, other than to medicinal agents. A person who has had an allergic episode to a substance or food in the past should always be considered allergic to the substance.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history V code categories are:

V10 Personal history of malignant neoplasm
V12 Personal history of certain other diseases
V13 Personal history of other diseases
Except: V13.4, Personal history of arthritis, and subcategory V13.6, Personal history of congenital (corrected) malformations. These conditions are life-long so are not true history codes.
V14 Personal history of allergy to medicinal agents
V15 Other personal history presenting hazards to health
Except: **Codes** V15.7, Personal history of contraception**; V15.84, Contact with and (suspected) exposure to asbestos; V15.85, Contact with and (suspected) exposure to**

potentially hazardous body fluids; V15.86, Contact with and (suspected) exposure to lead.

V16 Family history of malignant neoplasm
V17 Family history of certain chronic disabling diseases
V18 Family history of certain other specific diseases
V19 Family history of other conditions
V87 Other specified personal exposures and history presenting hazards to health

Except: Subcategories V87.0, Contact with and (suspected) exposure to hazardous metals; V87.1, Contact with and (suspected) exposure to hazardous aromatic compounds; V87.2, Contact with and (suspected) exposure to other potentially hazardous chemicals; and V87.3, Contact with and (suspected) exposure to other potentially hazardous substances

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease. Screenings that are recommended for many subgroups in a population include: routine mammograms for women over 40, a fecal occult blood test for everyone over 50, an amniocentesis to rule out a fetal anomaly for pregnant women over 35, because the incidence of breast cancer and colon cancer in these subgroups is higher than in the general population, as is the incidence of Down's syndrome in older mothers.

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The V code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening V code categories:
V28 Antenatal screening
V73-V82 Special screening examinations

6) Observation

There are three observation V code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding E code to identify any external cause.

The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from the V30, Live born infant, category. Then the V29 observation code is sequenced after the V30 code. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

Codes from subcategory V89.0, Suspected maternal and fetal conditions not found, may either be used as a first listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

Additional codes may be used in addition to the code from subcategory V89.0, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory V89.0 may not be used for encounters for antenatal screening of mother. *See Section I.C.18.d., Screening).*

For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category 655, 656, 657 or 658.

The observation V code categories:

V29	Observation and evaluation of newborns for suspected condition not found For the birth encounter, a code from category V30 should be sequenced before the V29 code.
V71	Observation and evaluation for suspected condition not found
V89	Suspected maternal and fetal conditions not found

7) Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury. The diagnosis code is to be used in these cases. Exceptions to this rule are codes V58.0, Radiotherapy, and codes from subcategory V58.1, Encounter for chemotherapy and immunotherapy for neoplastic conditions. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. Should a patient receive both chemotherapy and radiation therapy during the same encounter code V58.0 and V58.1 may be used together on a record with either one being sequenced first.

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

Certain aftercare V code categories need a secondary diagnosis code to describe the resolving condition or sequelae, for others, the condition is inherent in the code title.

Additional V code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status V codes may be used with aftercare V codes to indicate the nature of the aftercare. For example code V45.81, Aortocoronary bypass status, may be used with code V58.73, Aftercare following surgery of the circulatory system, NEC, to indicate the surgery for which the aftercare is being performed. Also, a transplant status code may be used following code V58.44, Aftercare following organ transplant, to identify the organ transplanted. A status code should not be used when the aftercare code indicates the type of status, such as using V55.0, Attention to tracheostomy with V44.0, Tracheostomy status.

See Section I. B.16 Admissions/Encounter for Rehabilitation

The aftercare V category/codes:

V51.0	Encounter for breast reconstruction following mastectomy
V52	Fitting and adjustment of prosthetic device and implant
V53	Fitting and adjustment of other device
V54	Other orthopedic aftercare
V55	Attention to artificial openings
V56	Encounter for dialysis and dialysis catheter care
V57	Care involving the use of rehabilitation procedures
V58.0	Radiotherapy
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.3x	Attention to dressings and sutures
V58.41	Encounter for planned post-operative wound closure
V58.42	Aftercare, surgery, neoplasm
V58.43	Aftercare, surgery, trauma
V58.44	Aftercare involving organ transplant
V58.49	Other specified aftercare following surgery
V58.7x	Aftercare following surgery
V58.81	Fitting and adjustment of vascular catheter
V58.82	Fitting and adjustment of non-vascular catheter
V58.83	Monitoring therapeutic drug
V58.89	Other specified aftercare

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes that explain current treatment for a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code.

The follow-up V code categories:

V24	Postpartum care and evaluation
V67	Follow-up examination

9) Donor

Category V59 is the donor codes. They are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self donations. They are not for use to identify cadaveric donations.

10) Counseling

Counseling V codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not necessary for use in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

The counseling V categories/codes:

V25.0	General counseling and advice for contraceptive management
V26.3	Genetic counseling
V26.4	General counseling and advice for procreative management
V61.X	Other family circumstances
V65.1	Person consulted on behalf of another person
V65.3	Dietary surveillance and counseling
V65.4	Other counseling, not elsewhere classified

11) Obstetrics and related conditions

See Section I.C.11., the Obstetrics guidelines for further instruction on the use of these codes.

V codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

The outcome of delivery, category V27, should be included on all maternal delivery records. It is always a secondary code.

V codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Obstetrics and related conditions V code categories:

V22	Normal pregnancy
V23	Supervision of high-risk pregnancy Except: V23.2, Pregnancy with history of abortion. Code 646.3, Recurrent pregnancy loss, from the OB chapter is required to indicate a history of abortion during a pregnancy.
V24	Postpartum care and evaluation
V25	Encounter for contraceptive management Except V25.0x *(See Section I.C.18.d.11, Counseling)*
V26	Procreative management Except V26.5x, Sterilization status, V26.3 and V26.4 *(See Section I.C.18.d.11., Counseling)*
V27	Outcome of delivery
V28	Antenatal screening *(See Section I.C.18.d.6., Screening)*
V91	Multiple gestation placenta status

12) Newborn, infant and child

See Section I.C.15, the Newborn guidelines for further instruction on the use of these codes.

Newborn V code categories:

V20	Health supervision of infant or child
V29	Observation and evaluation of newborns for suspected condition not found

(See Section I.C.18.d.7, Observation)

V30-V39 Liveborn infant according to type of birth

13) Routine and administrative examinations

The V codes allow for the description of encounters for routine examinations, such as, a general check-up, or examinations for administrative purposes, such as a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Pre-operative examination and pre-procedural laboratory examination V codes are for use only in those situations when a patient is being cleared for a procedure or surgery and no treatment is given.

The V codes categories/code for routine and administrative examinations:

V20.2 Routine infant or child health check
Any injections given should have a corresponding procedure code.

V70 General medical examination

V72 Special investigations and examinations
Codes V72.5 and V72.62 may be used if the reason for the patient encounter is for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

14) Miscellaneous V codes

The miscellaneous V codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter, others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Prophylactic Organ Removal
For encounters specifically for prophylactic removal of breasts, ovaries, or another organ due to a genetic susceptibility to cancer or a family history of cancer, the principal or first listed code should be a code from subcategory V50.4, Prophylactic organ removal, followed by the appropriate genetic susceptibility code and the appropriate family history code.

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory V50.4. A V50.4 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous V code categories/codes:

V07	Need for isolation and other prophylactic or treatment measures Except V07.5X, Use of agents affecting estrogen receptors and estrogen levels
V40.31	**Wandering in diseases classified elsewhere**
V50	Elective surgery for purposes other than remedying health states
V58.5	Orthodontics
V60	Housing, household, and economic circumstances
V62	Other psychosocial circumstances
V63	Unavailability of other medical facilities for care
V64	Persons encountering health services for specific procedures, not carried out
V66	Convalescence and Palliative Care
V68	Encounters for administrative purposes
V69	Problems related to lifestyle

15) Nonspecific V codes

Certain V codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific V code categories/codes:

V11	Personal history of mental disorder

A code from the mental disorders chapter, with an in remission fifth-digit, should be used.

V13.4 Personal history of arthritis
V13.6 Personal history of congenital malformations
V15.7 Personal history of contraception
V23.2 Pregnancy with history of abortion

V40 Mental and behavioral problems
Exception:
V40.31 Wandering in diseases classified elsewhere
V41 Problems with special senses and other special functions
V47 Other problems with internal organs
V48 Problems with head, neck, and trunk
V49 Problems with limbs and other problems

Exceptions:

V49.6	Upper limb amputation status
V49.7	Lower limb amputation status
V49.81	Asymptomatic postmenopausal status (age-related) (natural)
V49.82	Dental sealant status
V49.83	Awaiting organ transplant status
V49.86	Do not resuscitate status
V49.87	Physical restraints status

V51.8 Other aftercare involving the use of plastic surgery
V58.2 Blood transfusion, without reported diagnosis
V58.9 Unspecified aftercare
See Section IV.K. and Section IV.L. of the Outpatient guidelines.

e. V Codes That May Only be Principal/First-Listed Diagnosis

The list of V codes/categories below may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined or when there is more than one V code that meets the definition of principal diagnosis (e.g., a patient is admitted to home healthcare for both aftercare and rehabilitation and they equally meet the definition of principal diagnosis). These codes should not be reported if they do not meet the definition of principal or first-listed diagnosis.

See Section II and Section IV.A for information on selection of principal and first-listed diagnosis.

See Section II.C for information on two or more diagnoses that equally meet the definition for principal diagnosis.

V20.X Health supervision of infant or child
V22.0 Supervision of normal first pregnancy
V22.1 Supervision of other normal pregnancy
V24.X Postpartum care and examination
V26.81 Encounter for assisted reproductive fertility procedure cycle
V26.82 Encounter for fertility preservation procedure
V30.X Single liveborn
V31.X Twin, mate liveborn
V32.X Twin, mate stillborn
V33.X Twin, unspecified
V34.X Other multiple, mates all liveborn
V35.X Other multiple, mates all stillborn
V36.X Other multiple, mates live- and stillborn
V37.X Other multiple, unspecified
V39.X Unspecified
V46.12 Encounter for respirator dependence during power failure
V46.13 Encounter for weaning from respirator [ventilator]
V51.0 Encounter for breast reconstruction following mastectomy
V56.0 Extracorporeal dialysis
V57.X Care involving use of rehabilitation procedures
V58.0 Radiotherapy
V58.11 Encounter for antineoplastic chemotherapy
V58.12 Encounter for antineoplastic immunotherapy
V59.X Donors
V66.0 Convalescence and palliative care following surgery
V66.1 Convalescence and palliative care following radiotherapy
V66.2 Convalescence and palliative care following chemotherapy
V66.3 Convalescence and palliative care following psychotherapy and other treatment for mental disorder
V66.4 Convalescence and palliative care following treatment of fracture
V66.5 Convalescence and palliative care following other treatment
V66.6 Convalescence and palliative care following combined treatment
V66.9 Unspecified convalescence
V68.X Encounters for administrative purposes
V70.0 Routine general medical examination at a health care facility
V70.1 General psychiatric examination, requested by the authority
V70.2 General psychiatric examination, other and unspecified
V70.3 Other medical examination for administrative purposes
V70.4 Examination for medicolegal reasons
V70.5 Health examination of defined subpopulations

V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examination
V71.X Observation and evaluation for suspected conditions not found

19. Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Introduction: These guidelines are provided for those who are currently collecting E codes in order that there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes.

External causes of injury and poisoning codes (categories E000 and E800-E999) are intended to provide data for injury research and evaluation of injury prevention strategies. Activity codes (categories E001-E030) are intended to be used to describe the activity of a person seeking care for injuries as well as other health conditions, when the injury or other health condition resulted from an activity or the activity contributed to a condition. E codes capture how the injury, poisoning, or adverse effect happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the person's status (e.g. civilian, military), the associated activity and the place where the event occurred.

Some major categories of E codes include:

transport accidents
poisoning and adverse effects of drugs, medicinal substances and biologicals
accidental falls
accidents caused by fire and flames
accidents due to natural and environmental factors
late effects of accidents, assaults or self injury
assaults or purposely inflicted injury
suicide or self inflicted injury

These guidelines apply for the coding and collection of E codes from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings and provider offices, and nonacute care settings, except when other specific guidelines apply.

a. General E Code Coding Guidelines

1) Used with any code in the range of 001-V91

An E code from categories E800-E999 may be used with any code in the range of 001-V91, which indicates an injury, poisoning, or adverse effect due to an external cause.

An activity E code (categories E001-E030) may be used with any code in the range of 001-V91 that indicates an injury, or other health condition that resulted from an activity, or the activity contributed to a condition.

2) Assign the appropriate E code for all initial treatments

Assign the appropriate E code for the initial encounter of an injury, poisoning, or adverse effect of drugs, not for subsequent treatment.

External cause of injury codes (E-codes) may be assigned while the acute fracture codes are still applicable.
See Section I.C.17.b.1 for coding of acute fractures.

3) Use the full range of E codes

Use the full range of E codes (E800 – E999) to completely describe the cause, the intent and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.

See a.1.), j.), and k.) in this section for information on the use of status and activity E codes.

4) Assign as many E codes as necessary

Assign as many E codes as necessary to fully explain each cause.

5) The selection of the appropriate E code

The selection of the appropriate E code is guided by the Index to External Causes, which is located after the alphabetical index to diseases and by Inclusion and Exclusion notes in the Tabular List.

6) E code can never be a principal diagnosis

An E code can never be a principal (first listed) diagnosis.

7) External cause code(s) with systemic inflammatory response syndrome (SIRS)

An external cause code is not appropriate with a code from subcategory 995.9, unless the patient also has another condition for which an E code would be appropriate (such as an injury, poisoning, or adverse effect of drugs.

8) Multiple Cause E Code Coding Guidelines

More than one E-code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of E-codes should be sequenced in the following priority:

If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order:

E codes for child and adult abuse take priority over all other E codes.
See Section I.C.19.e., Child and Adult abuse guidelines.

E codes for terrorism events take priority over all other E codes except child and adult abuse.

E codes for cataclysmic events take priority over all other E codes except child and adult abuse and terrorism.

E codes for transport accidents take priority over all other E codes except cataclysmic events, child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) E codes.

The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

9) If the reporting format limits the number of E codes

If the reporting format limits the number of E codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional E codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity or external status.

b. Place of Occurrence Guideline

Use an additional code from category E849 to indicate the Place of Occurrence. The Place of Occurrence describes the place where the event occurred and not the patient's activity at the time of the event.

Do not use E849.9 if the place of occurrence is not stated.

c. Adverse Effects of Drugs, Medicinal and Biological Substances Guidelines

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) Use as many codes as necessary to describe

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.

If the reporting format limits the number of E codes, and there are different fourth digit codes in the same three digit category, use the code for "Other specified" of that category of drugs, medicinal or biological substances. If there is no "Other specified" code in that category, use the appropriate "Unspecified" code in that category.

If the reporting format limits the number of E codes, and the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.

3) If the same E code would describe the causative agent

If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.

4) If two or more drugs, medicinal or biological substances

If two or more drugs, medicinal or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals. In that case, assign the E code for the combination.

5) When a reaction results from the interaction of a drug(s)

When a reaction results from the interaction of a drug(s) and alcohol, use poisoning codes and E codes for both.

6) Codes from the E930-E949 series

Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

d. Child and Adult Abuse Guideline

1) Intentional injury

When the cause of an injury or neglect is intentional child or adult abuse, the first listed E code should be assigned from categories E960-E968, Homicide and injury purposely inflicted by other persons, (except category E967). An E code from category E967, Child and adult battering and other maltreatment, should be added as an additional code to identify the perpetrator, if known.

2) Accidental intent

In cases of neglect when the intent is determined to be accidental E code E904.0, Abandonment or neglect of infant and helpless person, should be the first listed E code.

e. Unknown or Suspected Intent Guideline

1) If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined E980-E989.

2) If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined E980-E989.

f. Undetermined Cause

When the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, Unspecified accident, E958.9, Suicide and self-inflicted injury by unspecified means, and E968.9, Assault by unspecified means.

These E codes should rarely be used, as the documentation in the medical record, in both the inpatient outpatient and other settings, should normally provide sufficient detail to determine the cause of the injury.

g. Late Effects of External Cause Guidelines

1) Late effect E codes

Late effect E codes exist for injuries and poisonings but not for adverse effects of drugs, misadventures and surgical complications.

2) Late effect E codes (E929, E959, E969, E977, E989, or E999.1)

A late effect E code (E929, E959, E969, E977, E989, or E999.1) should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905-909).

3) Late effect E code with a related current injury

A late effect E code should never be used with a related current nature of injury code.

4) Use of late effect E codes for subsequent visits

Use a late effect E code for subsequent visits when a late effect of the initial injury or poisoning is being treated. There is no late effect E code for adverse effects of drugs.
Do not use a late effect E code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

h. Misadventures and Complications of Care Guidelines

1) Code range E870-E876

Assign a code in the range of E870-E876 if misadventures are stated by the provider. When applying the E code guidelines pertaining to sequencing, these E codes are considered causal codes.

2) Code range E878-E879

Assign a code in the range of E878-E879 if the provider attributes an abnormal reaction or later complication to a surgical or medical procedure, but does not mention misadventure at the time of the procedure as the cause of the reaction.

i. Terrorism Guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed E-code should be a code from category E979, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at E979. The terrorism E-code is the only E-code that should be assigned. Additional E codes from the assault categories should not be assigned.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category E979 should not be assigned. Assign a code in the range of E codes based circumstances on the documentation of intent and mechanism.

3) Code E979.9, Terrorism, secondary effects

Assign code E979.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

4) Statistical tabulation of terrorism codes

For statistical purposes these codes will be tabulated within the category for assault, expanding the current category from E960-E969 to include E979 and E999.1.

j. Activity Code Guidelines

Assign a code from category E001-E030 to describe the activity that caused or contributed to the injury or other health condition.

Unlike other E codes, activity E codes may be assigned to indicate a health condition (not just injuries) resulted from an activity, or the activity contributed to the condition.

The activity codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign E030, Unspecified activity, if the activity is not stated.

k. External cause status

A code from category E000, External cause status, should be assigned whenever any other E code is assigned for an encounter, including an Activity E code, except for the events noted below. Assign a code from category E000, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from E000, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.
Do not assign a code from category E000 if no other E codes (cause, activity) are applicable for the encounter.

Do not assign code E000.9, Unspecified external cause status, if the status is not stated.

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

In determining principal diagnosis the coding conventions in the ICD-9-CM, Volumes I and II take precedence over these official coding guidelines.
(See Section I.A., Conventions for the ICD-9-CM)

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F. Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series and the code lacks the necessary

specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

I. Admission from Observation Unit

1. Admission Following Medical Observation

When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

2. Admission Following Post-Operative Observation

When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

J. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other

tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-9-CM diagnosis codes

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

D. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

E. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the

provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

F. Encounters for circumstances other than a disease or injury

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of factors Influencing Health Status and Contact with Health Services (V01.0- V91.99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems. *See Section I.C. 18 for information on V-codes.*

G. Level of Detail in Coding

1. ICD-9-CM codes with 3, 4, or 5 digits

ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.

2. Use of full number of digits required for a code

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.
See also discussion under Section I.b.3., General Coding Guidelines, Level of Detail in Coding.

H. ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

I. Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

J. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

K. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

L. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5 and/or a code from subcategory V72.6. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

M. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

N. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

O. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

P. Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, codes V22.0, Supervision of normal first pregnancy, or V22.1, Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.

Appendix I
Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Timeframe for POA Identification and Documentation

There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider's best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Assigning the POA Indicator

Condition is on the "Exempt from Reporting" list

Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign "U" when the medical record documentation is unclear as to whether the condition was present on admission. "U" should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.

Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign "W" when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

Chronic condition with acute exacerbation during the admission

If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.

If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of chronic leukemia), assign "Y."

Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings suspected at the time of inpatient admission, assign "Y."

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings that were not present on admission, assign "N".

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign "N".

Acute and Chronic Conditions

Assign "Y" for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign "Y" for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

Combination Codes

Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)

Assign "Y" if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y".

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Same Diagnosis Code for Two or More Conditions

When the same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter (e.g. bilateral condition, or two separate conditions classified to the same ICD-9-CM diagnosis code):

Assign "Y" if all conditions represented by the single ICD-9-CM code were present on admission (e.g. bilateral fracture of the same bone, same site, and both fractures were present on admission)
Assign "N" if any of the conditions represented by the single ICD-9-CM code was not present on admission (e.g. dehydration with hyponatremia is assigned to code 276.1, but only one of these conditions was present on admission).

Obstetrical conditions

Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.

If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y".

If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N".

If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign "N".

(e.g., Code 642.7, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension).

If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.

(e.g. Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination).

Perinatal conditions

Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y". This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).

Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies**, except for categories 740-759, Congenital anomalies, which are on the exempt list.** Congenital conditions are always considered present on admission.

External cause of injury codes

Assign "Y" for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign "N" for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

Categories and Codes
Exempt from
Diagnosis Present on Admission Requirement

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

Categories or subcategories listed are inclusive of all codes within those categories or subcategories, unless otherwise indicated. In order to streamline the POA exempt list and make it easier to read, where all of the codes in a code range are POA exempt, only the code range is shown, rather than listing each of the individual codes in the range.

137-139, Late effects of infectious and parasitic diseases

268.1, Rickets, late effect

326, Late effects of intracranial abscess or pyogenic infection

412, Old myocardial infarction

438, Late effects of cerebrovascular disease

650, Normal delivery

660.7, Failed forceps or vacuum extractor, unspecified

677, Late effect of complication of pregnancy, childbirth, and the puerperium

740-759, Congenital anomalies

905-909, Late effects of injuries, poisonings, toxic effects, and other external causes

V02, Carrier or suspected carrier of infectious diseases

V03, Need for prophylactic vaccination and inoculation against bacterial diseases

V04, Need for prophylactic vaccination and inoculation against certain viral diseases

V05, Need for other prophylactic vaccination and inoculation against single diseases

V06, Need for prophylactic vaccination and inoculation against combinations of diseases

V07, Need for isolation and other prophylactic or treatment measures

V10, Personal history of malignant neoplasm

V11, Personal history of mental disorder

V12, Personal history of certain other diseases

V13, Personal history of other diseases

V14, Personal history of allergy to medicinal agents

V15, Other personal history presenting hazards to health

V16, Family history of malignant neoplasm

V17, Family history of certain chronic disabling diseases

V18, Family history of certain other specific conditions

V19, Family history of other conditions

V20, Health supervision of infant or child

V21, Constitutional states in development

V22, Normal pregnancy

V23, Supervision of high-risk pregnancy

V24, Postpartum care and examination

V25, Encounter for contraceptive management

V26, Procreative management

V27, Outcome of delivery

V28, Antenatal screening

V29, Observation and evaluation of newborns for suspected condition not found

V30-V39, Liveborn infants according to type of birth

V42, Organ or tissue replaced by transplant

V43, Organ or tissue replaced by other means

V44, Artificial opening status

V45, Other postprocedural states

V46, Other dependence on machines and devices

V49.60-V49.77, Upper and lower limb amputation status

V49.81-V49.85, Other specified conditions influencing health status

V50, Elective surgery for purposes other than remedying health states

V51, Aftercare involving the use of plastic surgery

V52, Fitting and adjustment of prosthetic device and implant

V53, Fitting and adjustment of other device

V54, Other orthopedic aftercare

V55, Attention to artificial openings

V56, Encounter for dialysis and dialysis catheter care

V57, Care involving use of rehabilitation procedures

V58, Encounter for other and unspecified procedures and aftercare

V59, Donors

V60, Housing, household, and economic circumstances

V61, Other family circumstances

V62, Other psychosocial circumstances

V64, Persons encountering health services for specific procedures, not carried out

V65, Other persons seeking consultation

V66, Convalescence and palliative care

V67, Follow-up examination

V68, Encounters for administrative purposes

V69, Problems related to lifestyle

V70, General medical examination

V71, Observation and evaluation for suspected condition not found

V72, Special investigations and examinations

V73, Special screening examination for viral and chlamydial diseases

V74, Special screening examination for bacterial and spirochetal diseases

V75, Special screening examination for other infectious diseases

V76, Special screening for malignant neoplasms

V77, Special screening for endocrine, nutritional, metabolic, and immunity disorders

V78, Special screening for disorders of blood and blood-forming organs

V79, Special screening for mental disorders and developmental handicaps

V80, Special screening for neurological, eye, and ear diseases

V81, Special screening for cardiovascular, respiratory, and genitourinary diseases

V82, Special screening for other conditions

V83, Genetic carrier status

V84, Genetic susceptibility to disease

V85, Body Mass Index

V86, Estrogen receptor status

V87.32, Contact with and (suspected) exposure to algae bloom

V87.4, Personal history of drug therapy

V88, Acquired absence of other organs and tissue

V89, Suspected maternal and fetal conditions not found

V90, Retained foreign body

V91, Multiple gestation placenta status

E000, External cause status

E001-E030, Activity

E800-E807, Railway accidents

E810-E819, Motor vehicle traffic accidents

E820-E825, Motor vehicle nontraffic accidents

E826-E829, Other road vehicle accidents

E830-E838, Water transport accidents

E840-E845, Air and space transport accidents

E846-E848, Vehicle accidents not elsewhere classifiable

E849, Place of occurrence (Except E849.7)

E883.1, Accidental fall into well

E883.2, Accidental fall into storm drain or manhole

E884.0, Fall from playground equipment

E884.1, Fall from cliff

E885.0, Fall from (nonmotorized) scooter

E885.1, Fall from roller skates

E885.2, Fall from skateboard

E885.3, Fall from skis

E885.4, Fall from snowboard

E886.0, Fall on same level from collision, pushing, or shoving, by or with other person, In sports

E890.0-E890.9, Conflagration in private dwelling

E893.0, Accident caused by ignition of clothing, from controlled fire in private dwelling

E893.2, Accident caused by ignition of clothing, from controlled fire not in building or structure

E894, Ignition of highly inflammable material

E895, Accident caused by controlled fire in private dwelling

E897, Accident caused by controlled fire not in building or structure

E917.0, Striking against or struck accidentally by objects or persons, in sports without subsequent fall

E917.1, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall

E917.2, Striking against or struck accidentally by objects or persons, in running water without subsequent fall

E917.5, Striking against or struck accidentally by objects or persons, object in sports with subsequent fall

E917.6, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall

E919, Accident caused by machinery (Except E919.2)

E921, Accident caused by explosion of pressure vessel

E922, Accident caused by firearm and air gun missile

E926.2, Visible and ultraviolet light sources

E928.0-E928.8, Other and unspecified environmental and accidental causes

E929.0-E929.9, Late effects of accidental injury

E959, Late effects of self-inflicted injury

E970-E978, Legal intervention

E979, Terrorism

E981, Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted

E982, Poisoning by other gases, undetermined whether accidentally or purposely inflicted

E985, Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted

E987.0, Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises

E987.2, Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites

E989, Late effects of injury, undetermined whether accidentally or purposely inflicted

E990-E999, Injury resulting from operations of war

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 11. Certificate of Compliance for Petitions for Rehearing/Responses

Instructions for this form: http://www.ca9.uscourts.gov/forms/form11instructions.pdf

9th Cir. Case Number(s) 22-15862

I am the attorney or self-represented party.

I certify that pursuant to Circuit Rule 35-4 or 40-1, the attached petition for panel rehearing/petition for rehearing en banc/response to petition is (*select one*):

◉ Prepared in a format, typeface, and type style that complies with Fed. R. App. P. 32(a)(4)-(6) and **contains the following number of words**: 4,127.

(Petitions and responses must not exceed 4,200 words)

OR

○ In compliance with Fed. R. App. P. 32(a)(4)-(6) and does not exceed 15 pages.

Signature /s/William K. Hanagami **Date** 2/5/2024

*(use "*s/[typed name]*" to sign electronically-filed documents)*

CERTIFICATE OF SERVICE

U.S. Court of Appeals Case Number 22-15862

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the Appellate Electronic Filing System on February 5, 2024.

I certify that all participants in the case are registered Appellate Electronic Filing System users and that service will be accomplished by the Appellate Electronic Filing System.

Dated: February 5, 2024

/s/William K. Hanagami
William K. Hanagami