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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel.
RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

**REQUEST FOR JUDICIAL NOTICE AND
FOR INCORPORATION OF DOCUMENTS
BY REFERENCE IN SUPPORT OF
MOTION TO DISMISS UNITED STATES'
COMPLAINT-IN-INTERVENTION**

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel.
NASER AREFI, AJITH KUMAR and PRIME
HEALTHCARE SERVICES, INC.,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., et al.,

Defendants.

Case No. 3:16-cv-01558-EMC

**REQUEST FOR JUDICIAL NOTICE
AND FOR INCORPORATION OF
DOCUMENTS BY REFERENCE IN
SUPPORT OF MOTION TO DISMISS
UNITED STATES' COMPLAINT-IN-
INTERVENTION**

Hearing Date: TBD (Dkt. No. 129)
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UNITED STATES OF AMERICA ex rel.
MARCIA STEIN and RODOLFO BONE,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., et al.,

Defendants.

Case No. 3:16-cv-05337-EMC

**REQUEST FOR JUDICIAL NOTICE
AND FOR INCORPORATION OF
DOCUMENTS BY REFERENCE IN
SUPPORT OF MOTION TO DISMISS
UNITED STATES' COMPLAINT-IN-
INTERVENTION**

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Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel.
GLORYANNE BRYANT and VICTORIA
HERNANDEZ,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:18-cv-01347-EMC

**REQUEST FOR JUDICIAL NOTICE
AND FOR INCORPORATION OF
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SUPPORT OF MOTION TO DISMISS
UNITED STATES' COMPLAINT-IN-
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(CAPTION CONTINUED)

1 UNITED STATES OF AMERICA and
2 STATE OF CALIFORNIA ex rel. MICHAEL
BICOCCA,

3 Plaintiffs,

4 v.

5 PERMANENTE MEDICAL GROUP, INC.,
6 et al.,

7 Defendants.
8

Case No. 3:21-cv-03124-EMC

**REQUEST FOR JUDICIAL NOTICE
AND FOR INCORPORATION OF
DOCUMENTS BY REFERENCE IN
SUPPORT OF MOTION TO DISMISS
UNITED STATES' COMPLAINT-IN-
INTERVENTION**

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Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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10
11 UNITED STATES OF AMERICA ex rel.
12 JAMES M. TAYLOR,

13 Plaintiff,

14 v.

15 KAISER PERMANENTE, et al.,

16 Defendants.
17

Case No. 3:21-cv-03894-EMC

**REQUEST FOR JUDICIAL NOTICE
AND FOR INCORPORATION OF
DOCUMENTS BY REFERENCE IN
SUPPORT OF MOTION TO DISMISS
UNITED STATES' COMPLAINT-IN-
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I. INTRODUCTION

Pursuant to Federal Rule of Evidence 201 and the doctrine of incorporation by reference, Defendants¹ request that the Court consider the contents of **Exhibits A-J**. These documents are attached to the accompanying Declaration of David Deaton (“Deaton Declaration”).

This request for judicial notice and incorporation by reference is made in support of Defendants’ Motion to Dismiss the United States’ Complaint-in-Intervention (“Complaint”).

II. ARGUMENT

The Court may take judicial notice of matters “not subject to reasonable dispute” in that they “can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned.” Fed. R. Evid. 201(b). Courts may “consider . . . matters of judicial notice . . . without converting the motion to dismiss into a motion for summary judgment.” *United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003).

Courts may also consider “documents incorporated into the complaint by reference” when ruling on a motion to dismiss. *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007). Under the incorporation-by-reference doctrine, courts “may take into account documents whose contents are alleged in a complaint and whose authenticity no party questions, but which are not physically attached to the [plaintiff’s] pleading” and may “treat such a document as part of the complaint, and thus may assume that its contents are true for purposes of a motion to dismiss under Rule 12(b)(6).” *Davis v. HSBC Bank Nevada, N.A.*, 691 F.3d 1152, 1160 (9th Cir. 2012) (alteration in original) (internal citations and quotations omitted). The doctrine extends to situations where “the plaintiff refers extensively to the document or the document forms the basis of the plaintiff’s claims,” *Ritchie*, 342 F.3d at 908, and to situations where the “plaintiff’s claim depends on the contents of a document . . . and the parties do not dispute the authenticity of the document, even though the plaintiff does not explicitly allege the contents of that document in the complaint,” *Knievel v. ESPN*, 393 F.3d 1068, 1076 (9th Cir. 2005). Thus, “the requirements for

¹ “Defendants” are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.

the documents that are relied on by the complaint to be incorporated is that: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claim; and (3) no party questions the authenticity of the copy attached to the 12(b)(6) motion." *Al-Ahmed v. Twitter, Inc.*, 2022 WL 1605673, at *4 (N.D. Cal. May 20, 2022) (internal citations and quotations omitted).

A. Documents Referenced in the Government's Complaint-in-Intervention Are Subject to Incorporation by Reference

Incorporation by reference is appropriate for the contents of **Exhibits A-I** because the government referred to these documents in its Complaint and based its allegations on the representations within them. Dkt. No. 110 (U.S. Compl.) ¶¶ 5, 61–63, 68, 74–75, 78–84, 86, 125, 194–95. Therefore, Defendants request that the Court find that the following documents are incorporated into the Complaint and consider these documents when ruling on the Defendants' motion to dismiss:

Exhibit A is the publicly available 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide authored by the U.S. Centers for Medicare and Medicaid Services ("CMS"). The government cites this document in its Complaint to establish the allegedly "legitimate uses" of addenda. *Id.* ¶ 125. The validity of Defendants' addenda practices are central to the government's claims. *See e.g., id.* ¶ 1 (alleging that Defendants' addenda practices were unlawful).

Exhibit B is Chapter 3 of the publicly available Medicare Program Integrity Manual authored by CMS and issued on September 30, 2021. Like Exhibit A, the government cites this document in its Complaint to establish the allegedly "legitimate uses" of addenda, which are central to the Complaint. *Id.* ¶ 125.

Exhibit C is Chapter 7 of the publicly available Medicare Managed Care Manual authored by CMS and issued on September 19, 2014. The government cites this document in its Complaint to support the alleged requirements Medicare Advantage Organizations ("MAOs") must follow when submitting risk-adjustment data to CMS. *Id.* ¶ 61. The Medicare Managed Care Manual is central to the government's claims because the government asserts that

1 Defendants violated purported requirements in the Medicare Managed Care Manual. *See id.* ¶ 97.

2 **Exhibit D** is the publicly available ICD-10-CM Official Guidelines for Coding and
 3 Reporting (the “ICD Guidelines”), provided by CMS and the National Center for Health Statistics
 4 (“NCHS”) and approved by the American Hospital Association, the American Health Information
 5 Management Association (“AHIMA”), CMS, and NCHS, that were updated on April 1, 2022.²
 6 The government refers to the ICD Guidelines repeatedly in its Complaint and cites to websites
 7 where the relevant ICD Guidelines can be found. *See, e.g., Id.* ¶¶ 5, 61–63, 68, 81–84, 86. The
 8 government refers to the ICD Guidelines to establish alleged requirements MAOs must follow
 9 when submitting risk-adjustment data, which is central to the government’s claims because the
 10 government asserts that Defendants violated those purported requirements. *See id.* ¶¶ 81, 88.

11 **Exhibit E** is the 2013 National Technical Assistance Risk Adjustment 101 Participant
 12 Guide authored by CMS and dated July 23, 2013. The government cites this document in its
 13 Complaint to support, among other things, its allegation that a chronic condition must be
 14 supported by a “face-to-face visit each year” to be “accepted for risk adjustment.” *Id.* ¶ 84
 15 (quoting the 2013 National Technical Assistance Risk Adjustment 101 Participant Guide). The
 16 document is central to the government’s claims because the government asserts that Defendants
 17 violated the purported face-to-face requirement.

18 **Exhibit F** is the 2001 AHIMA practice brief titled “Developing a Physician Query
 19 Process.” The government cites to this practice brief in its Complaint to establish the alleged
 20 requirements for proper medical record queries to healthcare providers. *Id.* ¶ 195. The document
 21 is central to the government’s claims because the government asserts that Defendants violated this
 22 purported procedure.

23 **Exhibit G** is the 2008 AHIMA practice brief titled “Managing an Effective Query
 24 Process.” Like Exhibit F, the government cites to this practice brief in its Complaint to establish
 25

26 ² The United States notes that its Complaint does not “reference any particular version of the ICD
 27 Guidelines” because the “relevant guidelines have remained the same.” *Id.* ¶ 62 n.3. Defendants
 28 have attached the most recent version of the ICD Guidelines for the purposes of this request. Ex.
 D. at 1.

1 the alleged requirements for proper medical record queries to healthcare providers. *Id.* ¶ 194.
 2 The document is central to the government’s claims because the government asserts that
 3 Defendants violated this purported procedure.

4 **Exhibit H** is the 2013 AHIMA practice brief titled “Guidelines for Achieving a
 5 Compliant Query Practice.” Like Exhibits F and G, the government cites to this practice brief in
 6 its Complaint to establish the alleged requirements for proper medical record queries to healthcare
 7 providers. *Id.* ¶ 194. The document is central to the government’s claims because the
 8 government asserts that Defendants violated this purported procedure.

9 **Exhibit I** is the 2015 contract between Kaiser Foundation Health Plan, Inc. and CMS.
 10 While the government does not reference this specific contract in its Complaint, it repeatedly
 11 references Defendants’ contractual obligations, like those found in Exhibit I. *Id.* ¶¶ 74–75, 78–
 12 81. Contracts like Exhibit I are central to the government’s claims because the government
 13 asserts that Defendants violated the contracts. *See id.* ¶¶ 78–81.

14 **B. DOJ’s Justice Manual Is Judicially Noticeable**

15 “[I]nformation made publicly available on a website maintained by a government entity is
 16 judicially noticeable.” *Platte River Ins. Co. v. P & E Automation, Inc.*, 2013 WL 12123688, at
 17 *2-3 (C.D. Cal. June 19, 2013) (judicially noticing documents available on the California
 18 Secretary of State’s website); *Daniels-Hall v. Nat’l Educ. Ass’n*, 629 F.3d 992, 998–99 (9th Cir.
 19 2010) (finding judicial notice appropriate for information made publicly available on government
 20 entities’ websites where neither party disputed the websites’ authenticity or the displayed
 21 information’s accuracy). Thus, this Court should find that judicial notice is appropriate for the
 22 following document and should consider its content when ruling on the Defendants’ motion to
 23 dismiss the Complaint:

24 **Exhibit J** shows Section 1-19.000 of the U.S. Department of Justice’s (“DOJ’s”) Justice
 25 Manual, which is publicly available on DOJ’s official website.³

26
 27 ³ Exhibit J can be found at the following website: [https://www.justice.gov/jm/1-19000-limitation-](https://www.justice.gov/jm/1-19000-limitation-issuance-guidance-documents-1)
 28 [issuance-guidance-documents-1](https://www.justice.gov/jm/1-19000-limitation-issuance-guidance-documents-1).

REQUEST FOR JUDICIAL NOTICE
CASE NO. 3:13-CV-03891-EMC

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1 UNITED STATES OF AMERICA ex rel.
2 NASER AREFI, AJITH KUMAR and PRIME
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10 UNITED STATES OF AMERICA ex rel.
11 MARCIA STEIN and RODOLFO BONE,

12 Plaintiff,

13 v.

14 KAISER FOUNDATION HEALTH PLAN,
15 INC., et al.,

16 Defendants.

Case No. 3:16-cv-05337-EMC

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20 GLORYANNE BRYANT and VICTORIA
21 HERNANDEZ,

22 Plaintiff,

23 v.

24 KAISER PERMANENTE, et al.,

25 Defendants.

Case No. 3:18-cv-01347-EMC

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28 (CAPTION CONTINUED)

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2 STATE OF CALIFORNIA ex rel. MICHAEL
BICOCCA,

3 Plaintiffs,

4 v.

5 PERMANENTE MEDICAL GROUP, INC.,
6 et al.,

7 Defendants.

Case No. 3:21-cv-03124-EMC

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8
9
10 UNITED STATES OF AMERICA ex rel.
JAMES M. TAYLOR,

11 Plaintiff,

12 v.

13 KAISER PERMANENTE, et al.,

14 Defendants.

Case No. 3:21-cv-03894-EMC

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1 I, David Deaton, hereby declare and state as follows:

2 I am an active member in good standing of the State Bar of California. I am a partner of
3 O'Melveny & Myers LLP, counsel of record for Kaiser Foundation Health Plan, Inc.; Kaiser
4 Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California
5 Permanente Medical Group; and Colorado Permanente Medical Group, P.C. (collectively,
6 "Defendants"). I submit this declaration in support of Defendants' Request for Judicial Notice
7 and for Incorporation of Documents by Reference in support of Defendants' Motion to Dismiss
8 the United States' Complaint-in-Intervention. This declaration is based upon my personal
9 knowledge and, if called as a witness, I could and would testify to the matters set forth below.

10 1. A true and correct copy of the 2008 Risk Adjustment Data Technical Assistance For
11 Medicare Advantage Organizations Participant Guide is attached hereto as **Exhibit A**.

12 2. A true and correct copy of Chapter 3 of the Medicare Program Integrity Manual issued
13 on September 30, 2021 is attached hereto as **Exhibit B**.

14 3. A true and correct copy of Chapter 7 of the Medicare Managed Care Manual issued on
15 September 19, 2014 is attached hereto as **Exhibit C**.

16 4. A true and correct copy of the publicly available ICD-10-CM Official Guidelines for
17 Coding and Reporting that were updated on April 1, 2022 is attached hereto as **Exhibit D**.

18 5. A true and correct copy of the 2013 National Technical Assistance Risk Adjustment
19 101 Participant Guide dated July 23, 2013 is attached hereto as **Exhibit E**.

20 6. A true and correct copy of the 2001 American Health Information Management
21 Association ("AHIMA") practice brief titled "Developing a Physician Query Process" is attached
22 hereto as **Exhibit F**.

23 7. A true and correct copy of the 2008 AHIMA practice brief titled "Managing an
24 Effective Query Process" is attached hereto as **Exhibit G**.

25 8. A true and correct copy of the 2013 AHIMA practice brief titled "Guidelines for
26 Achieving a Compliant Query Practice" is attached hereto as **Exhibit H**.

27 9. A true and correct copy of the 2015 contract between Kaiser Foundation Health Plan,
28 Inc. and the U.S. Centers for Medicare and Medicaid Services is attached hereto as **Exhibit I**.

EXECUTED this 21st day of June, 2022.

David Deaton

EXHIBIT A



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

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2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

INTRODUCTION

INTRODUCTION

Purpose (Slide 3)

The purpose of this training is to provide participants who are new to risk adjustment the support necessary to understand risk adjustment. This information will enable new participants to collect and submit risk adjustment data in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

About This Training

This technical assistance session is organized into eight modules:

1. Risk Adjustment Methodology

Provides an understanding of CMS' Risk Adjustment models and payment methodologies.

2. Risk Adjustment Process Overview

Identifies the systems and timeline for the risk adjustment data collection, submission, editing, and reporting processes.

3. Data Collection

Describes the acceptable sources of risk adjustment data and data collection formats.

4. Data Submission

Describes the acceptable formats for submitting risk adjustment data.

5. Edits and Reports

Identifies data integrity logic and error codes, error resolution, and suggestions for avoiding errors. In addition, describes risk adjustment reports, and defines their uses in monitoring data collection and submission processes.

6. Diagnosis Codes & Risk Adjustment

Provides important medical record documentation and coding guidelines related to risk adjustment.

7. Data Validation (Medical Record Review)

Identifies the data validation approach under the CMS' Risk Adjustment models, including responding to CMS medical record requests.

8. Verifying Risk Scores

Describes the process for calculating the risk score and its impact on risk adjusted payment.

ICON KEY

Example



Reminder



Resource





2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

INTRODUCTION

This participant guide is designed as the foundation of the training program. The presentation slides complement the participant guide and both will be used extensively throughout this training. The participant binder includes the participant guide, presentation slides, a resource guide, and job aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

TABLE A – TRAINING TOOLS

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant risk adjustment information • Case studies • Exercises • Answer keys
Slides	• Organized by module • Printed two slides per page
Resource Guide	• List of common acronyms • Risk adjustment instructions • Contact information • Other source documents

Future Use of This Participant Guide

The participant guide, slides, and resource guide are designed for use when participants return to their organizations. Additional copies of the training materials are available at www.csscooperations.com. CMS revises training materials, when required. An appropriate label will appear in the footer of the replacement pages affected by the revisions. Organizations are encouraged to register at www.csscooperations.com to receive notification for these revisions.

Audience

This technical assistance program is designed for individuals new to the risk adjustment process. The primary audiences for this program are:

- Staff of new Medicare Advantage (MA) and Medicare Advantage – Prescription Drug (MA-PD) organizations, Regional and Employer Group Health plans, demonstration projects, Program of All-Inclusive Care for the Elderly (PACE) organizations, Cost Plans and specialty plans.
- Existing staff unable to attend previous training sessions.
- New staff at the existing organizations mentioned above.
- Third party submitters contracted to submit data on behalf of MA Risk Adjustment organizations.

The organizations listed in Table B will be used throughout this session.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

INTRODUCTION

TABLE B – ORGANIZATION DESCRIPTION

NAME	DESCRIPTIONS
MA Organizations	Organizations, including Health Maintenance Organizations with or without Prescription Drug Programs, Employer Group Health and Medical Savings Account organizations, private fee-for-service organizations, preferred provider organizations, and provider sponsored organizations that receive capitated payments to provide comprehensive medical services to Medicare beneficiaries.
PACE	Program of All-Inclusive Care for the Elderly (PACE) that serves a community of frail and elderly individuals who are eligible for nursing home placement based on State Medicaid criteria.
MSHO/ MnDHO	Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) are managed care products in a ten-county area in Minnesota, including the Twin Cities. They integrate Medicare and Medicaid financing of acute and long-term care service delivery for dually eligible and Medicaid eligible physically disabled adults and elderly. MnDHO is approved for Carver, Scott, Washington, Hennepin, Ramsey, Dakota, and Anoka counties.
S/HMO	Social Health Maintenance Organizations (SHMO) offer seniors an expanded care benefits package that may include prescription drugs and community-based services, which enables them to maintain independence and avoid nursing home placement.
WPP	Wisconsin Partnership Program (WPP) is a comprehensive program for Medicaid and Medicare beneficiaries who are elderly or disabled and meet the State's nursing home criteria. WPP integrates health and long-term support services, and includes home and community-based waiver services (HCBS), physician services, and all other medical care.
SCO	The MassHealth Senior Care Option (SCO) is a dual eligible demonstration that CMS and the Division of Medical Assistance for the Commonwealth of Massachusetts developed. The contractors provide care through managed care organizations to beneficiaries who enroll voluntarily. SCOs serve community-well, community-frail, and institutionalized beneficiaries age 65 and older. SCOs are required to contract with State Aging Services Access Point providers as part of the SCO care management team, which deliver home and community-based services as part of an integrated model of care.
Capitated Demonstration Projects	Capitated demonstration projects use alternative capitated financing to allow the provider to offer comprehensive medical service.
Cost Plans	A Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) that operates in accordance with a cost reimbursement contract under Section 1876(h) of the Act. These contracts provide the full Medicare benefit packages. Payment is based on the reasonable cost of providing services. Beneficiaries are not restricted to the HMO or CMP to receive covered Medicare services (i.e., services may be received through non-HMO/CMP sources and are reimbursed by Medicare intermediaries and carriers).



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

INTRODUCTION

Learning Objectives (Slide 6)

At the completion of this training, participants will be able to:

- Identify Risk Adjustment and payment methodologies.
- Describe the requirements for data collection.
- Determine the process for submitting data to CMS.
- Explain the process for validating risk adjustment data.
- Interpret the editing rules and reports for monitoring RAPS data.
- Demonstrate how to verify risk scores.

The roles and contact information for important resources are provided in Table C.

TABLE C – RISK ADJUSTMENT PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
CMS Center for Beneficiary Choices	Develops and implements the risk adjustment payment methodology for the MMA program. Monitors plans to improve the quality of data.	Sean Creighton sean.creighton@cms.hhs.gov Henri Thomas henry.thomas@cms.hhs.gov Louis Johnson louis.johnson@cms.hhs.gov Stephen Calfo stephen.calfo@cms.hhs.gov
CMS Regional Offices	Provide assistance to Risk Adjustment organizations and beneficiaries regarding various issues related to the Medicare program.	Contact your plan manager.
Palmetto Government Benefits Administration (Palmetto GBA)	Manages the Front-End Risk Adjustment System (FERAS) and the Customer Service and Support Center (CSSC).	www.csscooperations.com
Leading Through Change, Inc. (LTC, Inc.)	Training Contractor responsible for risk adjustment training initiatives, including regional training programs and User Group meetings.	TAregistration@tarasc.info



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

RISK ADJUSTMENT METHODOLOGY

MODULE 1 – RISK ADJUSTMENT METHODOLOGY

Purpose (Slide 2)

To provide information on risk adjusted data submission and payment under the risk payment models. The goal of risk adjustment is to pay applicable Parts C and D organizations accurately and fairly by adjusting payment for enrollees based on demographics and health status. Changes to risk adjustment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are also provided in this module.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Define the purpose of risk adjustment.
- Identify the components of risk adjusted payments.
- Describe the Part C community model.
- Describe how to calculate the frailty adjuster.
- Describe Part C Community and Long-term institutional models.
- Describe how to calculate a risk factor.
- Recognize the components of the Part C End-Stage Renal Disease (ESRD) model.
- Describe the Part D Prescription Drug Risk Adjustment model.
- Identify the new enrollee factors.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 Risk Adjustment History (Slides 4-9)

The following is a list of key dates that have occurred during the process of implementing a risk adjustment payment methodology.

- Balanced Budget Act of 1997 (BBA) (42 CFR 422).
 - Created the Medicare+Choice (M+C) program.
 - Mandated risk adjustment payment methodology to increase payment accuracy.
 - Mandated the implementation of a frailty adjuster for the Program for All-Inclusive Care for the Elderly (PACE) organizations.
- August 1998
 - Hospital inpatient encounter data collection began.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

RISK ADJUSTMENT METHODOLOGY

- January 2000 – Principal Inpatient Diagnostic Cost Group (PIP-DCG) Payment Model implemented.
 - Gradual phase-in of risk adjustment based on principal inpatient diagnosis and demographic factors (age, sex, Medicaid status, original reason for Medicare entitlement).
 - Implemented at 10 percent PIP-DCG and 90 percent demographic.
 - The PIP-DCG model is based on hospital inpatient diagnoses only.
- Benefits Improvement and Protection Act of 2000 (BIPA) (December).
 - Established the current implementation schedule to achieve 100 percent risk adjusted payment in 2007.
 - Mandated the incorporation of ambulatory data.
- May 2001 – Secretary of the Department of Health and Human Services suspended collection of ambulatory data to seek burden reduction for M+C organizations.
- January 2002 – CMS announced new risk adjustment data processing system—RAPS (Risk Adjustment Processing System).
- March 2002 – Draft CMS-HCC Payment Model selected.
 - New risk adjustment model needed to accommodate other types of data (hospital outpatient and physician)
 - Included approximately 70 condition groups with reduced number of diagnostic codes.
 - Proposed for implementation in calendar year 2004.
- February 3, 2003 – CMS presented a draft CMS-HCC model discussed at national public meeting and addressed the elimination of the data lag for payment.
- March 28, 2003 – Advanced Notice of Methodological Changes (i.e., 45-Day notice) published the proposed CMS-HCC model, ESRD model, frailty adjuster, and elimination of the data lag.
- May 12, 2003 – Published final M+C rates for 2004 payment.
 - Announced final CMS-HCC model, including the institutional and community models.
 - Provided risk adjustment new enrollee factors.
 - Delayed implementation of ESRD model for M+C until 2005.
 - Described process for elimination of the data lag.



See 2004 45-Day Notice at

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf> and May 12, 2003 Announcement of Rates for 2004 at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004.pdf>

- December 8, 2003 – Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Enacted (P.L. 108-173).
 - Created MA program to replace M+C program.
 - Retained many M+C provisions while introducing new plan types and new payment rules.
 - Created Medicare drug benefit to begin in 2006.
 - Established bidding methodology for MA organizations and drug plans in 2006.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

RISK ADJUSTMENT METHODOLOGY

- January 16, 2004-New ratebook for 2004 published.
 - Revised ratebook took into account changes from MMA, including introduction of a new rate - 100% of average FFS costs.
 - 2004 was a transitional year for the capitation rate setting – the FFS rate was the 4th prong to the previous “highest of three rates” methodology so for 2004 each county capitation rate was the higher of its FFS amount, minimum percentage increase rate, floor rate, or blended rate. (See Section 1.2.1 below.) Also, the MMA changed the calculation of the for 2004 and modifying the minimum percentage increase rate for 2004 and beyond.
 - Under the MMA, for 2005 and onward capitation rates are the minimum percentage increase rate, except in years when CMS retabulates “(rebases)” the FFS amounts, and in rebasing years the rate is the higher of the two.



See January 16, 2004 cover letter regarding revised MA rates at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004b.pdf>

- March 26, 2004-Advanced Notice of Methodological Changes for 2005 (i.e., 45-Day notice) published.
 - Announcement of MMA-required, ratebook transitions to “highest of 2.”
 - Proposes ESRD model for implementation in 2005.



See 2005 45-Day Notice for additional details at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf>

- May 2004-Announcement of draft diagnoses collected for drug risk adjustment model for payment beginning in 2006 and additional codes for CMS-HCC risk adjustment models.
- May 10, 2004-Announcement of rates for 2005.
 - Announced MA county capitation rates.
 - Announced final ESRD CMS-HCC risk adjustment model.
- February 18, 2005-Advanced Notice of Methodological Changes for 2006 (i.e., 45-Day notice) published.
 - Proposed changes in the MA capitation rate methodology due to implementation of MMA bidding and proposed changes to risk adjustment methodology under Part C.
 - Proposed the health status risk adjustment methodology for Part D [Draft Prescription Drug (RxHCC) Model].
 - Proposed payment methodologies for the direct, low income, and reinsurance subsidies, and risk sharing.



See 2006 45-Day Notice for additional details at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf>



April 4, 2005-Announcement of rates for 2006.

- Announced final Part D risk adjustment model.
- Rolled back proposed changes to MA risk adjustment model outlined in February 18, 2005 Advance Notice.
- April 8, 2005-Updated regional rates.
- April 13, 2005-Updated ratebook.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

RISK ADJUSTMENT METHODOLOGY



See Final 2006 Notice for additional details at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2006.pdf>

April 7, 2005- Risk Adjustment models and ICD-9/HCC crosswalks posted at

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp



April 3, 2006-Announcement of 2007 Payments posted at

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf>.

- Announced recalibrated version of the CMS-HCC model for 2007
- Announced updated normalization factor for CMS-HCC models



April 2, 2007—Announcement of 2008 Payments posted at

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf>.

- Announced recalibrated versions of ESRD models for 2008
- Announced normalization factor for Part D risk adjustment model
- Announced updated normalization factor for Part C CMS-HCC and functioning graft models
- Announced normalization factor for ESRD dialysis and transplant models
- Announced recalibrated frailty model
- Announced new frailty payment implementation for PACE and certain demonstration organizations



April 7, 2008—Announcement of 2009 Payments posted at

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf>.

- Announced recalibrated version of the Part C CMS-HCC model for 2009
- Announced updated normalization factors for Part C CMS-HCC, ESRD Dialysis model, and the functioning graft model
- Announced updated normalization factor for the Part D risk adjustment model
- Announced recalibrated frailty factors for 2009
- Announced standard set of ICD-9 Diagnosis codes for Risk Adjustment

1.2 Calculating Payments

1.2.1 Payments for 2004 and 2005

Traditionally, payments to MA organizations were based solely on demographic information. Risk adjustment provides more accurate payments for MA organizations. Payments are higher for less healthy enrollees and lower for more healthy enrollees. For 2004 and 2005, MA risk payment calculations involved two steps:

1. Identify the county risk rate for the enrollee's county of residence , and
2. Multiply by the enrollee's individual risk factor.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

RISK ADJUSTMENT METHODOLOGY

CMS derived county risk rates for Part A and Part B by multiplying the unadjusted Part A and Part B demographic county rates (used for demographic payments) by a rescaling factor, based on the CMS-HCC risk factor of the FFS enrollees in that county. The demographic rates were used in the older payment method where the county rate was standardized by the county average FFS demographic factor (based on age, sex, Medicaid, institutional, disabled, and working aged statuses) and payment equaled the county rate multiplied by the individual demographic factor, which was a proxy for expected health risk.) Under the new risk adjustment method being phase-in beginning in 2000, this county risk rate was then multiplied by the individual's CMS-HCC risk factor to determine the appropriate payment amount. The schedule from 2004-2007 for phasing-out the demographic payment method and phasing-in the risk-adjustment payment method was as follows:

- For 2004, MA organizations were paid using 70 percent of the demographic payments and 30 percent of the CMS-HCC payments.
- For 2005, MA organizations were paid using 50 percent of the demographic payments and 50 percent of the CMS-HCC payments.
- For 2006, MA organizations were paid using 25 percent of the demographic payments and 75 percent of the CMS-HCC payment.
- For 2007 and beyond, MA organizations are paid using 100 percent of the CMS-HCC payment.

Prior to the passage of the MMA, the 2004 MA (then M+C) rates for each county were defined as the highest of three rates: the blended capitation rate, minimum "floor" amount, or minimum two percent increase rate. With the enactment of the MMA in December 2003, the original 2004 payment methodology changed and required CMS to issue revised capitation rates for CY 2004.

The MMA mandated that a new rate type, 100 percent of projected average fee-for-service Medicare costs (with adjustments to exclude direct medical education and include a VA/DOD adjustment) be added to the payment methodology. Introducing the 100% FFS reconnects the link between managed care payment rates and fee-for-service spending at the county level that had existed prior to the BBA. For 2004 only (a transition year under the MMA rate-setting rules), the county capitation rate was this highest of four rates: blended rate, floor amount, minimum increase rate, and FFS rate.

For 2005 and subsequent years, the MA capitation rate for a county is the minimum percentage increase rate, except for years when CMS re-tabulates ("rebases") the FFS rates. In rebasing years, the county capitation rate is the higher of the minimum percentage increase rate or the FFS rate.

In addition, from 2004 onward, the MMA modifies the methodology for calculating the minimum percentage increase. The previous year's rate is increased by the larger of:

- 2 percent
- or
- the Medicare growth percentage, - with no adjustments to this growth trend for over/under projections for years before 2004.

The Deficit Reduction Act of 2005 redefined the minimum percentage increase rate to be the previous year's rate increased by the Medicare growth percentage, with no adjustments for over/under projections for years before 2004.



2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

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1.2.2 MA Capitation Rates for 2006 through 2008

CY 2006 was the first year that MAOs were paid based on the MMA bid-based methodology. Thus, the capitation rates are no longer the same as payment rates. Capitation rates are used to establish benchmarks, and payment rates are plan-specific per capita monthly bids (adjusted).

For 2006, the final estimate of the increase in the National Per Capita Medicare Advantage Growth Percentage for aged beneficiaries was 4.8 percent, which is greater than 2 percent. Therefore, 4.8 percent was used as the minimum update percentage in calculating the 2006 rates. For 2006, all capitation rates are the 2005 rate increased by 4.8 percent. Per the MMA, CMS is not required to rebase the county fee-for-service rate every year and did not do so for 2006. In addition, for 2006, MA organizations were paid using 25 percent of the demographic payments and 75 percent of the CMS-HCC risk payments.

For 2007, the final estimate of the National Per Capita Medicare Advantage Growth Percentage was 7.1 percent. Because fee-for-service rates were rebased (to reflect more recent county growth trends in fee-for-service expenditures), counties where the FFS rate is greater than the minimum percentage increase rate received the FFS rate. For 2007, 6 percent of the counties received the FFS rates. For 2007 and beyond, payments to MA organizations will be at 100 percent of the CMS-HCC risk rate.

For 2008, the final estimate of the National Per Capita MA Growth Percentage is 5.7%. This final estimate includes 4.3 percent for the 2008 underlying trend change and 1.3 percent due to corrections to prior years' estimates, as required by law. CMS did not re-tabulate the FFS rates for 2008, so all MA capitation rate are minimum percentage increase rates.

For 2009, the final estimate of the National Per Capita MA Growth Percentage is 4.2%. This final estimate includes 0.48 percent due to corrections to prior years' estimates, as required by law.

1.2.3 Risk Ratebook

For payments years through 2006, a rescaling factor has been used to convert the demographic capitation rates to the risk adjusted capitation rates for each county. This is referred to a restandardizing the ratebook. The rescaling factor is defined as the county rate properly standardized to the new risk adjustment factors divided by the demographic county rate. In addition to restandardizing the ratebook, a budget neutrality factor is applied to make risk adjustment budget neutral. (see below for more information)

Section 5301 of the Deficit Reduction Act (DRA) changes the way CMS develops its capitation rates, beginning in 2007. The DRA established a single risk ratebook for monthly capitation rates, because the statutory transition for MA plans from payment based on the demographic rates and demographic adjustment factors to payment based on risk adjustment rates and risk adjustment factors were completed in 2006. Effective 2007, MA capitation rates are risk rates. Capitation risk rates are used to determine the plan benchmarks for virtually all MA plans and MAOs set their bids in relation to their benchmarks.

The DRA defines the risk rates as the base ratebook, so CMS will now publish two sets of rates – risk and demographic rates. CMS will continue to publish the demographic rates because they are used in budget neutrality (BN) factor calculations. Also, the demographic rates will be used in 2007 to determine



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payments to certain demonstrations and PACE organizations, which lag one year in the transition blend so that 25 percent of their payments will be based on demographic rates.

In addition, the FFS normalization factor, which was applied in the rate book prior to 2007, is instead applied to the risk scores starting in 2007. The result of these two approaches is mathematically the same.

Table 1A shows the risk adjustment models and updates implemented for payments beginning with 2004. Note that all models are implemented with their associated new enrollee models.

TABLE 1A – RISK ADJUSTMENT MODEL IMPLEMENTATION FOR PAYMENT (Slides 16, 17, & 42)

PAYMENT YEAR	RISK ADJUSTMENT MODEL IMPLEMENTED FOR PAYMENT	CALIBRATION YEARS	NORMALIZATION FACTOR
2004-2006	CMS-HCC Community & Institutional	1999-2000	1.05
2005-2007	ESRD Functioning Graft	1999-2000	1.05
	ESRD Dialysis and Transplant	1999-2000	N/A
2006-current	RxHCC	2002-2006	N/A
2007-current	Recalibrated CMS-HCC Community & Institutional	2002-2003	1.029
2008	Recalibrated ESRD Functioning Graft	2002-2003	1.04
	Recalibrated ESRD Dialysis and Transplant	2002-2003	1.010
	Recalibrated CMS-HCC Community and Institutional	2002-2003	1.04*
	RxHCC	2002-2006	1.065**
2009	Recalibrated ESRD Functioning Graft	2002-2003	1.058
	Recalibrated ESRD Dialysis and Transplant	2002-2003	1.019
	Recalibrated CMS-HCC Community and Institutional	2004-2005	1.03
	RxHCC	2002-2006	1.085

*The 2008 normalization factor for the CMS-HCC community and institutional models was updated from 2007 to include one additional year of FFS data. Note that the 2007 recalibrated model did not change for 2008 payments.

**The 2008 normalization factor for the RxHCC model will be first implemented in 2008. Note that the 2006 model did not change for 2008 payments.

1.2.3.1 Adjustment for Budget Neutrality

While risk adjustment (without the implementation of budget neutrality) would reduce aggregate payments to the MA program, compared to aggregate payments under the older demographic method, budget neutrality redistributes these payments as a constant percentage to organizations affected by risk adjustment (including MA organizations, PACE, and certain demonstrations). In other words, under



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budget neutrality, savings that would have accrued to the Medicare Trust Fund due to the application of risk adjustment are instead redistributed among MA organizations. The budget neutrality factor is calculated as the difference between payments under 100 percent of the risk adjustment method (i.e., under the CMS-HCC model) versus payment under 100 percent of the demographic only method.

The following sections discuss recent changes in the application of budget neutrality policy.

1.2.3.2 Change in the Budget Neutrality Calculation to Account for Different Payment Methodologies for Local MA Plans Versus Regional MA Plans

Because of the difference in payment methods for local MA plans versus regional MA plans beginning in 2006, CMS will modify the budget neutrality calculation. Budget neutrality is calculated as the difference between aggregate MA payments at the local MA benchmark rate that would have been made using the demographic method for 100 percent of payments and the aggregate payments that would be made using 100 percent of risk adjusted payments. Budget neutrality will be applied to both local and regional MA plans. For regional plans, this means that the budget neutrality factor will be applied to the statutory component of the benchmark.

1.2.3.3 Phase Out of Budget Neutrality

The DRA mandates the phase-out schedule for the BN factor from 2007 through 2010. The phase out schedule is shown in Table 1B. Under the budget neutrality methodology, in 2006, 100 percent of the difference between payment under the demographic method and payment under risk adjustment was added back to the risk payment rates via a rescaling factor. However, due to the payment blend for 2006 this will result in 75 percent of the budget neutrality amount being added back to the blended benchmark. For 2007, 55 percent of the BN factor was applied to every risk rate. The percentage applied will decrease each year until 2011, when it is 0 percent (see Table 1B).

TABLE 1B – PHASE-OUT SCHEDULE FOR BUDGET NEUTRAL RISK ADJUSTMENT PAYMENTS

YEAR	BUDGET NEUTRALITY PERCENTAGE
2006	100% ^{1/}
2007	55%
2008	40%
2009	25%
2010	5%
2011	0%

^{1/} 100 percent of the difference between payment under the demographic method and the payment under the risk adjusted method will be added to the risk adjusted payment rates. However, due to the payment blend for 2006 of 25 percent demographic and 75 percent risk adjustment the net effect is a 75 budget neutrality adjustment.

1.2.4 Payment Blends

The schedule for implementing risk adjusted payments based on the CMS-HCC model and the blended transitional approach is shown below. In 2004, the CMS-HCC model was implemented at a 30 percent risk adjusted payment, with the remaining 70 percent represented by the demographic payment. The



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portion of risk adjusted payment will increase to 50 percent in 2005, to 75 percent in 2006, and finally to 100 percent in 2007. There was not blended payment transition for the Part C ESRD and Part D models. Payments under these models were implemented at 100 percent risk adjustment from the beginning. The CMS-HCC implementation schedule is shown in Table 1C. The Part C blended payment transition schedule for PACE and certain demonstration organizations is on a one year lag from the payment transition for MA organizations. Table 1D shows that CMS-HCC implementation schedule for specialty organizations.

**TABLE 1C – RISK ADJUSTMENT IMPLEMENTATION SCHEDULE FOR MA ORGANIZATIONS
AND FOR MA-PDS AND PDPS FOR DRUG BENEFIT**

PAYMENT YEAR	CMS-HCC MODEL -COMMUNITY -INSTITUTIONAL	ESRD CMS-HCC MODEL	DRUG BENEFIT MODEL
2004	70% Demographic 30% CMS-HCC Model	N/A	N/A
2005	50% Demographic 50% CMS-HCC Model	100%	N/A
2006	25% Demographic 75% CMS-HCC Model	100%	100%
2007	100% CMS-HCC Model	100%	100%

TABLE 1D – PAYMENT BLEND SCHEDULE FOR SPECIALTY ORGANIZATIONS

TYPE OF HEALTH PLAN	PART C TRANSITION BLEND*				
	2004	2005	2006	2007	2008
PACE	90/10%	70/30%	50/50%	25/75%	100%
WPP	90/10%	70/30%	50/50%	25/75%	100%
MSHO and MnDHO	90/10%	70/30%	50/50%	25/75%	100%
S/HMOs	90/10%	70/30%	50/50%	25/75%	100%
SCO	90/10%	70/30%	50/50%	25/75%	100%

*Represents percentage of original demographic payment methodology (specific to each plan type) versus CMS-HCC risk adjusted portion of payment. ESRD and Part D risk adjustment were implemented at 100 percent risk.



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1.2.5 Fee-for-Service Normalization Adjustment (Slide 42)

The purpose of the fee-for-service normalization adjustment is so that CMS payments are based on a population with an average risk score of 1.0. The CMS-HCC models are calibrated with FFS claims data. Because average predicted FFS expenditures 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. Through 2006, CMS adjusted the restandardized ratebook to the appropriate denominator for the payment year. The denominator represented the national average predicted fee-for-service expenditures per beneficiary in that year. Every year there are shifts in the Medicare population. Specifically, fee-for-service coding across all sites of service, coding has not yet stabilized as much as inpatient hospital coding. Therefore, it has been necessary to apply a fee-for-service normalization factor to adjust for changes in coding patterns.

The DRA required CMS to apply the fee-for-service normalization factor to the risk scores. For 2007 the Part C normalization factor for the recalibrated CMS-HCC model is 1.029, and 1.05 for the ESRD functioning graft models. The functioning graft normalization factor remained unchanged from the previous year since the ESRD models were not recalibrated for 2007. There was no normalization factor applied to the dialysis and transplant risk scores for 2007. For 2008, the normalization factor is 1.04 for the CMS-HCC and ESRD functioning graft risk scores. The Part D normalization factor is 1.065.

CMS will implement a four-year normalization phase-in of the Part C - ESRD dialysis and transplant risk scores. For 2008 (Y1) through 2011 (Y4), CMS will calculate a yearly normalization factor. The calculated normalization factor for each year will be adjusted using the specified phase-in percentage for that year. The risk scores will then be divided by the resulting adjusted normalization factor for that year. For example, in 2008 (Y1), dialysis and transplant risk scores will be divided by 25% of the calculated 2008 normalization factor. The normalization factor calculated for 2008 is .039 (or 3.9%). This factor will be multiplied by 25% to get the adjusted normalization factor. Therefore, the ESRD dialysis and transplant risk score normalization formula is $[\text{risk score}/(1+(\text{the adjusted factor}))]$, which is 1.010 (i.e., $1+(\text{.039} * 25\%)$) (See Table 1E).

Beneficiary risk scores are divided by a normalization factor. The fee-for-service normalized risk scores will appear on the MMRs. If plans calculate their own raw risk scores using the CMS-provided software, they will need to divide these raw risk scores by the respective normalization factors to obtain the risk scores used for payment.

**TABLE 1E – DIALYSIS AND TRANSPLANT RISK SCORE NORMALIZATION
PHASE-IN SCHEDULE**

YEAR	ADJUSTED NORMALIZATION FACTOR PHASE-IN PERCENTAGE
2008 (Y1)	1+ (.039*25%)
2009 (Y2)	1+ (Calculated Normalization Factor * 50%)
2010 (Y3)	1+ (Calculated Normalization Factor * 75%)
2011 (Y4) (forward)	1+ (Calculated Normalization Factor * 100%)



For a complete explanation of the derivation of the demographic and risk adjusted ratebook, see the following: <http://www.cms.hhs.gov/manuals/Downloads/mc86c08.pdf>



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1.2.6 Payments for 2006 and Beyond

1.2.6.1 Bidding Background

Beginning in 2006, CMS' payments for plan enrollees are based on the plan bid relative to the plan benchmark. An MA organization's combined bid for its service area, for both local and regional organizations (and service area segment, in the case of a local organization), will have three parts:

- An amount for the provision of Medicare Parts A and B medical benefits. (This is the standardized A/B bid, and does not include beneficiary cost-sharing.)
- An amount for basic coverage of Medicare prescription drug benefits (if any).
- An amount for the provision of supplemental medical and prescription drug benefits (if any).

Benchmarks. For both local and regional MA plans, the plan A/B benchmark, when compared against the plan A/B bid, determines whether a plan will have savings and rebates to offer additional benefits, or whether the MA organization will have to charge a basic premium for the plan's coverage of Part A and B benefits.

For local plans, the plan A/B benchmark is determined according to formulas established in the MMA. For a single-county plan (or segment), the plan A/B benchmark is the capitation rate for that county, adjusted to reflect the plan's projected risk profile to allow comparison to the plan A/B bid.

For local plans serving more than one county, the plan A/B benchmark is the enrollment-weighted average of all the county capitation rates in the plan's service area (or segment), adjusted by the projected risk profile of the plan. (In determining the enrollment-weighted average, the weights are based on the plan's projected enrollment in each county of its service area.)

The standardized benchmark for each MA region is a blend of two components: a statutory component consisting of the weighted average of the county capitation rates across the region; and, a competitive component consisting of the weighted average of all of the standardized A/B bids for regional plans in the region. The weighting for the statutory component is based on MA eligible individuals in the region. "MA eligibles" refers to all Medicare beneficiaries in the FFS and MA programs. The weighting for the competitive component (which includes each regional plan's bid) is based on the projected enrollment of the regional plans competing in the region. The blend of the two components will reflect the market share of traditional Medicare (for the statutory component) and the market share of all MA organizations (for the competitive component) in the Medicare population nationally.

1.2.7 Intra-Service Area Rate (ISAR) Adjusted County Payment Rates

In 2006 and beyond, payments to MA organizations must be adjusted to account for variations in MA local payment rates among the different MA local areas included in the MA plan's service area. For each MA plan, CMS will apply an ISAR adjustment based on the variation among MA capitation rates in the counties of a MA plan's service area. The ISAR is used to convert the plan's service-area bid into plan-specific county rates.



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The ISAR factor is calculated as the ratio of a county rate to the weighted average of all county rates for the service area, using plan projected county enrollment as the weights. For example, a plan with a service area of three counties (X, Y, and Z) could have ISAR factors of 0.98 for county X, 1.12 for county Y, and 0.9 for county Z. The weighted average of all the plan's county ISAR factors for that plan's service area must equal 1.0. Thus, for each county in the plan's service area, there will be a plan-specific county rate derived from the bid and the ISAR factor. Each county's ISAR factor is multiplied by the plan's standardized bid amount to derive the plan-specific payment rate for each county in the plan's service area.

1.2.8 Plan Payments

Plan payments Part C benefits are based on the relationship of the plan's bid with the plan benchmark.

(a) If the plan bid is less than the plan benchmark, monthly payment from CMS for an enrollee is:

ISAR-adjusted county rate $\times$ enrollee risk factor + rebate

(b) If the plan bid is equal to the plan benchmark, monthly payment from CMS for an enrollee is:

ISAR-adjusted county rate $\times$ enrollee risk factor

There is no rebate and no basic beneficiary premium.

(c) If the plan bid is greater than the plan benchmark, monthly payment from CMS for an individual is:

ISAR-adjusted county rate $\times$ enrollee risk factor + government premium adjustment.

There is no rebate and the enrollee pays a basic premium. The combined payment from CMS and the enrollee will on average equal the organization's bid (based on enrollment assumed in the bid submission).

For enrollees who are out of the service area, the base payment will be the 1.0 bid (with individual-level risk adjustment for demographic and health status factors). (Note that for plans with bids above benchmarks, the base payment for out-of-area enrollees is the benchmark because the beneficiary premium is subtracted from CMS' payment.) The rebate amount is not geographically or otherwise adjusted. It is a fixed amount determined through comparison of the plan A/B bid to the plan A/B benchmark based on the plan's projected enrollment.



Example: Plan with a Rebate

- Mr. Jones' plan:
 - Standardized ("1.0") A/B bid = \$600
 - Rebate = \$54
 - His plan's county ISAR factor = .98
 - His risk factor = 1.2
- ISAR-adjusted payment rate for Mr. Jones' county for his plan: $(\$600 \times .98) = \$588$
- Monthly Part C payment for Mr. Jones for his plan:
 $(\$588 \times 1.2) + 54 = \$759.60$

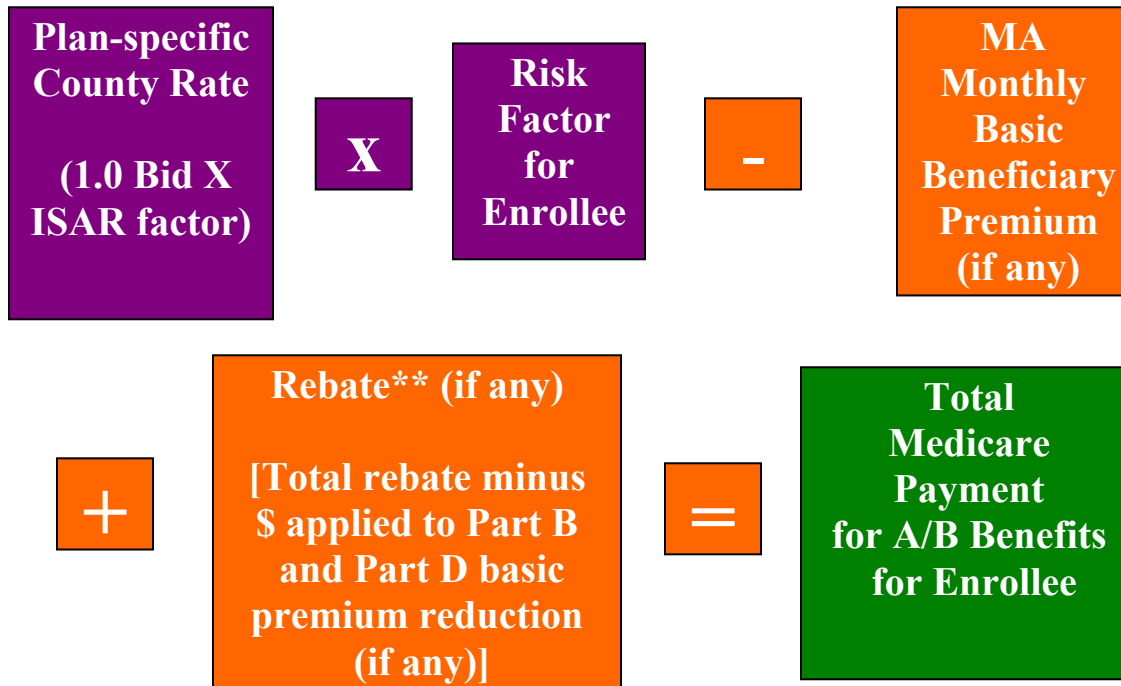


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Figure 1A illustrates the calculation of Risk Adjusted Payment for Plans.

Figure 1A – Calculation of Risk Adjusted Payment for Plans



**** Rebate applied to buy down the Part D basic premium is reflected in the part D payment; and rebate applied to buy-down the Part B premium is foregone revenue.**

1.3 Risk Adjustment Payment Models for Payment (Slide 13)

In 2003, after public comment, the CMS-HCC model was finalized as the risk adjustment payment model. The goal was to select a clinically sound risk adjustment model that improved payment accuracy while minimizing the administrative burden on MA organizations.

The model is a revision of the Hierarchical Condition Category model, originally developed by Health Economics Research, Inc. The CMS-HCC model functions by categorizing *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) codes into separate groups of clinically related codes, (e.g., diabetes, cancer, ischemic heart disease, infections, etc.) that have similar cost implications.

In order to improve payment further, CMS has developed separate models for different populations who have different cost patterns than the general Medicare population. There are four CMS-HCC models used to calculate risk scores for MA plans: a community model, a long-term institutional model, an ESRD



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model, and a new enrollee model. The new enrollee model is different than the other models in that it is not disease based.

CMS implemented the Prescription Drug (RxHCC) model in 2006 for payment under Part D. The RxHCC model is also a disease based model similar to the CMS-HCC model. However, it varies in that there is a base model and there are separate multipliers for the long term institutionalized (LTI) and low income beneficiaries which are applied to payment outside the model. The RxHCC model is described in detail towards the end of this module.

CMS has updated all of its Part C models and the frailty adjustment model, which is used for Non-ESRD ≥ 55 community residents. The result of the model recalibrations also yields updated normalization factors. Application of the normalization factors is described later in this module.

In 2007, CMS implemented updated versions of the CMS-HCC community and institutional risk adjustment models. Fee-for-service (FFS) claims data for the years 2002 and 2003 were used in the recalibrated model. Diagnosis data for 2002 predict 2003 expenditures. As these data are more current than the 1999 and 2000 data used for the original CMS-HCC model, the updated models reflect newer treatment and coding patterns in Medicare FFS.

For 2008, CMS recalibrated the original Part C ESRD models, and refined the frailty adjustment factors that are applied to the Part C community model risk scores. Similar to the community and institutional recalibration efforts, the ESRD models were recalibrated using 2002 and 2003 FFS claims data for ESRD enrollees. The frailty factors are used to calculate frailty scores applied to the payments to PACE organizations and certain demonstration plans. For PACE plans, CMS will transition from using the frailty factors used in 2007 to the revised frailty factors over five years. CMS will apply the current frailty adjustment factors to MA demonstration organization's payments on a phased-out schedule (described in the frailty section).

CMS' suite of payment models share common conceptual framework in general; however, the purpose for each is distinct to the expenditure patterns for specific Medicare populations.

Table 1F describes the characteristics of the Part C (CMS-HCC) and Part D (RxHCC) models.



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TABLE 1F – CHARACTERISTICS OF THE RISK ADJUSTMENT MODELS

CHARACTERISTIC	DESCRIPTION
SIMILAR MODEL CHARACTERISTICS (PART C AND PART D)	
Selected Significant Disease (SSD) Model	- Serious manifestations of a condition are considered rather than all levels of severity of a condition. - Models are additive. - Include most body systems and conditions.
Prospective Model	Uses diagnostic information from a base year to predict total 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 HCCs. - Model is most heavily influenced by Medicare costs associated with chronic diseases.
Disease Interactions and Hierarchies Included	- Interactions allow for additive factors based on chronic conditions and disabled status to increase payment accuracy. - Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist.
Demographic Variables	- Models include four demographic factors: age, sex, disabled status, and original reason for entitlement. - These factors are typically measured as of the data collection period.

PART C SPECIFIC CHARACTERISTICS	
Frailty Adjuster	Frailty add-on is used for PACE and certain demonstration plans with a frail elderly population in the community.
Medicaid Eligibility	- Medicaid status for full risk enrollees is prospective and always determined based on the data collection period. - Medicaid status for new enrollees is concurrent and based on Medicaid status during the payment year (during final payment).
Community-Based and Long-Term Institutionalized Enrollees Distinguished	- Long-term institutionalized is defined as enrollees with 90 days or greater of residence in a nursing home. - Institutional model is not based on institutional factor demographic-only model. - Separate models account for higher treatment costs of similarly-ill community residents. - Community and institutional models both include 70 disease groups.
ESRD CMS-HCC Model	- Model addresses disparate treatment costs structures related to ESRD enrollee status. - The model includes specific payments for individuals with dialysis, transplant, and functioning graft. - The ESRD model includes 67 disease groups.
PART D SPECIFIC CHARACTERISTICS	
LTI Multiplier	- Long term institutional (LTI) factor – gets assigned to the risk scores of beneficiaries with 90 days of residence or greater in a nursing home. - LTI status is determined based on the data collection period.
LIS Multiplier	- Two low income status (LIS) factors (full subsidy, and partial subsidy) – one or the other gets assigned to the risk score for enrollees based on their Part D determined LIS status. - LIS status is determined during the payment year.



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1.3.1 Components of the Risk Score in the CMS-HCC Model

CMS uses diagnoses from Medicare fee-for-service and/or from RAPS for determining the HCCs for each enrollee. Medicare fee-for-service data are utilized for risk adjusted payment when an enrollee joins an MA organization (or PACE/demonstration) after opting out of traditional Medicare fee-for-service coverage. That is, if an enrollee new to an MA organization enrolls in January of a calendar year, then CMS will use up to 12-months of prior fee-for-service data within the data collection period (both Part A and Part B) to obtain diagnostic data. Where data for a person have been submitted via RAPS, those data are also used in calculating the risk score for a person.

The risk score used in calculating payments under the CMS-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The model allows for the recognition of coexisting diseases when calculating payment by recognizing multiple chronic conditions listed for the beneficiary. Interactions (i.e., combinations) are used to account for expected costs that are higher because, for example, multiple coexisting diseases cause additional complications. Hierarchies are imposed to provide payments only for the most severe manifestation of a certain disease.

1.3.1.1 Demographic Factors (Slide 19)

The risk score uses five demographic factors in calculating the risk score under the CMS-HCC model, including age, sex, Medicaid status, disability, and original reason for Medicare entitlement (i.e., disability).

Age and Sex: Based upon the enrollee's age and sex, risk adjusted demographic factors are assigned for the calculation of the enrollee's risk factor.

Under the CMS-HCC model, CMS bases payments for the entire payment year upon the age an enrollee attains as of February 1st of each year with one exception, when an enrollee ages in to Medicare. (i.e., Beneficiaries are treated as age 65 for risk adjustment purposes when they attained 65 years of age in the payment year and the reason for entitlement is age.)

Disabled Status: The disabled factors for enrollees under 65 years old are labeled as "disabled" and those over 65 years old are labeled as "aged." Under the CMS-HCC model, additional payments are made for Medicaid eligible disabled individuals.

Original Reason for Medicare Entitlement (OREC): The factors labeled "originally disabled" apply to enrollees that are 65 years old or over who were originally entitled for Medicare due to disability. Under the CMS-HCC model, additional payments are made for OREC individuals with Medicaid based on age and sex.

Medicaid Status: The Medicaid factor applies to enrollees who are entitled to Medicaid under Title XIX of the Social Security Act. A Medicaid factor is applied based on the "aged", "disabled", or "originally disabled" status of the Medicaid enrollee.

1.3.1.2 Disease Groups/HCCs (Slide 20)

Disease groups contain major diseases and are broadly organized into body systems. For risk adjustment purposes, CMS refers to disease groups as HCCs. The HCC assigned to a disease is determined by the



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ICD-9-CM diagnosis codes submitted during a data collection period. Only selected diagnosis codes are included in the CMS-HCC model. There are 70 distinct disease groups for payment for community and long-term institutionalized residents. The ESRD model has approximately 67 disease groups, depending on the subpart of the model.



Example 1

DISEASE GROUP/HCC	DESCRIPTION
HCC92	Specified Heart Arrhythmia
HCC158	Hip Fracture/Dislocation

1.3.1.3 Disease Hierarchies (Slide 22)

Finally, the CMS-HCC model incorporates disease hierarchies. These hierarchies are used to provide payments for only the most severe manifestation of a disease, even when diagnoses for less severe manifestations of a disease are also present in the beneficiary during the data collection year. For example, an individual with diabetes that progresses over a year from having no complications (HCC19) to having acute complications (HCC17) would trigger the payments for HCC17 but not for HCC19. (Note that payments for HCC17 are higher than for HCC19.)



Example 2

Cancer

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
9	Lymphatic, head & neck, brain & other major cancers	10	Breast, prostate, colorectal & other cancers & tumors

1.3.1.4 Disease Interactions (Slide 23 & 24)

Certain combinations of coexisting diagnoses for an individual can increase their medical costs. The CMS-HCC model recognizes these higher costs through incorporating payments for disease interactions.

There are six disease interactions in the community model and five in the institutional model. Examples of the disease interactions include a two-way combination of diabetes mellitus (DM) and congestive heart failure (CHF) or a three-way combination of chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), and coronary artery disease (CAD).



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In calculating this part of the risk score for an individual, the individual score for each HCC is added and then the disease interaction score is added. In the example below, the risk adjusted payment would include an additional factor when an enrollee has both diabetes mellitus and congestive heart failure.

Example 3

Two-disease Interaction for Community-Based Enrollee

Factor 1: Diabetes Mellitus (DM), HCC15 = 0.508

Factor 2: Congestive Heart Failure (CHF), HCC80 = 0.410

Factor 3: Interaction: DM*CHF = 0.154

Risk Score = (demographics) + 0.508 + 0.410 + 0.154

In this case, the enrollee receives an additional interaction instead of only two factors for HCC15 and HCC80.

1.3.1.5 Disabled/Disease Interactions

Another type of interaction accounted for in the CMS-HCC model involves certain diseases and the disabled status for an enrollee. There are five disabled/disease interactions in the community model and four in the institutional model.

Below is an example of an individual who is disabled and has been diagnosed with rheumatoid arthritis and an opportunistic infection.

Example 4

Disabled/Disease Interaction for Community-Based Enrollee

Factor 1: Rheumatoid Arthritis, HCC38 = 0.346

Factor 2: Opportunistic Infection, HCC5 = 0.300

Factor 2: Disabled * Opportunistic Infection, D HCC5 = 0.623

Risk Score = (demographics) + 0.346 + 0.300 + 0.623

1.3.2 New Enrollee Factors

For purposes of risk adjustment, new enrollees are defined as newly eligible disabled or age-in beneficiaries (including "ever-disabled" age-in beneficiaries) with less than 12 months of Medicare Part B entitlement during the data collection year. Note that payments based on Medicaid eligibility will be made retroactively for all new enrollees, once enrollment can be established and verified.

As indicated in Table 1G, 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.



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Previously, 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 determining payments for this category of enrollees. Effective for 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.

This option elected by the organization will remain turned "on" until CMS is notified otherwise prior to August 31st of any successive year. CMS will apply this option during reconciliation for a payment year only (that is, it will not be applied prospectively). Plans interested in this option must contact: Henry Thomas at Henry.Thomas@cms.hhs.gov by 8/31/2008 to elect this option.

TABLE 1G – WHICH RISK ADJUSTMENT FACTORS 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).

During the payment year, a new enrollee factor will also be assigned to any beneficiary whose risk score is not available. In this case, the beneficiary's correct risk score will be determined during the next reconciliation.



The new enrollee factors for Part C are available at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf>

1.3.3 Community and Long-Term Institutional Model Distinctions

The CMS risk adjustment approach for Part C uses separate models for non-ESRD community and long-term institutional residents. Separate models were necessary because there are significant cost differences between the traditional community-based MA beneficiary population and the long-term institutionalized beneficiary population with the same disease profile. An adjustment for place of residence improves the payment accuracy of risk adjustment.

A long-term institutionalized MA enrollee is defined as someone who resides in an institution for more than 90 days as identified using the Minimum Data Set (MDS). The costs of the short term institutionalized (less than 90 days) are recognized in the community model.

Table 1H lists the considerations for community and long-term institutionalized populations.



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TABLE 1H – COMMUNITY VERSUS LONG-TERM INSTITUTIONALIZED POPULATIONS

CMS-HCC MODEL CONSIDERATIONS FOR COMMUNITY AND LONG-TERM INSTITUTIONALIZED POPULATIONS	
Community-Based	Long-Term Institutionalized
• Disease-related incremental payments for the community population are generally higher. • Community-based payment includes costs for the short term institutionalized (i.e., less than 90 days in an institution). • Community-based population payment would over predict costs for long-term institutionalized population, even with the same health status. • Currently, most MA organizations have a small proportion of long-term institutionalized enrollees (less than 10 organizations have more than 5% long-term institutionalized enrollees). • For 2004 and 2005, CMS paid all enrollees in most MA organizations as community based. Beginning in 2006, CMS will make prospective payments based on the beneficiaries' statuses (i.e., community or institutional). • The final reconciliation for a payment year will incorporate the correct institutional status for each enrollee for each month.	• Age and sex payment factors are generally higher for the long-term institutionalized population. • Many of the costs of the long-term institutionalized population are not paid for by Medicare. • Institutional model merges a number of disease groups to assure stable coefficients for this population. • Long-term institutional status will be recognized in the payment year. • MDS collected from nursing homes will be used to identify long-term institutionalized enrollees. • The presence of a 90-day assessment and current residence in an institution = long-term institutionalized enrollee. • No additional reporting by MA organizations is required. • Enrollees remain in long-term institutionalized status until discharged to the community for more than 14 days.

As described above in Table 1H, institutional status will be determined from information included in the MDS that is reported by Medicare certified nursing homes. Under the CMS-HCC model, MA organizations **will not report** the institutional status of their enrollees.



Example 5

Below is an example of the different HCC factors for community versus long-term institutional enrollees.

DISEASE GROUP	DESCRIPTION	COMMUNITY FACTOR	INSTITUTIONAL FACTOR
HCC1	HIV/AIDS	0.945	0.967
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.053	0.470



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1.3.4 Frailty Adjuster (Slides 27-30)

The frailty adjuster is included as part of risk adjusted payments for A and B services to PACE and certain demonstration organizations. The purpose of the frailty adjuster is to predict Medicare expenditures that are unexplained by the risk adjustment methodology alone. The CMS-HCC model uses diagnoses to adjust the payments to MA organizations. This model was calibrated based on the general Medicare population that has an average level of functional impairment. The frailty model further adjusts payment based on whether an organization's enrollees are more or less frail than the average.

Under frailty adjustment, the relative frailty of an organization is measured in terms of the number of functional limitations as represented by the Activities of Daily Living (ADL) scale. There are six ADLs: 1) bathing and showering; 2) dressing; 3) eating; 4) getting in or out of bed or chairs; 5) walking; and 6) using the toilet. A sample of individuals in each organization is surveyed to determine the relative frailty of the organization. Frailty adjustment lowers risk scores for individuals with 0 ADLs and increases risk scores for all of the categories of ADLs.

1.3.4.1 Why is There a Frailty Adjuster?

- The Balanced Budget Act of 1997 (BBA) mandated that Medicare capitated payments to PACE organizations be based on MA payment rates, adjusted to account for the comparative frailty of PACE enrollees.
- The CMS-HCC model does not explain all of the variation in expenditures for the frail, community-based population. The frailty adjuster is used to project the Medicare expenditures of community populations age 55 and over that are unexplained by risk adjustment.

1.3.4.2 Which Organizations Are Currently Being Paid Under Frailty Adjustment?

Table 1I lists the types of health plans being paid under frailty adjustment.

TABLE 1I – PLANS RECEIVING FRAILTY ADJUSTMENT

TYPE OF HEALTH PLAN	FRAILTY ADJUSTER IS PART OF RISK ADJUSTED PAYMENT
MA	NO
PACE	YES
Wisconsin Partnership Program (WPP)	YES
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	YES
Social Health Maintenance Organizations (S/HMOs)	YES
Massachusetts Senior Options (SCO)	YES



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1.3.4.3 How Does the Frailty Adjuster Work Under the CMS-HCC Model?

The frailty adjustment factors were designed to explain (or predict) the Medicare expenditures that are unexplained by risk adjustment for groups with similar functional impairments. Therefore, frailty adjustment was designed to be applied in conjunction with the CMS-HCC model. Since the CMS-HCC model adequately predicts the Medicare expenditures of the long-term institutionalized and the under-55 disabled population, frailty adjustment is only applied to non-ESRD community residents who are 55 and over.

CMS calculates an organization-level frailty score based on the difficulties in activities of daily living (ADLs) that are reported by enrollees. The organization-level frailty score is then added to the risk score for each 55 and over community resident.

1.3.4.4 Frailty Model Development (Slide 27)

The current frailty factors were calibrated using ADL limitation information from the Medicare Current Beneficiary Survey (MCBS) -- which is a face-to-face survey. Annual frailty factors were calculated using the Health Outcomes Survey – Modified (HOS-M) -- which is an anonymous mail-in survey with telephone follow-up.

For 2008 payments, CMS has changed its source for calibrating the frailty model from the MCBS to the FFS CAHPS data. The change has the advantage of using two surveys with similar methodologies for calibrating the model and for calculating annual frailty scores -- both the HOS-M and FFS CAHPS collect ADL information via mail surveys with telephone follow-up. CMS added questions regarding ADLs to the FFS CAHPS surveys collected between March 2003 and February 2004, used claims data for the beneficiaries in the sample, and recalibrated the frailty factors with these data. For 2009 payments, CMS will continue to use the FFS CAHPS data as the data source for calibrating the frailty model.

The revised frailty factors are also generally lower because:

1. Through mail versus face-to-face survey, beneficiaries more accurately report their functional impairments. Researchers have recognized that written surveys capture more accurate accounts of personal reporting than surveys that are conducted face-to-face. The changes in reporting of ADL limitations resulted in more accurate accounting of the residual expenditures from the CMS-HCC model; and
2. The decrease in home health payments mandated by BBA—as frailty is highly correlated with home health expenditures in a community setting. CMS will continue to use the current frailty methodology to transition frailty payment for PACE organizations and phase-out frailty payments for certain demonstration organization. This implementation schedule is provided in Section 1.3.4.5.

The CAHPS frailty calibration sample is much larger than the MCBS sample. These data have helped to better determine the relationship between frailty and costs given Medicaid and non-Medicaid status in the general Medicare population. For this reason, CMS is able to reliably estimate separate frailty factors for Medicaid and non-Medicaid frail Medicare beneficiaries—because the Medicaid and non-Medicaid frail populations show differences in the relationships between unexplained expenditures (in the CMS-HCC model) and functional impairments. Table 1J provides the Current and Revised Frailty Factors by ADL distribution.



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CMS has considered the impact of applying a program wide frailty adjuster and the effect of this on the current bidding methodology. CMS decided that the frailty adjuster will not be applied across all MA organizations. Methodologically, a program-wide adjustment does not improve payment accuracy for two reasons:

1. The HOS data used currently to determine frailty scores for payment is sampled only at the contract level, and therefore, does not allow for accurate calculation of frailty scores at the plan benefit package (PBP) level--thus, contract level frailty scores would lead to inconsistent payments across plans and beneficiaries; and
2. MA organizations would need to project frailty scores in their bids. Due to the changing nature of the marketplace and the different enrollment profiles of plans from year to year, this creates a risk that the level of frailty assumed by a plan in its bid would not reflect its actual score in the payment year.

TABLE 1J – 2008 AND 2009 FRAILTY FACTORS

ADL LIMITATIONS	2008 FRAILTY FACTORS		2009 FRAILTY FACTORS	
	NON-MEDICAID	MEDICAID	NON-MEDICAID	MEDICAID
0	-0.089	-0.183	-.093	-0.180
1-2	+0.110	+0.024	+0.112	+0.035
3-4	+0.200	+0.132	+0.201	+0.155
5-6	+0.377	+0.188	+0.381	+0.200

1.3.4.5 Frailty Payment Implementation

In 2008, CMS will begin transitioning PACE organization payments to 100 percent of the revised frailty factors over a 5-year period through 2012. In each year, the monthly PACE organizations payment would be based on the A/B risk score plus the established frailty transition amount. CMS will also begin a four year phase-out of frailty payments using the current methodology through 2011 for the dual demonstration organizations-- 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). Table 1K shows the frailty payment implementation schedule for PACE and demonstration organizations. The percentage (%) represents the percent of the contract-level frailty factor (current and/or revised) that will be added to the monthly A/B risk scores for payment.



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TABLE 1K – FRAILTY PAYMENT IMPLEMENTATION SCHEDULE FOR PACE AND DUAL DEMONSTRATION ORGANIZATIONS

TYPE OF CONTRACT	2008 FRAILTY PAYMENT SCHEDULE	2009 FRAILTY PAYMENT SCHEDULE	2010 FRAILTY PAYMENT SCHEDULE	2011 FRAILTY PAYMENT SCHEDULE	2012 FRAILTY PAYMENT SCHEDULE
% current frailty factor / % revised frailty factor					
PACE	90 / 10	70 / 30	50 / 50	25 / 75	0 / 100
Wisconsin Partnership Program (WPP)	75 / 0	50 / 0	25 / 0	0 / 0	
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	75 / 0	50 / 0	25 / 0	0 / 0	
Social Health Maintenance Organizations (S/HMOs)	75 / 0	50 / 0	25 / 0	0 / 0	
Massachusetts Senior Options (SCO)	75 / 0	50 / 0	25 / 0	0 / 0	

The range of frailty scores varies considerably among the organizations to which frailty adjustment applies (i.e., “frailty” plans). Table 1L shows a range of frailty scores by type of organizations for the current frailty methodology conducted using the MCBS and the new frailty calibration methodology using the FFS CAHPS data.

TABLE 1L – RANGE OF FRAILTY SCORE BY TYPE OF ORGANIZATION

ORGANIZATION TYPE	CURRENT MODEL FRAILTY SCORE (MCBS DATA)	RECALIBRATED—MEDICAID/ NON-MEDICAID FRAILTY SCORE (FFS CAHPS DATA)
PACE	0.375 – 0.791	0.064-0.226
S/HMOs	0.057 – 0.122	0.008-0.039
WPP	0.371 – 0.574	0.091-0.162
MnDo	0.583	0.143
MSHO	0.176 – 0.263	-0.017-0.009
SCO	0.166 – 0.414	-0.033-0.053

1.3.4.6 ADL Information Collection and Frailty Adjuster Development

CMS will continue to calculate annual contract-level frailty scores using results from the HOS-M survey. The revised frailty adjuster that will be used for PACE organization payments will include eight factors (instead of four factors under the current model): Medicaid eligible ADL limitations 0, 1-2, 3-4, and 5-6; and Non-Medicaid ADL limitations 0, 1-2, 3-4, and 5-6. The weighted factors will be summed to get the



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contract-level frailty score for payment. Demonstration organizations stated in Section 1.3.4.4 will continue to receive frailty payments based on the single frailty factor that is calculated using the current methodology (i.e., MCBS).

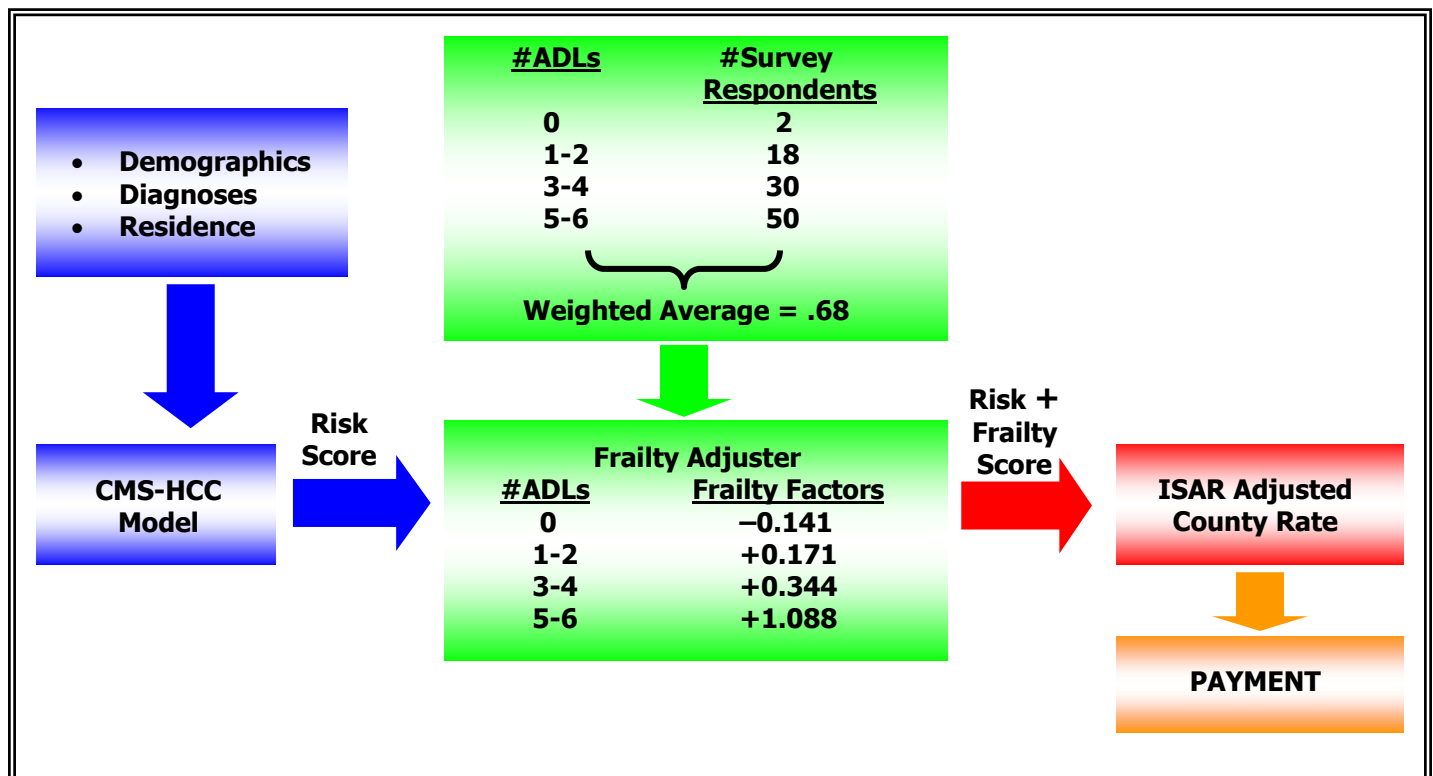
1.3.4.7 Calculating the Frailty Score for Payment

The organization-level frailty score is calculated as the weighted average frailty factor across all 55 and over community survey respondents for that organization.

The first step is to determine the number of ADLs with which each respondent has difficulty or is unable to do. Then the number of respondents in each ADL category (0 ADLs, 1 to 2 ADLs, 3 to 4 ADLs and 5 to 6 ADLs) is counted. These counts are multiplied by the corresponding frailty factor for each ADL category. The resulting products are then summed for each organization. This sum is divided by the number of 55 and over community respondents, yielding a weighted average factor (or frailty score) for each organization. The same frailty score is used for all 55 and over respondents and non-respondents of a plan who reside in the community.

This frailty score is added to the risk score of each 55 and over community enrollee in the organization (including new enrollees), resulting in a risk+frailty score for each individual. Payments to these plans are the product of this combined score and the risk adjusted county rate. Figure 1B illustrates this calculation and includes the ADL-based frailty factors.

Figure 1B – Frailty Adjustment Calculation





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Note: For new PACE organizations not yet participating in the survey, their frailty score is the weighted average factor across all community respondents of all PACE organizations.

1.3.5 Payment Methodology for ESRD Enrollees (Slides 30-32)

In order to further improve payment accuracy, CMS implemented the ESRD risk adjustment model. Effective January 2005, MA enrollees with ESRD were incorporated into diagnosis-based risk adjustment using a different version of the CMS-HCC model. This ESRD models were re-estimated for payments beginning in 2007 and ESRD risk score normalization of dialysis and transplant risk scores will be implemented in 2008. Section 605 of BIPA required CMS to adjust its approach to computing ESRD payment rates to reflect the method used in the ESRD S/HMO demonstration then in place. The three parts of the ESRD CMS-HCC model are:

Dialysis Status—A risk adjustment model that is calibrated for people on dialysis, so the payment weights are unique to these beneficiaries. The State ratebook used for dialysis payments was rebased with more recent data.

Transplant Status—Kidney or Kidney/Pancreas – CMS calculates the payment amount by calculating the cost of services during the month of the transplant and for the two succeeding months. CMS makes different payments for those who have a kidney transplant and for those who have a pancreas transplant simultaneous with the kidney transplant. However, because the initial data system used for payment will not be able to distinguish individuals with a double transplant in a timely manner, all transplants will initially be paid at the kidney transplant rate. The rarer double transplant will be taken into account in reconciliation. CMS also differentiates payments for months close to the transplant period from those further out.

Functioning Graft Status—A modified version of the CMS-HCC model for people who have functioning kidney grafts, i.e., that 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. The model has an additional term to recognize the extra costs of immunosuppressive drugs and higher intensity of care for this group.

CMS developed this three-part model in response to the findings on expenditure patterns for ESRD beneficiaries. Dialysis patients have high ongoing costs, while transplant patients incur a very high one-time cost. Functioning graft patients are much more similar to the general population than they are to dialysis patients except for the cost of immunosuppressive drugs. Using the same payment weights for all three groups would lead to over- or underpayments to MA organizations.

CMS updated the state ratebook used to make payments for enrollees in dialysis and transplant status. CMS will phase-in the revised State rates by blending payments based on the current ratebook and the ratebook using the dialysis-only trend. Over a 4-year period, CMS will apply the payment blend according to the schedule described below in Table 1M.



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TABLE 1M – NEW ESRD DIALYSIS AND TRANSPLANT PAYMENT TRANSITION

YEAR	CURRENT RATEBOOK PERCENTAGE	REVISED RATEBOOK PERCENTAGE
2008	75%	25%
2009	50%	50%
2010	25%	75%
2011	0	100%

1.3.5.1 Risk Adjustment Model for Dialysis Patients

The dialysis model has the same HCC categories used for the CMS-HCC model. The exception is that the HCCs representing dialysis status and kidney failure are excluded (HCC130 to HCC131). This means that the ESRD model has only 68 HCC categories. The model is calibrated only on dialysis patients, so the disease weights used for payment recognize disease and expenditure patterns are unique to this population.

The data used for calibrating the ESRD models were 2002 (diagnostic) and 2003 (program payment) data on fee-for-service ESRD beneficiaries. For example, expenditures for a fee-for-service beneficiary on dialysis from January through August 2003 who received a transplant in September 2003 are included in the dialysis group for eight months, but then are excluded. From September through November 2003, this beneficiary's costs are included in the transplant data to determine estimated average transplant costs. As of December 2003, this beneficiary is included in the functioning graft model.

1.3.5.2 Transplant Model

To accommodate the high one-time cost of a transplant, CMS will make payments over three months to cover the costs for this transplant and payments for the immediate subsequent services. CMS calibrated the payments by using fee-for-service hospital stay payments for the transplant, and physician and other services rendered for the hospital stay and the two months after discharge. The national average was converted to a relative factor by dividing by the national average payment for dialysis patients. For example, the factor for month 1 is calculated as: \$32,558 (average transplant costs in month 1) divided by \$5,039 (mean monthly dialysis costs, i.e., \$60,471/12). The relative factors for transplant reflect the costs in each month; therefore, the 1st month has a substantially higher factor (6.45) than months 2 and 3 (1.01). The transplant factor is applied to the dialysis state ratebook to provide a transplant payment. Payment will be made in practice by determining the month of transplant and paying the amount over the three-month period starting with the transplant month.

1.3.5.3 Functioning Graft Model

The model for functioning graft enrollees is based on the model for the general population, except that HCCs for kidney transplant status, dialysis status, and renal failure are excluded. For their members with functioning grafts, as for dialysis members, MA organizations will be paid in 2008 based on the diseases reported from all risk adjustment sources in the prior year. However, functioning graft status is recognized in the payment year. In the adapted general population model, almost all of the HCC disease



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coefficients have been held to their general population values. A few HCCs have been removed and extra terms have been added specific to being in functioning graft status.

The values for the add-on terms have been estimated with data specific to this population and recognize the Medicare coverage of immunosuppressive drugs and the added intensity of services required by this population. They are identified as “graft factors” in the functioning graft model. The graft factors include two sets of coefficients. One set is used between the fourth and the end of the ninth month after a transplant and the second set is used for tenth month and all months thereafter. The functioning graft payment automatically begins the month after the third transplant payment unless the ESRD Network reports that the member has returned to dialysis or had to have another transplant. Anytime a functioning graft patient returns to dialysis, payment is made using the dialysis model.

1.3.5.4 Model Comparison of Coefficients (Slide 33)

The ESRD dialysis model has a higher base factor (age/sex) and lower factors associated with diagnoses than does the CMS-HCC model. This is because Medicare costs for ESRD beneficiaries are much higher than they are for the average Medicare beneficiary, but they are relatively uniform. This means that the Medicare costs for ESRD beneficiaries do not vary as much as the Medicare costs for Medicare beneficiaries in general. Hence, diseases do not explain as much of the cost variation among ESRD beneficiaries and therefore, these costs are retained in the age/sex coefficient in the ESRD dialysis model.

1.3.5.5 New Enrollee Factor

The dialysis and functioning graft models have new enrollee factors for enrollees whose risk scores are not available. New enrollees with transplants receive the normal transplant model factors.

1.3.5.6 Reporting of ESRD Status

In implementing the new ESRD risk adjustment method, CMS will utilize the existing systems for identification of enrollees receiving dialysis services. Currently, MA enrollees are assigned ESRD status as a result of a physician certifying their ESRD status on CMS Form 2728, the End-Stage Renal Disease Medical Evidence Report. The ESRD facility sends Form 2728 to the Renal Network, which then transmits the status to CMS systems where various databases are updated to record the ESRD status. Payments for dialysis are triggered by this system.

1.3.6 Medicare Part D

Medicare Part D Drug Benefit. In Title I, in addition to the creation of the MA program in Title II of the MMA, Congress added a voluntary prescription drug benefit to Medicare (known as Part D) to be made available for all Medicare beneficiaries through either the MA program or the prescription drug plans. To that end, MA organizations will be required to provide at least one MA plan that provides a “required drug coverage” in each of its service areas. MA plans that offer drug coverage are called MA prescription drug plans (MA-PDs). Beneficiaries receiving health care benefits through fee-for-service Medicare will have the option of accessing prescription drug coverage through sponsors of prescription drug plans (PDPs). Unlike PDPs which can offer supplemental drug coverage only when they offer a standard package in an area, MA-PDs can offer plans with supplemental coverage that qualify as “required prescription drug coverage.” Similar to the MA program, CMS established regions (34) through which PDP sponsors will offer Part D drug coverage. To the extent practicable, CMS designed the PDP



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regions to overlap with the MA regions. Payments to PDP plans for eligible low-income Medicare beneficiaries will be subsidized at different levels depending upon the income and asset of the enrollee.

The MMA requires organizations intending to offer MA plans with original Medicare Parts A and B benefits and/or Part D benefits to submit bids in early June of each year for their basic, supplemental and/or Part D benefit packages. Each bid must reflect a plan's actual revenue requirements to provide the benefits offered in the proposed benefit packages. Benchmarks will be created for local and/or regional plans for bid-benchmark comparisons. Monthly capitated payments will be made based on each plan's bid risk adjusted for health status minus the beneficiary premium amount. The MMA mandates MA organizations and PDPs to provide basic prescription drug coverage as one of their benefit plans.

1.3.6.1 Part D Risk Adjustment Model (Slides 34-37)

The Part D model is similar to the CMS-HCC risk adjustment model. The model includes 113 coefficients: 84 disease groups, 24 age-sex adjustments, 3 interactions between age and disease, and 2 sex-age-originally disabled status interactions. The model was developed assuming an unlimited drug benefit, and was then adjusted for the plan's liability under the Medicare standard Part D benefit.

CMS announced the final Part D risk adjustment on April 4, 2005. The model is published at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

The Part D risk adjustment model shares most of the characteristics of the CMS-HCC model. That is, the model is: prospective, additive, hierarchical, and contains demographic new enrollee model.

The key differences are:

- The Part D model is designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than Medicare Part A/B costs.
- Different diseases predict drug costs than Part A/B costs.
- Incremental costs of low-income (LI) and long term institutional (LTI) beneficiaries are multipliers to the base RxHCC model score.

As in the CMS-HCC model, some of the disease groups fall into hierarchies. Drug regimens may intensify and more drugs added in cases where a disease has a higher severity. In such an instance, the highest cost category of the related diseases is triggered and the lower cost category does not increase the Part D risk score.

Like the CMS-HCC model, the Part D model uses the presence of particular demographic characteristics and diagnoses to predict costs in the following year for an individual. The model clusters a set of ICD-9-CM diagnoses within groups that are similar clinically and in terms of their expected costs. The groupings used to predict drug spending are variants of the groups used to predict Part A and B spending, and the data sources for diagnoses are the same as those used in Part C. Disease groups and draft coefficients for the Part D risk adjustment can be found on the CMS web site at:

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp



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In development of the model, drug spending in dollars is used as the dependent variable of a regression model that estimates the marginal or incremental spending related to each of the explanatory variables (demographics and conditions) in the model. The model is ultimately expressed not in dollars, but as relative factors. The incremental dollars associated with each variable in the model are divided by the mean predicted dollars to produce a "relative costliness" or risk factor. Summing the risk factors for an individual yields a total risk adjustment factor that, when multiplied by a base rate, yields an individualized capitation rate.

Recent research has found that the variation in drug expenditures that can be explained is primarily driven by chronic conditions persisting from year to year. The research suggests many of the diagnoses used by CMS for the CMS-HCC model could be used in the Part D risk adjustment model in addition to new diagnosis codes collected. For example, the findings indicated that certain chronic conditions such as congestive heart failure and schizophrenia (CMS-HCC model diagnoses) are good predictors of drug expenditures. However, this research also shows that hypertension and glaucoma, not currently in the model, are also key predictors of drug expenditures. Hence, such findings lead to the conclusion that additional diagnoses, beyond those in the current CMS-HCC model, need to be collected to properly develop a drug risk adjustment model. It is equally true that some conditions currently included in the CMS-HCC model are predictive of Medicare Part A and B medical costs, but not predictive of Part D costs. As such, these diseases could decrease drug expenditures.

Using a similar methodology to that used for the development of the CMS-HCC risk adjustment model, CMS created a list of diagnoses for the drug risk adjuster and, in April 2005, announced the final list of conditions for inclusion in the drug risk adjustment model. Some of the diagnoses overlap with the current CMS-HCC model and others do not. In particular, there are 1,540 ICD-9 codes unique to the CMS-HCC model, 1,940 ICD-9 codes unique to the Part D risk adjustment model, and 1,622 ICD-9 codes included in both models. Collection of the diagnoses for the CMS drug risk adjustment model from current MA organizations began in July 2004 and will begin payment in January 2006.

Beneficiaries with less than 12 months of Part B enrollment prior to the payment year and who do not have a complete diagnostic record in the Medicare files will be classified as new enrollees. These individuals will receive the new enrollee factor for the RxHCC model.

1.3.6.2 Low Income and Long Term Institutionalization Multipliers (Slides 36-37)

Base Part D risk factors are incremented by either a LI or a LTI multiplier to account for the additional costs of beneficiaries in these categories. See Table 1N for the definition of LI multipliers for the Part D benefit.



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TABLE 1N – DEFINITION OF THE LOW INCOME MULTIPLIERS FOR PART D BENEFIT

	GROUP 1	GROUP 1	GROUP 2	GROUP 2
Income test	Medicaid Dual <100% FPL	<135% FPL	<135% FPL	135-150% FPL
Asset test	<2× SSI	<3× SSI	>3× SSI & <\$10,000 single \$20,000 couple	<\$10,000 single \$20,000 couple
Deductible	\$0	\$0	\$50	\$50
Copay for generic drugs up to catastrophic threshold	\$1	\$2	—	—
Copay for brand-name drugs up to catastrophic threshold	\$3	\$5	—	—
Coinsurance up to catastrophic threshold	—	—	15%	15%
Coinsurance above catastrophic threshold	0%	0%	0%	0%
Copay for generic drugs above catastrophic threshold	\$0	\$0	\$2	\$2
Copay for brand-name drugs above catastrophic threshold	\$0	\$0	\$5	\$5
Premium subsidy	100%	100%	100%	Sliding scale

The LI multiplier is estimated to be 1.08 for Group 1 LI individuals (as defined above) and 1.05 for Group 2 individuals (as defined above). This multiplier is defined on a concurrent basis. (For example, if an individual were not defined as LI for January 2007 but was determined to be a Group 1 beneficiary for February 2007, the plan would receive the LI multiplier for February (and beyond) but not for January.)

An enhancement was also computed for the predicted spending by persons institutionalized in nursing facilities for more than 90 days. Spending for this group is expected to be higher because prices for the specific packages of drugs they receive are somewhat higher than the same drugs in the community. (An analysis of drug data done by IMS Health shows that the price differences in the claims were small, particularly for brand name drugs that dominate the spending.) There are also effects related to compliance in acquiring and taking drugs in the institutional environment. On the other side, often patients take fewer drugs because of more careful monitoring of interactions.

An analysis was done for the spending by the institutionalized by first using the base model to predict for this population and then comparing the actual spending and liability to the predicted. For the case of spending, there was a significant positive effect for the aged and the disabled who are in institutions. The effect for the disabled is greater than for the aged. It was also observed that average spending for both groups was in the 100 percent coinsurance range. The disabled mean was quite close to the catastrophic limit. The implications of additional demand being, to a large extent, in the range in which plans do not have incremental liability means that the effect on plan liability is much smaller than the effect on spending. The final payment adjustments for the institutionalized are smaller for the aged than for the



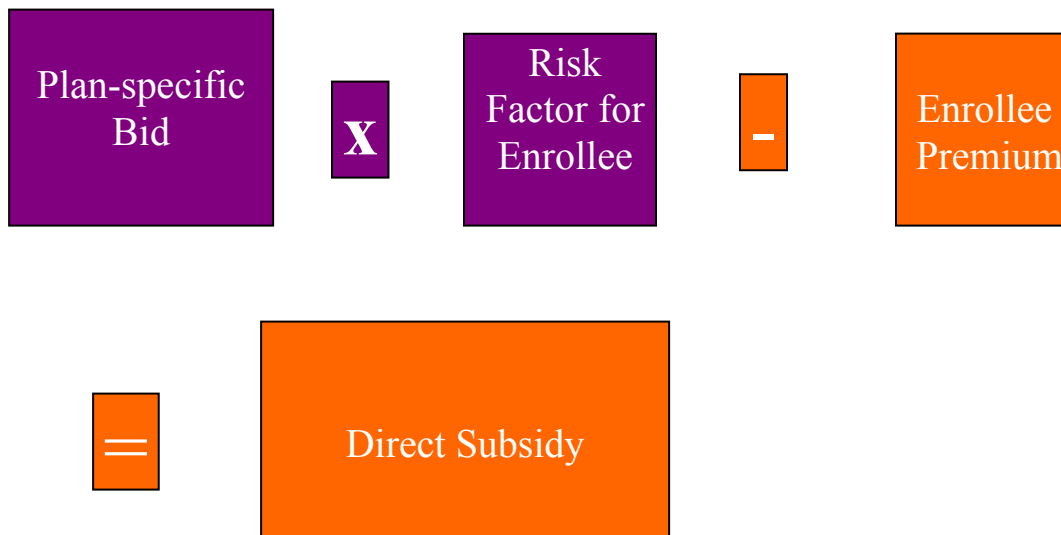
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RISK ADJUSTMENT METHODOLOGY

disabled and smaller perhaps than some people expect because the final measure is plan liability rather than spending.

Figure 1C illustrates the calculation of the Part D Direct Subsidy.

Figure 1C – Calculation of Part D Direct Subsidy



1.4 Parts C and D Final Submission of Risk Adjustment Data (Reconciliation)

Reconciliation is used to complete the implementation of payments, with CMS calculating final risk adjustment factors and beneficiary status based on complete data. CMS continues to allow a period (approximately 13 months after the data collection year) for submitting final RAPS data for the appropriate data collection period. Data not received or submitted by the initial submission deadline for a data collection period can be submitted by the final submission deadline (reconciliation). In addition to incorporating new RAPS and fee-for-service diagnoses, reconciliation takes into account necessary adjustments to institutional status and demographic data for enrollees.

Note: CMS reconciles risk-adjusted payments for a calendar year only one time. When submitting risk adjustment data for reconciliation, plans may submit as well as correct data that was previously submitted.

1.4.1 Parts C and D Risk Adjustment Schedule & Elimination of the Payment Lag

Risk adjusted payments were originally implemented with a 6-month payment lag from the end of the collection period to the start of revised payments, based on the data collected.



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RISK ADJUSTMENT METHODOLOGY



Example: 6

Data Collection Period: July 1, 2006 through June 30, 2007

Data Collection End Date: June 30, 2007

CY2007: First payment made based on this collection period = January 1, 2008

As you can see, payments began 6 months after the end of the data collection period.

Note: The purpose of eliminating the lag between the end of the data collection period and the payment based on that year's data is to use the most recent data for more accurate payment.

Data Collection Period: January 1, 2007 through December 31, 2007

Data Collection End Date: December 31, 2007

CY2007: Updated payment made based on the non-lagged data collection period = July, 2008

- CMS calculates a preliminary risk factor based on lagged data. For 2008, it will be based on data from July 2006 through June 2007. Payments from January 2008 through June 2008 will be based on this factor.
- In July 2008 CMS will use a risk factor based on non-lagged data (i.e., from calendar year 2007) for calculating payments. That factor will be used for the remainder of the year.
- By eliminating the lag, the collection period will change from July 1 through June 30 to January 1 through December 31 (or a calendar year).

1.5 Updating Diagnosis Codes in the Parts C and D Risk Adjustment Models

CMS updates the risk adjustment models to reflect the annual updates to the ICD-9 diagnostic code set. After clinical review, new ICD-9 diagnosis codes are added to the appropriate diagnostic categories and included in the CMS-HCC model. A comprehensive listing of the ICD-9 codes that MA organizations are required to submit for all risk adjustment models can be found at

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. This list will be updated annually to take into account new codes that are required for risk adjustment.



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

MODULE 2 – RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

Purpose

The success of Medicare Advantage (MA) risk adjustment is dependent upon organizations understanding the process of collecting and submitting accurate risk adjustment data. The purpose of this module is to provide participants with important terms, key resources, and schedule information that will provide the foundation for this training.

Learning Objectives

At the completion of this module, participants will be able to:

- Define common risk adjustment terminology.
- Demonstrate knowledge in interpreting key components of the risk adjustment process.
- Interpret the risk adjustment schedule.
- Identify the Centers for Medicare & Medicaid Services (CMS) outreach efforts available to organizations.

ICON KEY	
Example	
Reminder	
Resource	

2.1 Common Risk Adjustment Terms (Slide 7)

Table 2A provides descriptions of common risk adjustment terminology.

TABLE 2A – RISK ADJUSTMENT COMMON TERMS

TERM	DESCRIPTION
FERAS	Risk adjustment submitters send data to Palmetto through the Front-End Risk Adjustment System .
RAPS	Risk adjustment data are processed by the Risk Adjustment Processing System .
RAS	The Risk Adjustment System calculates the risk score.
MARx	The Medicare Advantage Prescription Drug System calculates the risk payment.
Common UI	The Common UI maintains Medicare beneficiary eligibility data.
HPMS	The Health Plan Management System is a CMS MA information system that contains health plan-level data.
Required Diagnosis	ICD-9-CM diagnosis codes required to be submitted for the CMS-Hierarchical Condition Category (HCC) model and for future model development.



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.2 Risk Adjustment Process Overview

Hospital inpatient, hospital outpatient, and physician risk adjustment data must be submitted at least quarterly. Risk adjustment data are processed through RAPS.

2.2.1 Risk Adjustment Data Requirements (Slide 8)

- The data required under the risk adjustment process include:
 - Health Insurance Claim (HIC) number.
 - Diagnosis code.
 - Service from date.
 - Service through date.
 - Provider type (hospital inpatient, hospital outpatient, physician).
- 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.
- All beneficiary ICD-9-CM diagnosis codes required for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period.

2.2.2 Risk Adjustment Data Collection (Slide 9)

- MA organizations may choose to collect data from providers in a variety of formats:
 - Standard fee-for-service claim or encounter formats
 - Uniform Billing Form (UB-04)
 - HCFA 1500
 - National Standard Format (NSF) v3.01
 - American National Standards Institute (ANSI) X12 837 v30.51 or v40.10. Health Insurance Portability and Accountability Act (HIPAA) mandated transactions must use v40.10.
 - Superbill
 - RAPS format
 - HIC number
 - Provider type
 - Diagnosis code
 - Service from date
 - Service through date



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.2.3 Risk Adjustment Data Submission (Slide 10)

- MA organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing the following formats:
 - RAPS format (all types of data)
 - Direct Data Entry Screen (all types of data)

Figure 2A illustrates the risk adjustment dataflow.



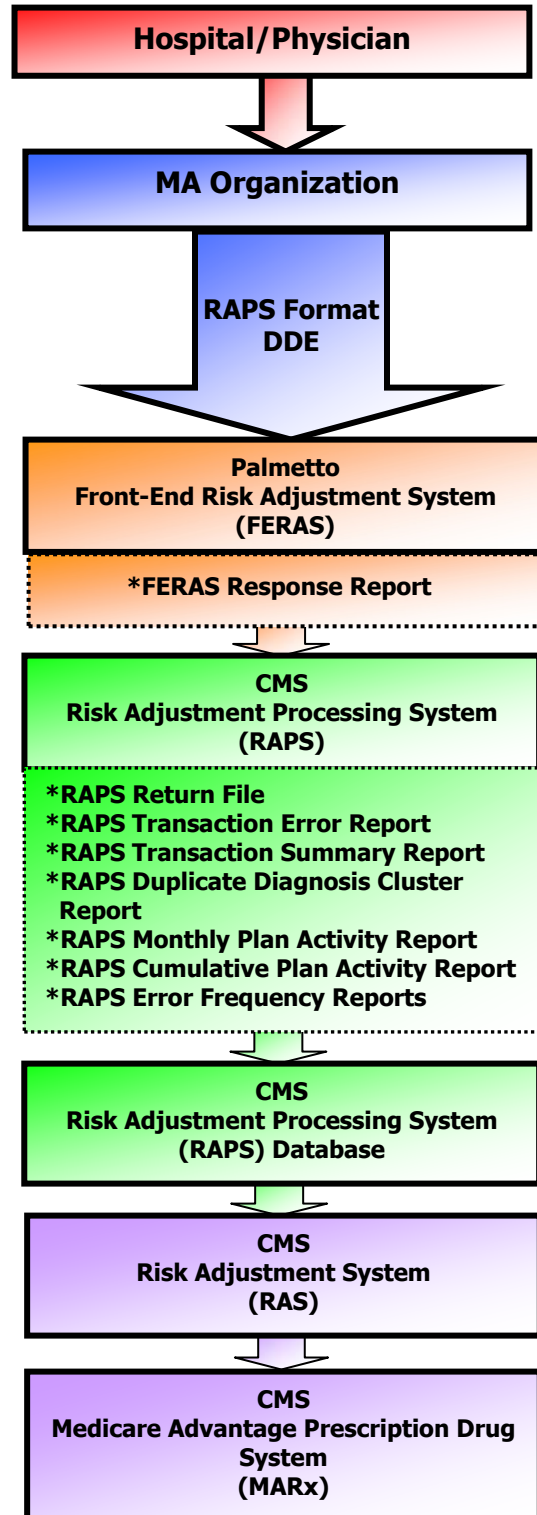
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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.2.4 Risk Adjustment Dataflow (Slide 11)

- Hospital/physician submits data to MA organization via:
 - Full or abbreviated UB-04, HCFA 1500, NSF v3.01, ANSI x837 v30.51 or v40.10, Superbill or RAPS format.
- The MA organization submits these data at least quarterly to Palmetto GBA.
- The MA organization submits the data via Direct Data Entry or in the RAPS format.
- The data are sent to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
- If any data are rejected, then data are reported on the FERAS Response Report.
- After passing the FERAS checks, the file is submitted to RAPS where detail editing is performed.
- The RAPS Return File is returned daily and shows all records approved and where errors occurred.
- The RAPS Transaction Error Report displays records on which errors occurred.
- The RAPS Transaction Summary Report is sent to the MA organization daily and identifies data that have been finalized in RAPS database.
- The Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report provides a summary of all diagnoses stored for a given time period.
- Distributed monthly and quarterly, the Error Frequency Report provides an overview of all errors associated with files submitted in test and production.
- 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. MARx replaced Medicare Managed Care System (MMCS) on November 15, 2005.

Figure 2A – Risk Adjustment Dataflow



* These reports/ files are returned to the MA organization



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.2.5 Important Information About Risk Adjustment Processing

- MA organizations transmit data to FERAS at Palmetto GBA.
- FERAS performs format and face validity checks on the file- and batch- level as well as formatting verification on the first and last detail record (CCC) in the file.
- If the data fail the front-end checks, the complete file is rejected at the front end.
- The FERAS Response Report identifies whether the file is accepted or rejected up front.
- Once the file has passed front-end checks, it moves to RAPS. All validity edits on detail-level data are performed in this system.
- Processing time from beginning to end should take approximately 1 to 2 days.
- After the file has processed through RAPS, the MA organization will receive a RAPS Return File and RAPS Transaction Error Report identifying any errors.
- All ICD-9-CM diagnoses that pass validity edits are stored in the RAPS database.
- The MA organization will also receive a RAPS Transaction Summary Report reflecting all finalized data sent to the RAPS database along with all rejected data.
- The MA organization also receives two monthly risk adjustment management reports: 1) the RAPS Monthly Plan Activity Report and 2) the RAPS Cumulative Plan Activity Report.
- All data are converted to the RAPS format and returned in the RAPS Return File.
- Interim bills (112 and 113 bill types) are not accepted. If a MA organization receives interim bills, do not submit the hospital inpatient diagnoses on receipt of the final bill (114 bill type).



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.3 Submission Schedule (Slide 12)

The elimination of the payment lag changes the submission schedule. This requires MA organizations to meet three submission deadlines—the first Friday in September, the first Friday in March of each year, and a reconciliation (final submission) deadline of January 31. The schedule is illustrated in Table 2B.

TABLE 2B – SUBMISSION TIMETABLE

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	NA
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	NA
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



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RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

2.4 Training and Support (Slide 13)

To ensure that participating organizations have the necessary tools and information to be successful with the risk adjustment process, CMS has planned the following outreach efforts, as described in Table 2C.

TABLE 2C – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday, 9:00 a.m. to 7:00 p.m. Eastern Time (ET) (with the exception of corporate observed holidays) to provide assistance. The support center provides ongoing assistance. The FERAS system is available to submit risk adjustment data 24 hours a day, 7 days a week regardless of holidays. The only exception is from 5:00 PM EST - 10:00 PM EST on Sunday when systems and equipment undergo routine maintenance.
<u>www.csscooperations.com</u>	The CSSC website, www.csscooperations.com is the gateway to RAPS. Visitors to the site can access information about RAPS/FERAS, including opportunities to register for service, enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. Monthly User Group and other training information are regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions (FAQs) about risk adjustment. To register for email updates, go to www.csscooperations.com, click on Risk Adjustment Processing System (RAPS), and then click on “Register for Medicare Advantage”. Afterwards, click on “new registrations only” and complete the registration form.
User Groups	Conducted once each month from 1:30 – 2:30 p.m. ET. The purpose of the User Group meeting is to share information among participants, distribute new information, and identify issues for future resolution. Meeting notes and Q&As are provided. To register online for User Groups, go to ugregistration@tarasc.info.
Onsite Consultation	On-site consultation visits provide MA organizations with the opportunity to gain valuable information about risk adjustment data submission and data validation processes. These consultations generally occur between April and May. Each visit includes a review of the MA organization’s system.
<u>www.tarasc.info</u>	The website, www.tarasc.info is the website for risk adjustment training and User Group information. The website includes information about trainings and user groups, training dates, locations, online registration, and training FAQs.



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DATA COLLECTION

MODULE 3 – DATA COLLECTION

Purpose (Slide 2)

For the purpose of risk adjustment, Medicare Advantage (MA) organizations must collect data from hospital inpatient facilities, hospital outpatient facilities, and physicians. The collection of data from the appropriate risk adjustment sources and formats is critical for accurate risk adjusted payment. This module is designed to offer participants an opportunity to apply data collection principles in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify the data elements required for risk adjustment.
- List the three sources of risk adjustment data.
- Describe the data collection formats.
- Discuss factors to consider when determining the method for collection of diagnostic data.
- Apply Health Insurance Portability and Accountability Act (HIPAA) transaction standards for purposes of risk adjustment data collection.

ICON KEY	
Example	
Reminder	
Resource	

3.1 Required Risk Adjustment Data Elements (Slide 5)

MA organizations must collect certain data elements from the sources (providers/physicians) of risk adjustment data described in this module. The minimum data elements that must be collected are:

- Health Insurance Claim (HIC) Number
- ICD-9-CM Diagnosis Codes
- Service From Date
- Service Through Date
- Provider Type

3.1.1 HIC Number (Slides 6-7)

A HIC number is a Medicare beneficiary's identification number. Both CMS and the Railroad Retirement Board (RRB) issue Medicare HIC numbers. The format of a HIC number issued by CMS is a Social Security number followed by an alpha or alphanumeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers preceded by an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 3A shows the characteristics for each HIC type.



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TABLE 3A – STRUCTURE OF HIC NUMBERS

HIC TYPE	CHARACTERISTICS
CMS	9-Digit Social Security number - alpha suffix "A" beneficiary "B" spouse "C" children "D" divorced spouse, widow, widower - alpha-numeric suffix - indicates number of children (e.g., "C1" first child)
RRB pre-1964	- alpha prefix 6-digit random numbers
RRB post-1964	- alpha prefix 9-digit Social Security number

Note: MA organizations are not required to collect HIC numbers from physicians and providers, but must identify beneficiaries using the HIC number when submitting data to CMS.

3.1.2 ICD-9-CM Diagnosis Code (Slide 8)

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. ICD-9-CM 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.

3.1.2.1 Description of Diagnosis Code Files

Current model diagnoses.xls:

Comprehensive list of all risk adjustment model diagnoses used for risk adjustment payments in 2004-2009.

Specifically, the file:

- Contains all diagnoses used in the CMS-HCC models and the RxHCC (prescription Drug Risk Adjustment Model)
- Indicates whether or not the diagnosis code is used for payment for 2004-2009.
- Includes the associated condition category for the RxHCC model and/or the CMS-HCC model, and
- Indicates the diagnosis code effective date.

Please see

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage and click on "Risk model diagnosis codes" for more information about model diagnosis codes.



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Future model diagnoses.xls:

Comprehensive list of all additional model diagnoses that plans are required to collect and submit. These diagnoses, while not used for payment, are needed so that CMS can conduct analyses of future models that may include these diagnoses. Please note that these codes are sometimes referred to as "Non-model" diagnosis codes. Please see http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage and click on "Future model diagnoses" for more information regarding future model diagnoses codes.

3.1.3 Service From and Through Dates (Slide 9)

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 different from each other, and reflect the dates of admission to and discharge from a facility.



Date span is the number of days between the From Date and Through Date for a reported diagnosis. For risk adjustment, the date span is important to determine if the reported diagnosis cluster falls within the data reporting period.

3.1.4 Provider Type (Slide 10)

For the purpose of risk adjustment, MA organizations must collect data from the following provider types:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians

These are the three principal sources of data. MA organizations are responsible for determining provider type based on the source of the data.

3.2 Data Sources

MA organizations are responsible for ensuring that the data they collect comes from acceptable sources. These sources are hospital inpatient facilities, hospital outpatient facilities, and physicians.

3.2.1 Hospital Inpatient (Slide 11)

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.

Inpatient hospital data should be differentiated based on whether it is received from within or outside of the MA organization's provider network. Effective May 1, 2007, a network hospital should have a National Provider Identifier (NPI) number as a hospital inpatient facility. Table 3B identifies covered and non-covered facilities with regard to risk adjustment data collection.



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TABLE 3B – HOSPITAL INPATIENT

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.



When submitting hospital inpatient data, MA organizations must make a distinction between the principal diagnosis and other diagnoses. The Data Submission Module covers the details of submitting data.

3.2.2 Hospital Outpatient (Slide 12)

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

Data must be collected from hospital outpatient departments. As with hospital inpatient facilities, the MA organization must determine which facility is Medicare certified, network, or non-network. Table 3C identifies covered and non-covered hospital outpatient facilities.



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TABLE 3C – HOSPITAL OUTPATIENT

PROVIDER TYPE	COVERED FACILITIES	NON-COVERED FACILITIES*
Hospital Outpatient	- 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**	- Free-standing Ambulatory Surgical Centers (ASCs) - Home Health Care - Free-standing Renal Dialysis Facilities
	NON-COVERED SERVICES	
	- Laboratory Services - Ambulance - Durable Medical Equipment - Prosthetics	- Orthotics - Supplies - Radiology Services

* 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.

It is important for MA organizations to note that regardless of the type of diagnostic radiology bill (outpatient department or physician component), the 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 therefore not assigned in the medical record documentation from diagnostic radiology services alone.

3.2.2.1 Determining Whether Facilities Are Acceptable for Risk Adjustment (Slide 13)

MA organizations are responsible for ensuring data collected and submitted are acceptable for the risk adjustment process. In the past, the provider number has been used to assist in this. However, CMS is in the process of implementing a new provider identifier, the National Provider Identification (NPI) number.



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As will be discussed below, the CMS will continue to allow the use of the legacy provider number along with the new NPI for a transition time. However, the NPI does not have intelligence, so a new code called the "taxonomy code" was developed 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 3D illustrates the steps MA organizations may use to identify the provider numbers or taxonomy codes for facilities.

TABLE 3D – DETERMINING COVERED HOSPITAL ENTITY PROVIDER NUMBERS

SITUATION	ISSUE	ACTION
Situation 1	The provider number 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 the provider number or taxonomy code.	Obtain the provider number or taxonomy code and 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 certified Medicare 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.	Try to obtain a provider number or taxonomy code, if possible. If not available, check the list of Veterans Administration and Department of Defense (VA/DoD) listings published on csscooperations.com . If the provider is listed there, submit the data. If the provider is not on the VA/DoD list, the organization may need to contact CMS to determine if the provider is acceptable for risk adjustment. NOTE: All network providers are required to have certified Medicare provider numbers or taxonomy codes; therefore, do not submit risk adjustment data for this provider until these numbers are obtained.

3.2.2.2 National Provider Identifier

CMS has recently issued contingency guidance for National Provider Identifier implementation. This contingency guidance provides that, for a period of 12 months after the NPI Rule compliance date of May 23, 2007, CMS will not impose civil money penalties on covered entities that deploy contingency plans, including (in order to ensure the smooth flow of payments) continuing to use and accept legacy identifiers on HIPAA transactions, if they have made reasonable and diligent efforts to become compliant



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and, in the case of health plans (that are not small health plans), in order to facilitate the compliance of their trading partners.

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; and in the interim 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 legacy Medicare provider numbers or the taxonomy code to determine if facilities and services are acceptable for risk adjustment.

MA organizations 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 provider number, please note that it has six characters. The first two characters are numerals and represent the state/territory as illustrated in Table 3E.

TABLE 3E – 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		



States and territories are included in the list of Medicare provider numbers.

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



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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 in non-covered entity such as a swing bed component of a hospital or a skilled nursing facility.

As an additional check, refer to Tables 3F and 3G, which provide the only acceptable ranges for hospital facilities. The tables reflect the range of provider numbers for risk adjustment covered hospital entities. Risk Adjustment data are not acceptable when received from facilities with numbers outside the ranges.



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

TABLE 3F – 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 3G – 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
Rural Health Clinics, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999	TOB 71X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X



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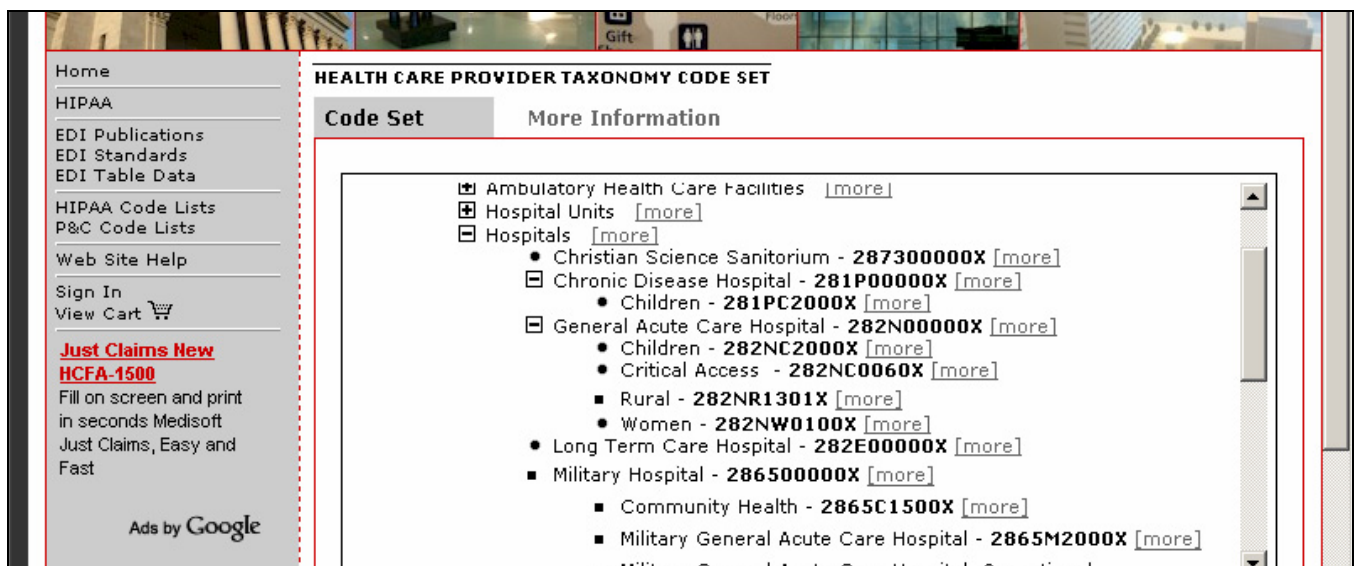
The implementation of the NPI did not change the valid Hospital Inpatient and Outpatient facilities for submission of risk adjustment data nor eliminate the process for receiving and verifying information from Medicare health care providers that are in network. Institutional providers that currently 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 following web site serves as a reference to types of facilities and taxonomy codes.

<http://www.wpc-edi.com/codes/taxonomy>

Figure 3A is a screen shot of the wpc-edi.com website which serves as a reference tool to determine types of facilities and taxonomy codes.

Figure 3A – WPC-EDE.COM



The following website serves as a reference for hospital provider numbers:

<http://www.ahd.com/freesearch.php3>

Figure 3B is a screenshot of the search page on the American Hospital Directory website. This web-based search database allows MA organizations the opportunity to access Medicare provider number by entering key words, city, state, zip code, or area code. When using the search tool, users need to be aware of the following:

- The most effective search option is to select the state where the provider is located.
- When entering the hospital name, users should be aware that the official name of the hospital may be different than what is included in the database.
- Avoid entering abbreviations.



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Figure 3B – American Hospital Directory



See Resource Guide for more information about Medicare provider numbers.

3.2.3 Physician Data (Slide 14)

The collection of physician data for risk adjustment is associated with the physician's specialty. That is, all ICD-9-CM diagnoses that are required for the risk adjustment models and rendered as a result of a physician face-to-face visit must be collected by the MA organization. This includes data collected from non-network as well as network physicians.

Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment.



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TABLE 3H – ACCEPTABLE PHYSICIAN SPECIALTIES

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
01	General Practice	29	Pulmonary Disease	70*	Multispecialty Clinic or Group Practice
02	General Surgery	33*	Thoracic Surgery	72*	Pain Management
03	Allergy/Immunology	34	Urology	76*	Peripheral Vascular Disease
04	Otolaryngology	35	Chiropractic	77	Vascular Surgery
05	Anesthesiology	36	Nuclear Medicine	78	Cardiac Surgery
06	Cardiology	37	Pediatric Medicine	79	Addiction Medicine
07	Dermatology	38	Geriatric Medicine	80	Licensed Clinical Social Worker
08	Family Practice	39	Nephrology	81	Critical Care (Intensivists)
10*	Gastroenterology	40	Hand Surgery	82	Hematology
11	Internal Medicine	41	Optometry (specifically means optometrist)	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	42	Certified Nurse Midwife	84	Preventive Medicine
13	Neurology	43	Certified Registered Nurse Anesthetist	85	Maxillofacial Surgery
14	Neurosurgery	44	Infectious Disease	86	Neuropsychiatry
16*	Obstetrics/Gynecology	46*	Endocrinology	89*	Certified Clinical Nurse Specialist
18*	Ophthalmology	48*	Podiatry	90	Medical Oncology
19	Oral Surgery (Dentists only)	50*	Nurse Practitioner	91	Surgical Oncology
20	Orthopedic Surgery	62*	Psychologist	92	Radiation Oncology
22*	Pathology	64*	Audiologist	93	Emergency Medicine
24*	Plastic and Reconstructive Surgery	65	Physical Therapist	94	Interventional Radiology
25	Physical Medicine and Rehabilitation	66	Rheumatology	97*	Physician Assistant
26	Psychiatry	67	Occupational Therapist	98	Gynecologist/Oncologist
28*	Colorectal Surgery	68	Clinical Psychologist	99	Unknown Physician Specialty

* Indicates that a number has been skipped.



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



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3.2.4 Alternative Data Sources

Alternative data sources (ADS) include diagnostic data from sources other than hospital inpatient, hospital outpatient, and physician services. MA organizations may use ADS as a **check** to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes, such as pharmacy records and information provided to national or state cancer registries. The MA organization may not, however, use ADS as substitutes for documenting diagnoses from a hospital/physician. As in all diagnoses submitted, there must be medical record documentation to support the diagnosis as having been documented as a result of a hospital inpatient stay, a hospital outpatient visit, or a physician face-to-face visit during the data collection period.

For example, a prescription for an ACE inhibitor, alone, is not considered sufficient for the sole data source of “clinical evidence” of congestive heart failure (CHF); instead, the medical record needs to document an appropriate clinician’s diagnosis of CHF during the data collection period (e.g., where an “appropriate clinician” is a physician/nurse practitioner/physician assistant). A laboratory test showing one reading of high blood sugar is not considered sufficient “clinical evidence” of diabetes—the medical record needs to document a clinician’s diagnosis of diabetes during the data collection period.

3.2.5 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. 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.html>.

3.3 Data Collection Formats and Considerations

There are several formats that MA organizations can accept when collecting data from medical providers. Table 3I lists the formats by provider type.

3.3.1 Data Collection Formats (Slide 16)

For facility services, the standard billing format is UB-04 (Uniform Billing Form–2004 version). The HCFA 1500 form is the standard format for physician services.

TABLE 3I – DATA COLLECTION FORMATS

HOSPITAL INPATIENT/HOSPITAL OUTPATIENT	• UB-04 • ANSI X12 837 4010 • RAPS Format
PHYSICIAN	• HCFA 1500 • NSF 3.01 • ANSI X12 837 4010 • RAPS Format • Superbill



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3.3.2 Collection Format Features

MA organizations need to carefully consider decisions regarding data collection tools, as they may impact the volume and accuracy of data received from physicians and providers. When examining the data collection options, the organization's management should consider the features of each of the approved data collection tools. Table 3J describes key features of each data collection tools.

TABLE 3J – COLLECTION FORMAT FEATURES

FORMAT	FEATURE					
	PHYSICIAN SERVICES	HOSPITAL INPATIENT/ OUTPATIENT SERVICES	MINIMUM DATA SET	FULL CLAIMS DATA	PAPER FORMAT	ELECTRONIC
HCFA 1500*	•			•	•	
UB-04*		•		•	•	
NSF*	•			•	•	•
ANSI X12 837	•	•		•		•
Superbill	•		•		•	
RAPS Format	•	•	•			•

*These data collection formats are not HIPAA compliant transactions. However, if your plan is HIPAA compliant and your trading partners are not HIPAA compliant, CMS is allowing receipt of non-HIPAA formats until such time as your trading partners are prepared to submit the HIPAA transaction sets.

The data collection options provided by CMS offer the MA organization the ability to determine which format works best for each of the plan's providers. A variety of collection formats may be used for different providers. If an organization plans to use multiple collection formats, consideration should be given to the complexity and costs associated with supporting these formats (e.g., systems, processes, staffing, etc.).

3.3.3 Collecting Data from Physicians Using a Superbill

The superbill is a data collection option for risk adjustment. The superbill is a common physician office claim form that lists standard ICD-9-CM codes, CPT (Current Procedural Terminology) codes, and beneficiary information. Typically, physicians use the superbill to record clinical information with the appropriate codes to aid in preparing claims or encounter data for submission. MA organizations may develop superbills for use by their capitated physicians for capturing diagnostic information for risk adjustment.



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If the MA organization currently utilizes a superbill that works well for its data collection needs, then it is not necessary to create a new format for risk adjustment data collection. Additionally, if a physician group has a superbill that will capture all relevant risk adjustment diagnoses, it is not necessary for the MA organization to replace that superbill with one that is specific to risk adjustment requirements.



Examples

Examples of Superbills

Two examples of superbills are provided in Figures 3C and 3D. The first example is a typical fee-for-service superbill for an internist. This superbill contains both ICD-9-CM diagnosis codes and CPT procedure codes. For illustrative purposes, the required risk adjustment diagnoses have been bolded.

The second example illustrates what the same superbill might look like if used specifically for collection of risk adjustment data. The ICD-9-CM code list provided by CMS is used to develop the list of common internist ICD-9-CM diagnoses codes on the superbill. These are codes that are relevant diagnoses for the risk adjustment model, related conditions that are not specific to risk adjustment, as well as other common internists' diagnoses. A space was left for the internist to enter diagnoses that are not on the list. Note that there are no CPT procedure codes on the superbill because they are not required for risk adjustment.



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FIGURE 3C – SAMPLE FEE-FOR-SERVICE SUPERBILL

JOHN E. DOE, M.D. <i>Internal Medicine</i> <i>Board Certified</i> 123 Main Street Anytown, UL 99999 Office (555) 555-5555 Billing (555) 555-5550 TAX I.D. #12345678		PATIENT NAME		INSURANCE			
		OFFICE 847	PATIENT NUMBER	ADMIT DATE	DIAGNOSIS		
		DR#	ACCIDENT TYPE ☐ Work Comp ☐ Auto ☐ Other	DATE OF ACCIDENT ____/____/____		1)	2)

OFFICE SERVICE <table style="width: 100%;"> <tr> <th></th> <th>New</th> <th>Mod</th> <th>Fee</th> <th>DX</th> <th>Est.</th> <th>Mod</th> <th>Fee</th> <th>DX</th> </tr> <tr> <td>Level 1</td> <td>99201</td> <td>48</td> <td></td> <td></td> <td>99211</td> <td>27</td> <td></td> <td></td> </tr> <tr> <td>Level 2</td> <td>99202</td> <td>82</td> <td></td> <td></td> <td>99212</td> <td>48</td> <td></td> <td></td> </tr> <tr> <td>Level 3</td> <td>99203</td> <td>121</td> <td></td> <td></td> <td>99213</td> <td>67</td> <td></td> <td></td> </tr> <tr> <td>Level 4</td> <td>99204</td> <td>176</td> <td></td> <td></td> <td>99214</td> <td>105</td> <td></td> <td></td> </tr> <tr> <td>Level 5</td> <td>99205</td> <td>222</td> <td></td> <td></td> <td>99215</td> <td>155</td> <td></td> <td></td> </tr> </table> PHYSICALS <table style="width: 100%;"> <tr> <th></th> <th>New</th> <th>Mod</th> <th>Fee</th> <th>DX</th> <th>Est.</th> <th>Mod</th> <th>Fee</th> <th>DX</th> </tr> <tr> <td>2-17yrs</td> <td>99354</td> <td>168</td> <td></td> <td></td> <td>99394</td> <td>133</td> <td></td> <td></td> </tr> <tr> <td>18-39yrs</td> <td>99385</td> <td>182</td> <td></td> <td></td> <td>99385</td> <td>140</td> <td></td> <td></td> </tr> <tr> <td>40-64yrs</td> <td>99386</td> <td>189</td> <td></td> <td></td> <td>99396</td> <td>147</td> <td></td> <td></td> </tr> <tr> <td>>65yrs</td> <td>99387</td> <td>203</td> <td></td> <td></td> <td>99397</td> <td>154</td> <td></td> <td></td> </tr> </table> INITIAL HOSPITAL CARE <table style="width: 100%;"> <tr> <td>Level 1</td> <td>99221</td> <td>95</td> <td></td> </tr> <tr> <td>Level 2</td> <td>99222</td> <td>156</td> <td></td> </tr> <tr> <td>Level 3</td> <td>99223</td> <td>213</td> <td></td> </tr> </table> DAILY HOSPITAL CARE <table style="width: 100%;"> <tr> <td>Level 1</td> <td>98231</td> <td></td> </tr> <tr> <td>From _____ To _____ @ \$55</td> <td>99232</td> <td></td> </tr> <tr> <td>Level 2</td> <td>99232</td> <td></td> </tr> <tr> <td>From _____ To _____ @ \$87</td> <td>99233</td> <td></td> </tr> <tr> <td>Level 3</td> <td>99233</td> <td></td> </tr> <tr> <td>From _____ To _____ @ \$145</td> <td>99234</td> <td></td> </tr> <tr> <td>Discharge</td> <td>98238</td> <td>92</td> </tr> <tr> <td>Discharge-over 30 min</td> <td>99239</td> <td>172</td> </tr> </table> GOING HOME CARE <table style="width: 100%;"> <tr> <td>Partial Detailed</td> <td>99302</td> <td>13</td> </tr> <tr> <td>Partial Comprehensive</td> <td>99303</td> <td>6</td> </tr> <tr> <td>Follow Up Level 1</td> <td>99311</td> <td></td> </tr> <tr> <td>Follow Up Level 2</td> <td>99312</td> <td>71</td> </tr> <tr> <td>Follow Up Level 3</td> <td>99313</td> <td>99</td> </tr> <tr> <td>Discharge-30 minutes or less</td> <td>99315</td> <td></td> </tr> <tr> <td>Discharge-over 30 minutes</td> <td>99316</td> <td></td> </tr> </table> PROCEDURES <table style="width: 100%;"> <tr> <td>Venipuncture</td> <td>38415</td> <td>17</td> </tr> <tr> <td>Ear Irrigation</td> <td>69210</td> <td>44</td> </tr> <tr> <td>ECG With Interpretation & Report</td> <td>93000</td> <td>39</td> </tr> <tr> <td>ECG Only</td> <td>93005</td> <td>25</td> </tr> <tr> <td>ID Abcess</td> <td>10060</td> <td>119</td> </tr> <tr> <td>ID</td> <td>86580</td> <td>12</td> </tr> <tr> <td>Stool WBC</td> <td>82270</td> <td>6</td> </tr> <tr> <td>Analysis with Micro</td> <td>81000</td> <td>9</td> </tr> <tr> <td>Analysis without Micro</td> <td>81002</td> <td>7</td> </tr> </table> IMMUNIZATIONS & INJECTIONS <table style="width: 100%;"> <tr> <td>B-12</td> <td>J3420</td> <td>3</td> </tr> <tr> <td>Hepatitis A, Adult</td> <td>90632</td> <td>70</td> </tr> <tr> <td>Hepatitis B, Adult</td> <td>90746</td> <td>70</td> </tr> <tr> <td>Hepatitis B, adolescent</td> <td>90744</td> <td>60</td> </tr> <tr> <td>Influenza-Whole</td> <td>90550</td> <td>15</td> </tr> <tr> <td>MMR</td> <td>90707</td> <td>57</td> </tr> <tr> <td>Pneumovax</td> <td>90732</td> <td>40</td> </tr> <tr> <td>Tetanus</td> <td>90703</td> <td>26</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>		New	Mod	Fee	DX	Est.	Mod	Fee	DX	Level 1	99201	48			99211	27			Level 2	99202	82			99212	48			Level 3	99203	121			99213	67			Level 4	99204	176			99214	105			Level 5	99205	222			99215	155				New	Mod	Fee	DX	Est.	Mod	Fee	DX	2-17yrs	99354	168			99394	133			18-39yrs	99385	182			99385	140			40-64yrs	99386	189			99396	147			>65yrs	99387	203			99397	154			Level 1	99221	95		Level 2	99222	156		Level 3	99223	213		Level 1	98231		From _____ To _____ @ \$55	99232		Level 2	99232		From _____ To _____ @ \$87	99233		Level 3	99233		From _____ To _____ @ \$145	99234		Discharge	98238	92	Discharge-over 30 min	99239	172	Partial Detailed	99302	13	Partial Comprehensive	99303	6	Follow Up Level 1	99311		Follow Up Level 2	99312	71	Follow Up Level 3	99313	99	Discharge-30 minutes or less	99315		Discharge-over 30 minutes	99316		Venipuncture	38415	17	Ear Irrigation	69210	44	ECG With Interpretation & Report	93000	39	ECG Only	93005	25	ID Abcess	10060	119	ID	86580	12	Stool WBC	82270	6	Analysis with Micro	81000	9	Analysis without Micro	81002	7	B-12	J3420	3	Hepatitis A, Adult	90632	70	Hepatitis B, Adult	90746	70	Hepatitis B, adolescent	90744	60	Influenza-Whole	90550	15	MMR	90707	57	Pneumovax	90732	40	Tetanus	90703	26	Other _____			Other _____			☐ MCR PAP SMEAR <table style="width: 100%;"> <tr> <td>992 -25</td> <td>E&M</td> </tr> <tr> <td>Q0091</td> <td>Pap \$50</td> </tr> <tr> <td>G0101</td> <td>P&B Exam \$60</td> </tr> <tr> <td>V15.80</td> <td>High Risk Dx</td> </tr> <tr> <td>V76.2</td> <td>Routine Dx</td> </tr> </table> ☐ FLU SHOT <table style="width: 100%;"> <tr> <td>90659</td> <td>Flu Shot</td> </tr> <tr> <td>90471</td> <td>Admin</td> </tr> <tr> <td>V04.8</td> <td>Flu Vaccine Dx</td> </tr> </table> ☐ MCR FLU SHOT <table style="width: 100%;"> <tr> <td>90859</td> <td>Flu Shot</td> </tr> <tr> <td>G0008</td> <td>Admin</td> </tr> <tr> <td>V04.8</td> <td>Flu Vaccine Dx</td> </tr> </table> ☐ PNEUMOVAX <table style="width: 100%;"> <tr> <td>80732</td> <td>Shot</td> </tr> <tr> <td>90471</td> <td>Admin</td> </tr> <tr> <td>V03.82</td> <td>Vaccine Dx</td> </tr> </table> ☐ MCR PNEUMOVAX <table style="width: 100%;"> <tr> <td>90732</td> <td>Shot</td> </tr> <tr> <td>G0008</td> <td>Admin</td> </tr> <tr> <td>V03.82</td> <td>Vaccine Dx</td> </tr> </table> ☐ HEPATITIS A <table style="width: 100%;"> <tr> <td>90746</td> <td>Adult Shot</td> </tr> <tr> <td>90744</td> <td>Adolescent Shot</td> </tr> <tr> <td>90746</td> <td>Adult Shot</td> </tr> <tr> <td>V03.82</td> <td>Vaccine Dx</td> </tr> </table> ☐ HEPATITIS A <table style="width: 100%;"> <tr> <td>90632</td> <td>Shot</td> </tr> <tr> <td>90471</td> <td>Admin</td> </tr> <tr> <td>V08.3</td> <td>Vaccine Dx</td> </tr> </table> ☐ TETANUS <table style="width: 100%;"> <tr> <td>90707</td> <td>Shot</td> </tr> <tr> <td>90471</td> <td>Admin</td> </tr> <tr> <td>906.5</td> <td>Vaccine Dx</td> </tr> </table> ☐ B-12 INJECTION <table style="width: 100%;"> <tr> <td>J3420</td> <td>Shot</td> </tr> <tr> <td>80782</td> <td>Admin</td> </tr> <tr> <td>266.2</td> <td>B-12 Dx</td> </tr> </table>	992 -25	E&M	Q0091	Pap \$50	G0101	P&B Exam \$60	V15.80	High Risk Dx	V76.2	Routine Dx	90659	Flu Shot	90471	Admin	V04.8	Flu Vaccine Dx	90859	Flu Shot	G0008	Admin	V04.8	Flu Vaccine Dx	80732	Shot	90471	Admin	V03.82	Vaccine Dx	90732	Shot	G0008	Admin	V03.82	Vaccine Dx	90746	Adult Shot	90744	Adolescent Shot	90746	Adult Shot	V03.82	Vaccine Dx	90632	Shot	90471	Admin	V08.3	Vaccine Dx	90707	Shot	90471	Admin	906.5	Vaccine Dx	J3420	Shot	80782	Admin	266.2	B-12 Dx	DIAGNOSIS CODES: ICD-9-CM <table style="width: 100%;"> <tr> <td>789.00 Abdominal Pain, NEC</td> <td>704.1 Hirsutism</td> </tr> <tr> <td>796.4 Abnor Unexpl Tst</td> <td>276.7 Hyperker</td> </tr> <tr> <td>762.3 Adema</td> <td>272.4 Hyper</td> </tr> <tr> <td>427.31 A. Fib.</td> <td>276.0 Hyper</td> </tr> <tr> <td>285.9 Anemia NOS</td> <td>252.0 Hyperparathyroid</td> </tr> <tr> <td>413.9 Angina</td> <td>401.9 Hypertension</td> </tr> <tr> <td>V58.61 Anticoag Med</td> <td>242.90 Hyperthyroid</td> </tr> <tr> <td>300.00 Anxiety</td> <td>276.8 Hypokalemia</td> </tr> <tr> <td>427.9 Arrhythmia NOS</td> <td>276.1 Hyponatremus</td> </tr> <tr> <td>719.40 Arthralgia</td> <td>244.9 Hypothyroid</td> </tr> <tr> <td>716.00 Arthritis Acu Chron</td> <td>788.30 Incon Urinary</td> </tr> <tr> <td>714.0 Arthritis, Rheum</td> <td>487.1 Influenza</td> </tr> <tr> <td>429.2 ASCVD</td> <td>V04.8 Influenza Vac</td> </tr> <tr> <td>493.90 Asthma</td> <td>780.52 Insomnia</td> </tr> <tr> <td>724.2 Back Pain</td> <td>564.1 Irrit Bowel Syn</td> </tr> <tr> <td>578.1 Blood in Stool</td> <td>386.30 Labyrinthitis</td> </tr> <tr> <td>726.91 Bone Spur</td> <td>710.0 Lupus</td> </tr> <tr> <td>174.9 Breast CA, Female</td> <td>263.9 Malnutrition</td> </tr> <tr> <td>611.72 Breast Lump</td> <td>995.2 Med Side Effect</td> </tr> <tr> <td>490 Bronchitis</td> <td>410.9 MI, Acu, Unspec</td> </tr> <tr> <td>727.3 Bursitis</td> <td>412 MI, Old 8+ wks</td> </tr> <tr> <td>682.9 Cellulitis, NOS</td> <td>424.0 Vive Pro</td> </tr> <tr> <td>767.99 Chg/Bowel/Habits</td> <td>728.85 Muscle Spasm</td> </tr> <tr> <td>780.9 Chg</td> <td>355.9 Neuropathy</td> </tr> <tr> <td>786.50 Chest Pain</td> <td>278.00 Obesity</td> </tr> <tr> <td>428.0 CHF</td> <td>110.0 Onychomycosis</td> </tr> <tr> <td>574.20 Cholelithiasis, NOS</td> <td>733.00 Osteoposin</td> </tr> <tr> <td>153.9 Colon CA</td> <td>388.70 Otalgia</td> </tr> <tr> <td>564.0 Constipation</td> <td>362.9 Otitis Media</td> </tr> <tr> <td>496 COPD</td> <td>V15.89 Pap High Risk</td> </tr> <tr> <td>436 CVA</td> <td>V76.2 Pap Rout MCR</td> </tr> <tr> <td>799.4 Decondition</td> <td>625.9 Pelvic Pain, Fem</td> </tr> <tr> <td>276.5 Dehydration</td> <td>281.0 Perrouout Anem</td> </tr> <tr> <td>294.8 Dementia</td> <td>462. Pharyngitis</td> </tr> <tr> <td>311 Depression</td> <td>486 Pneumonia</td> </tr> <tr> <td>692.9 Der. 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767.99 Chg/Bowel/Habits	728.85 Muscle Spasm																																																																																																																																																																																																																																																																																																																																																																																																																										
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799.4 Decondition	625.9 Pelvic Pain, Fem																																																																																																																																																																																																																																																																																																																																																																																																																										
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250.50 Diab, Retinopathy	601.9 Prostatitis																																																																																																																																																																																																																																																																																																																																																																																																																										
250.00 Diabetes, Type II	896.1 Psoriasis																																																																																																																																																																																																																																																																																																																																																																																																																										
250.32 Diabetic Coma	415.19 Pulmon Embol																																																																																																																																																																																																																																																																																																																																																																																																																										
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780.4 Dizziness/Vertigo	477.9 Rhinitis, Allergic																																																																																																																																																																																																																																																																																																																																																																																																																										
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240.9 Goiter	241.0 Thyroid Nodule																																																																																																																																																																																																																																																																																																																																																																																																																										
242.0 Graves Disease	245 Thyroiditis																																																																																																																																																																																																																																																																																																																																																																																																																										
245.2 Hashimoto's	533.9 Ulcer, Peptic																																																																																																																																																																																																																																																																																																																																																																																																																										
307.81 Headache, Tension	411.1 Unstable Angina																																																																																																																																																																																																																																																																																																																																																																																																																										
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V70.0 Health Maint	599.0 UTI																																																																																																																																																																																																																																																																																																																																																																																																																										
V43.2 Heart Valve Repl	615.10 Vaginitis																																																																																																																																																																																																																																																																																																																																																																																																																										
455.6 Hemorrhoids	286.2 Vit B-12 Deficiency																																																																																																																																																																																																																																																																																																																																																																																																																										
573.3 Hepatitis, NOS	380.4 Wax in Ears																																																																																																																																																																																																																																																																																																																																																																																																																										
070.1 Hepatitis A	783.2 Weight Loss																																																																																																																																																																																																																																																																																																																																																																																																																										
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070.54 Hepatitis, C, Chron																																																																																																																																																																																																																																																																																																																																																																																																																											
V05.3 Hepatitis Viral, Vac																																																																																																																																																																																																																																																																																																																																																																																																																											

Next Visit

Total: \$ _____

Amt Pd \$ _____

11 ☐ Check # _____

43 ☐ Co-Pay Not Collected

Physician Signature _____ Date _____

NOT INTENDED FOR REPRODUCTION



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DATA COLLECTION

FIGURE 3D – SAMPLE RISK ADJUSTMENT SUPERBILL

JOHN E. DOE, M.D. <i>Internal Medicine</i> <i>Board Certified</i> 123 Main Street Anytown, UL 99999 Office (555) 555-5555 Billing (555) 555-5550 TAX I.D. #12345678	PATIENT NAME		INSURANCE	
	DR#	ACCIDENT TYPE ☐ Work Comp ☐ Auto ☐ Other	DATE OF ACCIDENT ____/____/____	
	DIAGNOSIS CODES: ICD-9-CM			

427.3 A. Fib/flutter

427.9 Arrhythmia

285.9 Anemia,NOS

284 Aplastic Anemia

413 Angina

300.00 Anxiety

716.90 Arthritis, NOS

714 Arthritis, Rheumatoid

427.9 Arrhythmia,NOS

429.2 ASCVD

493.90 Asthma

493.2 Asthma, COP

174 Asthma, COP, male

511.72 Asthma, COP

490 Bronchitis, NOS

466.0 Bronchitis, acute

491 Bronchitis, chronic

482.9 Bronchitis, NOS

786.50 Chest pain

428 CHF

574.20 Cholelithiasis, NOS

153 Colon CA

496 COPD

436 CVA

276.5 Dehydration

294.8 Dementia

311 Depression

296 Depression, major

692.9 Dermatitis

250 Diabetes

250.9 Diabetes, Brittle

250.3 Diabetic Coma

250.1 Diabetic Keto

250.4 Diabetic Nephrosis

250.6 Diabetic Neuropathy

250.0 Diabetes,NIDDM

250.7 Diabetic PVD

250.5 Diabetic Retinopathy

562.11 Diverticulitis

453.8 DVT

610.1 Fibrocystic Breast

729.1 Fibromyalgia

558.9 Gastroenteritis

530.81 GERD

578.9 GI Bleeding

240.9 Goiter

274.9 Gout

242.0 Graves' Disease

573.3 Hepatitis,NOS

070.1 Hepatitis A

070.30 Hepatitis B

070.51 Hepatitis C, Acute

070.54 Hepatitis C, Chronic

401.9 Hypertension

242.90 Hyperthyroidism

276.8 Hypokalemia

276.0 Hyponatremia

244.9 Hypothyroidism

487.1 Influenza

564.1 Irrit. Bowel Syn

36.30 Labyrinthitis

710 Lupus

263 Malnutrition

995.2 Medicine Side Effect

410 MI

471.0 Mitral Valve

59.9 Neuropathy

110.0 Onychomycosis

715.90 Osteoarthritis

733.00 Osteoporosis

427.0 PAT

427.1 PVT

427.2 Parox Tachycardia

462 Pharyngitis

486 Pneumonia

48 Pneumonia, specified

185 Prostate Cancer

600.00 Prostate Hypertrophy

415.19 Pulmonary Embolism

592.0 Renal Lithiasis

477.9 Rhinitis, Allergic

473.9 Sinusitis

079.89 Systemic Viral Infec

451.9 Thrombophlebitis

193 Thyroid Cancer

241.0 Thyroid Nodule

245.9 Thyroiditis

533.9 Ulcer, Peptic

53 Ulcer, perforated

411 Unstable Angina

465.9 URI

599.0 UTI

Next Visit

Total: \$ _____

Amt Pd \$ _____

12 ☐ Check # _____

44 ☐ Co-Pay Not Collected

Physician Signature _____ Date _____

**NOT INTENDED FOR
REPRODUCTION**

Other: _____



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DATA COLLECTION

3.3.4 Factors Affecting Data Collection Method (Slide 17)

The risk adjustment model requires that MA organizations collect a subset of data from their providers/physicians. While CMS requires that only the minimum data are collected for risk adjustment, MA organizations should also consider their business needs.

- The organization may decide to collect full claims data for a variety of reasons:
 - The organization has fee-for-service contracts and pays providers and physicians based on the specific service provided to patients.
 - The organization is earning or maintaining National Committee for Quality Assurance (NCQA) accreditation and is therefore required to collect Health Employers Data Information Set (HEDIS) data used to evaluate the plan's performance in areas of customer service, access to care, and claims processing.
 - The organization has established an internal process for credentialing purposes that requires evidence of compliance with regulatory and other standards of practice such as Joint Commission on Accreditation of Health Care Organizations (JCAHO) or American College of Surgeons. The JCAHO certification requires extensive onsite review to evaluate the health organization's performance in areas that impact healthcare.
- The organization may decide to collect the minimum data set for a variety of reasons:
 - The organization has capitated payment arrangement with physicians and providers, and pays a fixed amount for services provided.
 - The organization's physicians are paid employees of the managed care plan.

3.3.4.1 Contractual Relationships and Implications for Data Collection (Slide 18)

There are several types of contractual payment relationships that MA organizations have with network physicians. These relationships include: fee-for-service, capitated, staff model, and mixed services. These contractual relationships affect how MA organizations collect data from physicians. Table 3K describes the contractual payment relationships.

TABLE 3K – CONTRACTUAL PAYMENT RELATIONSHIPS

FEE-FOR-SERVICE	In a fee-for-service contract, the physician is paid based on the specific services provided to each patient.
CAPITATED	The physician is paid a fixed amount per patient per month, regardless of the types of services provided.
STAFF MODEL	Physicians are paid employees of the managed care plan. Physicians generally provide services in a clinic setting.
MIXED SERVICES MODEL	In a mixed services model environment, managed care organizations use a combination of contractual arrangements.



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DATA COLLECTION

3.4 Health Information Portability and Accountability Act (HIPAA) (Slide 19)

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 ANSI X12 837 v.40.10 format. This means that after the MA organization receives electronic data in HIPAA format, it cannot request that the physician resubmit the identical information (same patient, same diagnosis) in a different format (e.g., HCFA 1500) for purposes of risk adjustment data collection.

However, if needing to clarify original information or to obtain additional information, MA organizations may use an abbreviated data collection instrument for the sole purpose of collecting supplemental diagnostic information.

UB-92 and NSF are the old data collection formats and are not HIPAA compliant transactions. However, if your plan is HIPAA compliant and your trading partners are not HIPAA compliant, CMS is allowing receipt of the non-HIPAA formats until such time as your trading partners are prepared to submit the HIPAA transaction sets. This allowance is not an extension of the mandatory date of HIPAA (October 2003), and all organizations must be able to accept the HIPAA transactions. This extension simply allows plans to continue electronic commerce while their trading partners work toward compliance.



If the transaction is from a provider to an MA organization (i.e., data collection) **and** the transaction is a claim or an encounter, **then** data must be used for risk adjustment **and** the same data cannot be requested in a different format from the provider.

3.5 Provider Communication and Risk Adjustment

Communicating risk adjustment requirements to physicians and providers can help to improve the quality and quantity of the data submitted by MA organizations. It can also help physicians and providers understand the importance of accurate coding and medical record documentation, and their role in data validation. This section describes key messages to include in provider communications, characteristics of effective communication with physicians and providers, and communication methods to consider when sending messages about risk adjustment.

3.5.1 Key Messages

Physicians and providers receive many messages from MA and other managed care organizations. It is easy for a message about risk adjustment to get lost in the stream of communications sent to physicians and providers. To help ensure that messages about risk adjustment get the attention of the provider community, it is important that organizations routinely include basic information about risk adjustment in a variety of provider communications. The key messages to reinforce are:

- **What is the purpose of risk adjustment?**

Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to MA organizations based on the health status of their enrolled beneficiaries. Accurate payments to MA organizations help ensure that providers are paid appropriately for the services they provide to MA beneficiaries. Finally, risk adjustment provides MA organizations with incentives to enroll and treat less healthy individuals.



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DATA COLLECTION

- **Why is risk adjustment important to physicians and providers?**

The risk adjustment model relies on the ICD-9-CM diagnosis codes to prospectively reimburse MA organizations based on the health status of their enrolled beneficiaries. Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-9-CM coding guidelines.

- **What are the responsibilities of physicians and providers?**

Physicians must report the ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately. This requires accurate and complete medical record documentation. They are required to alert the MA organization of any erroneous data submitted and to follow the MA organization's procedures for correcting erroneous data. Finally, they must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).



Organizations may also want to include information about the correct data collection formats available to them, as well as any information revealed through analysis of data collection trends uncovered through monitoring of the risk adjustment process.

3.5.2 Characteristics of Effective Communication

Physicians and providers tend to respond more positively to communications from MA organizations when the messages are considered reliable, accurate, timely, and helps them make their organization or practice more efficient. For this reason, it may be helpful to consider the following characteristics when developing provider communications:

- **Authoritative**

Make the "look and feel" of provider communications conservative, official, and factual. Be certain all information is accurate. Grammar, spelling, and punctuation must be perfect, or the errors will undercut the reader's level of confidence in the message.

- **Current**

Ensure that risk adjustment information is the most recent available. Update provider handbooks, websites, job aids, and training materials routinely so all information is current. Physicians and providers will not spend time reading information they know is outdated.

- **Timely**

Provide information to providers when they need to know it. For example, if MA organizations need physicians and providers to send their diagnostic data via a specific format by a certain date, send that message to them with enough lead-time to allow them to prepare for and meet the deadline for the change.

- **Consistent**

Send consistent messages about risk adjustment. MA organizations can contact the Customer Service and Support Center (CSSC) anytime to confirm that information they are about to send out to providers is correct. Physicians and providers appreciate receiving the right information the first time and every time.



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DATA COLLECTION

- **Practical, relevant, and well organized**

Delete “background noise” from your physician and provider messages. That is, identify the primary message you want to send and provide the key information necessary to make the point. That is, focus the message. Identify any specific actions that are required in clear, easy-to-read language.

- **Accessible**

Create materials for physicians and providers that are easy to access. Information that physicians and providers can locate quickly helps to ensure compliance with risk adjustment requirements, whether that information is available on the Internet, or in a paper document.

3.5.3 Communication Methods

Many MA organizations indicate that communicating to physicians and providers through a single medium, like a newsletter, is not effective. A multimodal approach is more successful at reaching the provider community because it reaches a broader audience and reinforces the message in a number of different formats.

When deciding the methods to communicate with physicians and providers, consider the following steps:

- **Identify the methods that tend to work best for the organization.** Many MA organizations indicate that the organization’s provider Web page and newsletters reach audiences, but small and large group training sessions are most successful for causing a change in action.
- **Determine the goal of the message.** If the message’s intent is to raise awareness about a topic, then broad-based communication methods may be appropriate. However, if the message is intended to change the way physicians and providers do something, then group meetings, followed up by emails, and provider handbook and contract updates may be excellent options.
- **Consider the physician’s and provider’s response.** If the message is likely to provoke a negative reaction from the provider community, then meetings with them can be helpful in addressing and clarifying issues, and discussing possible solutions to problems.

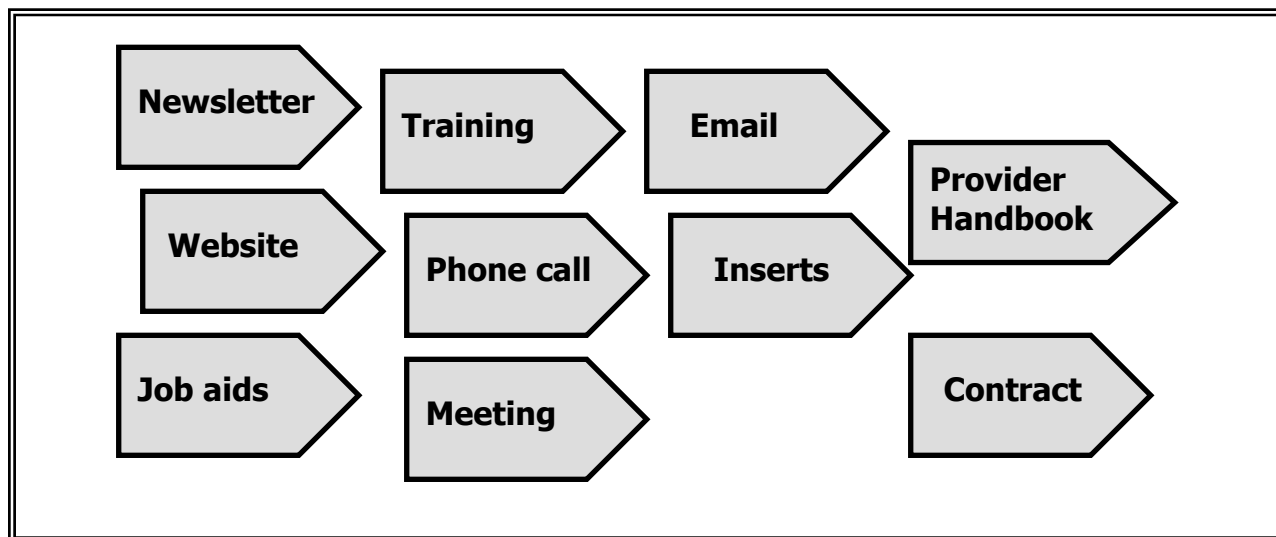
There are a number of methods MA organizations may use to communicate risk adjustment messages to the provider community. These are illustrated in Figure 3E. Understand that, once your organization establishes a communication channel, physicians and providers will rely on that channel to receive information. Any new channels MA organizations use may not be as effective as established ones.



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DATA COLLECTION

Figure 3E – Communication Methods





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DATA SUBMISSION

MODULE 4 – DATA SUBMISSION

Purpose (Slide 2)

Medicare Advantage (MA) organizations must submit accurate diagnostic data when submitting risk adjustment data. This module describes the file layout for risk adjustment process submissions.

Learning Objectives (Slides 3-4)

At the completion of this module, participants will be able to:

- Understand the submission process requirements, connectivity options, and Risk Adjustment Processing System (RAPS) file layout.
- Identify the data elements required to submit risk adjustment data.
- Locate and describe the diagnosis clusters in the RAPS format.
- Understand the Direct Data Entry (DDE) process.
- Describe the filtering process.
- Describe the diagnoses deletion process.

ICON KEY

Example



Reminder



Resource



4.1 Submission Process Requirements (Slide 6)

New MA organizations must complete an Electronic Data Interchange (EDI) Agreement with the Centers for Medicare & Medicaid Services (CMS) and submit that Agreement to the Customer Service and Support Center (CSSC) prior to submitting risk adjustment data. The EDI Agreement is a contract between the MA organization and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the MA organization must sign this document. New Plans must submit the EDI Agreement within 1 month of the HPMS effective date.

MA organizations must make special arrangements to use a third party submitter. If the submitter is an entity other than an MA organization, the submitter must complete the Submitter ID Application Form, and an EDI Agreement form. MA organization must complete, sign, and return the EDI Agreement for each plan number submitting data. CMS holds the MA organization accountable for the content of submissions regardless of who submits the data.

New MA organizations must submit test data within 3 months of the HPMS effective date and a production file must be submitted within 4 months of the effective date.

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



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MA organizations must submit during each calendar quarter, at a minimum, approximately one-fourth of their total risk adjustment data submission for the collection period. More frequent submissions are recommended and may benefit MA organizations in identifying data collection and submission issues early.

4.2 Connectivity Options (Slide 7)

Connectivity refers to the electronic connection between the MA organization and CMS. MA organizations use the electronic connection to submit risk adjustment data to CMS and receive information in return. All third party submitters and large plans that submit their own data must establish a connection to the Front End Risk Adjustment System (FERAS) through the Medicare Data Communication Network (MCDN) that AT&T Global Network Services (AGNS) provides. The MCDN is the secure network linking RAPS data processing entries. Table 4A describes the three connectivity options.

TABLE 4A – CONNECTIVITY OPTIONS

Connect:Direct (File transfer software Product)	Formerly Network Data Mover (NDM). Mainframe-to-mainframe connection. Next day receipt of FERAS response.
File Transfer Protocol (FTP)	Modem-to-modem (dial-up) or lease line connection. Requires password and phone line. Same day receipt of FERAS response.
Gentran (CMS Enterprise File Transfer)	Two connectivity options: -Secure File Transfer Protocol (SFTP); standards based protocol via a vender. -Secure Hyper Text Transfer Protocol (HTTPS), secure web interface.

Small plans with less than or equal to 100,000 members may submit data using the Gentran Mailbox. For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (800) 927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at <http://www.cms.hhs.gov/mmahelp>.

4.3 Required Diagnosis (Slide 8)

Valid diagnosis codes are ICD-9-CM codes that CMS accepts as valid, but may not be included in the CMS-HCC Model. Required diagnosis codes are ICD-9-CM codes that CMS accepts as valid, and are included in the current or future CMS HCC Models.

MA organizations must submit each required diagnosis at least once during a reporting period for each enrolled beneficiary.



For payments beginning on January 1, 2009, the initial submission deadline is September 5, 2008 for the reporting period July 1, 2007 through June 30, 2008. For payments beginning on July 1, 2009, March 6, 2009 is the submission deadline for reporting data with dates of service January 1, 2008 through December 31, 2008. **Refer to the Risk Adjustment Process Overview module, Table 2B.**



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A required (model) diagnosis must meet the following criteria:

- The diagnosis is included in the current or future CMS-Hierarchical Condition Category (CMS-HCC), Prescription Drug (RxHCC) or End Stage Renal Disease (ESRD) risk adjustment models.
- The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.
- The diagnosis must be collected according to the risk adjustment data collection instructions.

MA organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that recorded diagnosis was from a face-to-face visit with one of the three provider types covered under risk adjustment. MA organizations may submit any diagnoses received from the three covered provider types, including diagnoses that are not in the CMS-HCC risk adjustment model. Diagnoses that are in the model, but not collected from one of the three provider types cannot be submitted as risk adjustment data.



A list of valid ICD-9-CM codes for the risk adjustment models for any given payment year includes a list of published NCHS/CMS codes that are valid for the payment year. The list is posted on the CMS website at http://www.cms.hhs.gov/MedicareAdvgtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage, listed under "Risk Model Diagnosis Codes (ZIP, 340 KD) – Updated 10/04/2008 for current model codes, and future model codes are listed under "Future Model Diagnoses." Please be aware that both models (i.e., **Current Model** and **Future Model**) are required.



Do not submit risk adjustment diagnoses based on any diagnostic radiology services, regardless of the type of diagnostic radiology bill (outpatient department or physician component). Diagnostic radiologists typically do not document confirmed diagnoses. Confirmed diagnoses come from referring physician or physician extenders.

4.4 Submission Formats (Slide 9)

Effective October 1, 2007, MA organizations must submit data electronically using one of two formats:

- RAPS format (all provider types)
- DDE screen (all provider types)

4.5 Submission File Layout Logic (Slide 10)

Submissions are organized into three levels of data:

- File-level information—identifies the submitter
- Batch-level information—identifies the MA organization
- Detail-level information—identifies the beneficiary

Figure 4A illustrates a summary of the RAPS file structure.



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Figure 4A – RAPS File Structure Summary

RT AAA – FILE HEADER (Submitter Info)

Always the first record on the file, and must be followed by Record Type (RT) BBB.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

RT BBB – BATCH HEADER (MA Organization Info)

Must follow RT AAA or RT YYY and must be followed by RT CCC.

- Record ID
- Sequence Number
- Plan Number
- Filler

RT CCC – DETAIL RECORD (Beneficiary Info)

Must follow RT BBB or RT CCC and may be followed by another RT CCC.

- Record ID
- Sequence Number
- Sequence Number Error
- Patient Control Number (optional)
- HIC Number
- HIC Error Code
- Patient Date of Birth (optional)
- Date of Birth Error Code
- Diagnosis Cluster (10 Occurrences)
 - Provider Type
 - From Date
 - Through Date
 - Delete Indicator
 - Diagnosis Code
 - Diagnosis Code – Filler
 - Diagnosis Cluster – Error 1
 - Diagnosis Cluster – Error 2
- Corrected HIC Number
- Filler

RT YYY – BATCH TRAILER

Must follow RT CCC and may be followed by another RT BBB or RT ZZZ.

- Record ID
- Sequence Number
- Plan Number
- CCC Record Total
- Filler

RT ZZZ – FILE TRAILER

Must follow RT YYY, and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- BBB Record Total
- Filler

DETAIL LEVEL

BATCH LEVEL

FILE LEVEL



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4.6 Diagnosis Cluster

The diagnosis cluster contains the core information used to calculate a risk adjustment factor. The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- 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.

4.7 Provider Type

MA organizations must submit risk adjustment data for hospital inpatient, hospital outpatient, and physician services. MA organizations may submit all provider types in the same CCC record. The provider type must be coded accurately. There is one provider type per diagnosis cluster. Table 4B shows the provider types and their codes.

Type of Bill (TOB), which is coded on the UB-04 during the collection of hospital data, may be used to assist in translating the correct provider type. Table 4B also shows the TOB and provider type correlation.

TABLE 4B – PROVIDER TYPES

PROVIDER TYPE	CODE	TYPE OF BILL
Principal Hospital Inpatient (principal diagnosis)	01	111 or 11Z
Hospital Inpatient Other (other diagnosis)	02	111 or 11Z
Hospital Outpatient	10	131, 13Z, 141 or 14Z
Physician	20	N/A

Interim bills (112 and 113 bill types) are not accepted. If an MA organization receives interim bills, do not submit the hospital inpatient diagnoses until the receipt of the final interim bill (114 bill type).

4.8 From and Through Dates

- CCYYMMDD is the correct submission format for the "From and Through" dates of service.
- The "Through Date" defines the data used in the data collection year for risk adjustment purposes.



June 30, 2006 is submitted as 20060630.

Table 4C shows the "From" and "Through Dates" for each provider type.



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TABLE 4C – 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		



When a submitter submits a "From Date" that does not include a "Through Date" for physician or hospital outpatient services, RAPS automatically copies the "From Date" into the "Through Date" field.

4.9 Diagnosis Code

- Each required diagnosis code must be submitted at least once during a reporting period.
- The decimal is implied in the format.

4.10 RAPS Format

Table 4D describes each field of the 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.



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TABLE 4D – 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 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.



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TABLE 4D – 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.



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TABLE 4D – 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	Diagnosis Code	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).
9.5		SPACE	Diagnosis Code Filler	This field is designed to allow space for future ICD-10-CM codes and any other growth in the diagnosis cluster. This field must be populated with spaces.
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.
20	438-512	Spaces	Filler	Must be populated with 75 spaces. The "Filler" field allows for additional fields in the future.



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TABLE 4D – 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 records.
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 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.



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4.11 Filtering Risk Adjustment Data (Slides 13-14)

MA organizations are required to filter risk adjustment data to ensure that they submit data from only appropriate data sources (e.g., hospital inpatient, hospital outpatient, and physician provider types). A filtering process is used to identify the correct provider types in claims and encounter data. CMS further recommends the following filtering guidelines:

- Hospital inpatient data require admission and discharge dates of service from appropriate facilities. **Refer to the Data Collection module** for examples of covered facilities.
- Physician data require face-to-face visits with a professional listed on the CMS specialty list. **Refer to the Data Collection module** for the list of acceptable physician data sources.
- Hospital outpatient data require the most demanding or accurate filtering. Data requirements include diagnoses from appropriate facilities and covered services contained on the CMS covered outpatient listings. **Refer to the Data Collection module** for examples of covered facilities and non-covered services/facilities.

The following over-filtering and under-filtering examples may be useful:

- Hospital Inpatient:**
 - Over-filtering - Failing to submit data from specialized facilities (e.g., Rehabilitation and Psychiatric Hospitals).
 - Under-filtering - Submitting data from interim bills or from non-covered institutional stays (e.g., nursing facility data).
- Hospital Outpatient:**
 - Over-filtering - Failing to submit data from specialized facilities, particularly those that do not appear on the inpatient provider list (e.g., Rural Health Clinics, Federally Qualified Health Centers) excluding bills with both covered and non-covered procedure codes.
 - Under-filtering - Submitting data from non-covered facilities or submitting non-covered services from covered facilities (e.g., laboratory only or radiology only claims).
- Physicians:**
 - Over-filtering - Failing to capture data from non-physician practitioners that appear on the physician specialty list (e.g., nurse practitioners, physician assistants, etc.).
 - Under-filtering - Submitting all paid claims from the claims database, including laboratory, Durable Medical Equipment (DME), ambulance, etc.



For those plans that use CPT codes to screen diagnosis codes that are submitted to CMS, please note that the CPT range for radiology is 70000 through 79999. The following CPT codes indicate diagnostic radiology and other diagnoses that should not be submitted as risk adjustment data: 70010 through 76999 and 78000 through 78999. Plans should update these codes annually.

4.12 Modifying Risk Adjustment Data (Slide 15)

RAPS allows for the correction of risk adjustment data submitted to CMS. This correction process is based on the concept that the incorrect cluster must be deleted from the system before the correct cluster is added. For this reason, data correction is at least a two-step process.



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4.13 Deleting Diagnosis Clusters (Slide 16)

Each diagnosis cluster ("Diagnosis Code," "From Date," "Through Date," and "Provider Type") is stored separately as a unique cluster associated with a beneficiary's HIC number. If a diagnosis was submitted in error and needs to be corrected, the original diagnosis cluster must be resubmitted with a delete indicator in the appropriate field. **Delete transactions may only be submitted using the RAPS format or the DDE function.** When a delete record is received, CMS maintains the original diagnosis cluster on file and adds a delete indicator to it and the date of the deletion.

4.14 Reasons to Delete a Diagnosis Cluster (Slide 17)

There are three reasons MA organizations may delete a diagnosis cluster:

- Diagnosis cluster submitted erroneously (e.g., data from an interim bill was submitted for hospital inpatient).
- Incorrect HIC number used for submission of a beneficiary's diagnostic information.
- An error in a diagnosis cluster field (i.e., "Provider Type," "Dates of Service," "Diagnosis Code").

MA organizations submit deletions within a file, batch, or record containing previously submitted risk adjustment data.

4.15 Steps for Deleting a Diagnosis Cluster (Slides 18-20)



Before deleting an error, verify that the diagnosis cluster appears on the RAPS Return File. Only diagnosis clusters accepted by RAPS and stored in the RAPS database may be deleted.

There are two methods for deleting diagnosis clusters:

Method 1 for Deleting Clusters

1. Submit RAPS format using normal submission process with appropriate HIC number included.
2. Enter information in the diagnosis cluster fields (9.0, 9.1, 9.2, 9.4, 9.5) exactly as it appeared in the original submission.
3. In field 9.3 enter a "D" for delete.
4. Enter the appropriate information in all other records to ensure the submission file is complete.
5. Transmit the file to FERAS. (See www.csscooperations.com for details.)

Method 2 for Deleting Clusters

1. Create a file using the DDE screens available through FERAS at Palmetto (detailed information about the DDE process is located in Section 4.20).
2. Enter information exactly as it appeared in the original submission.
3. In the DDE "CCC" record screen, hit the down arrow key and select "D."
4. Proceed with entering all appropriate information.
5. Upload the file created in DDE to FERAS at Palmetto.



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4.16 MA Organization Responsibilities Regarding Deletions (Slide 21)

- MA organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS database.
- If a diagnosis cluster is deleted for the purpose of correcting data, the MA organization is responsible for submitting the correct diagnosis cluster. Conversely, if the MA organization submits corrected data, the MA organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same "CCC" record as the deletion. (Do not exceed 10 diagnosis clusters per "CCC" record.)
- If only one of several clusters within the CCC record requires modification, do not resubmit all other associated clusters. If clusters are resubmitted exactly the same without the delete indicator, the plans will generate a duplicate cluster error.
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.



MA organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. MA organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

4.17 Direct Data Entry (Slide 22)

MA organizations have the option of manually entering diagnostic information via the DDE application offered by Palmetto. DDE instructions are illustrated in the screen shots below. DDE is available in FERAS at Palmetto via the Medicare Data Communications Network (MDCN).

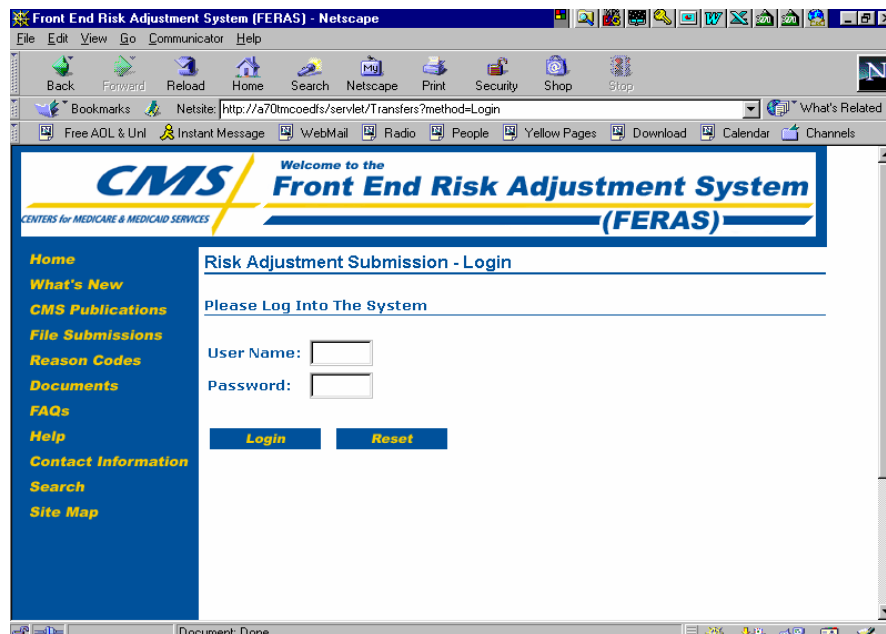
- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 4B through 4G, automatically prevent the placement of incorrect data characters (e.g., alpha characters will not be accepted in the "From" or "Through Date" fields).
- After the user has entered all relevant data, the user will click on the "Create File" button in FERAS. This will create a file on the user's local PC.
- After the file is created on the local PC, the user must upload the file to FERAS in order to complete the process.
- Files created in DDE and uploaded to FERAS will receive a FERAS Response Report, which may be downloaded from the MA organization's electronic mailbox.



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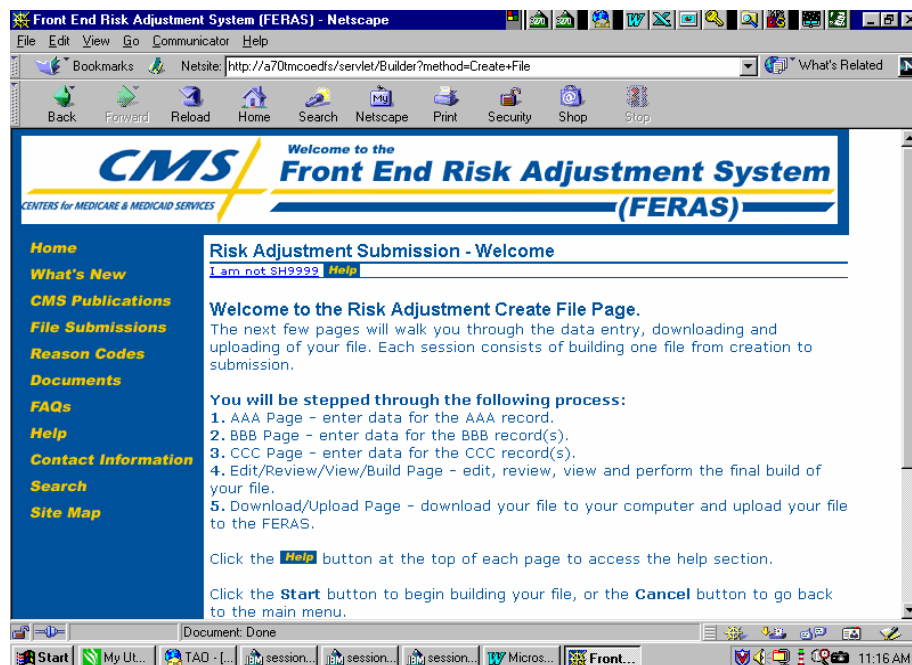
DATA SUBMISSION

Figure 4B – DDE 1



LOGIN PAGE – Submitters are assigned a User Name and Password to access the DDE application.

Figure 4C – DDE 2



WELCOME PAGE – Submitters are provided instructions on the use of the DDE.



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Figure 4D – DDE 3

The file-level information is entered and must begin with RT AAA.

Figure 4E – DDE 4

The batch-level information is entered and must begin with RT BBB.



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Figure 4F – DDE 5

Record ID: ccc Sequence Number: 0000001

Patient Control Number: 9876543210

HIC Number: 123456789a DOB: 19320621 (YYYYMMDD)

Diagnosis Cluster	Provider Type	From Date (YYYYMMDD)	Thru Date (YYYYMMDD)	Delete Ind	Diagnosis Code
1.	01	20020101	20020110		25001
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Build File Next BBB Next CCC Cancel Reset

The CCC Record allows up to 10 diagnostic clusters.

Figure 4G – DDE 6

Welcome to the
Front End Risk Adjustment System (FERAS)

Risk Adjustment Submission - File Submitted

Your file has been submitted to the FERAS.

File Statistics:

AAA Records	0000001
BBB Records	0000001
CCC Records	0000001
YYY Records	0000001
ZZZ Records	0000001
File Size	2570 bytes

Your response file will be available shortly.

Check for your response using either the [Download](#) or [View Page](#).

Upload File Download File View File Delete File Create File

The file has been uploaded to FERAS.



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EDITS AND REPORTS

MODULE 5 – EDITS AND REPORTS

Purpose (Slide 2)

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation and the status of submitted diagnosis clusters via reports. This module introduces participants to the Front-End Risk Adjustment System (FERAS) and the Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Processing System (RAPS) data logic and editing processes and provides insights on the appropriate use of the risk adjustment reports to manage data collection, data submission, and error resolution processes.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Interpret the FERAS and the RAPS data integrity logic and error codes.
- Describe the FERAS and RAPS editing processes.
- Explain the purpose of the FERAS and RAPS reports in monitoring RAPS data.
- Analyze risk adjustment reports to identify and submit corrections.

ICON KEY

Example



Reminder



Resource



5.1 Data Flow and Reporting

After MA organizations submit data to Palmetto, FERAS performs format and integrity checks on the file and batch levels, as well as on the first and last detail (CCC) record. After the data pass the checks, they are sent to RAPS for complete editing of all detail records before they are stored in the RAPS database.

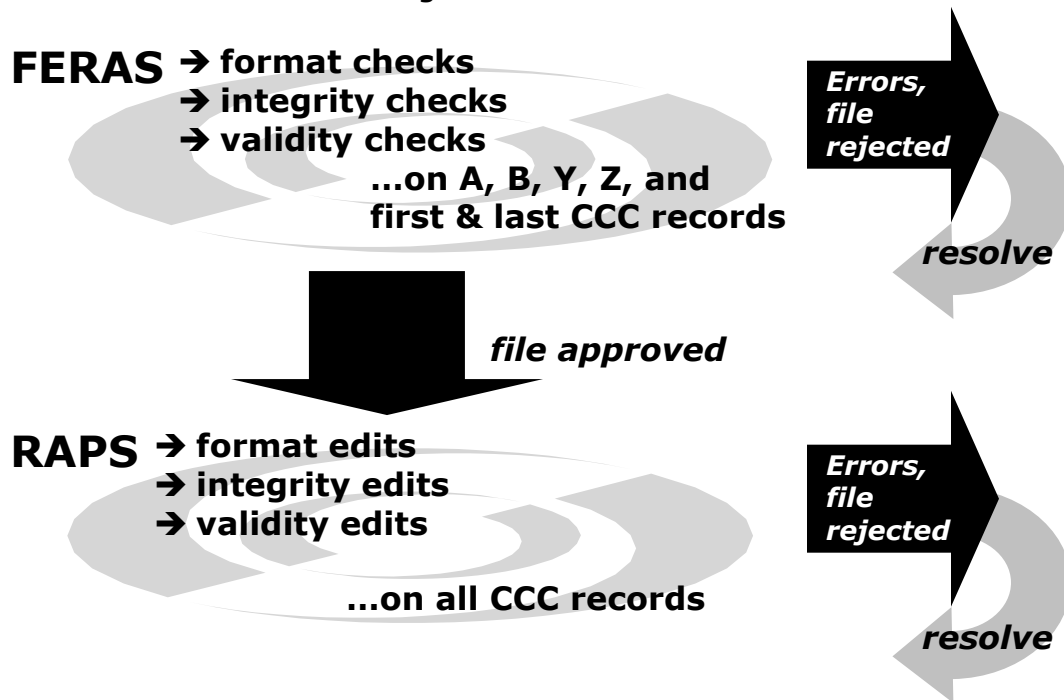
Files submitted in Test and Production are processed through FERAS and RAPS, and all edits are performed. Test files, however, are not stored in the RAPS database. Figure 5A illustrates the flow of data for edit processing.



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EDITS AND REPORTS

Figure 5A – Data Flow



Both the FERAS and RAPS systems generate reports that provide the results of the edit checks in each stage of processing. Some reports present summary-level data, others present details about individual diagnosis clusters, including whether or not a cluster generated an error in RAPS. In addition, RAPS generates a series of management reports to assist plans with managing data collection and submission. It is essential that the appropriate staff at MA organizations understand how to read the reports and resolve any issues identified.

Table 5A provides basic information about accessing and printing reports. Table 5B summarizes the content and general information about each of the reports.



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EDITS AND REPORTS

TABLE 5A – ACCESSING AND PRINTING REPORTS

Accessing Reports	
Methods of Access	• File Transfer Protocol (FTP) • Connect:Direct • Gentran
Report Receipt following File Submission	FTP Users: • Receive FERAS reports typically within 15 minutes of submission • Receive RAPS transaction processing reports the day after submission Connect:Direct and Gentran Users: • Receive FERAS reports the following business day if the file transfer is complete by 5:00 p.m. Eastern Time (ET) • Receive FERAS reports 2 business days after submission if the file transfer is complete after 5:00 p.m. ET • Receive RAPS transaction processing reports the day after submission
Report Distribution	• Reports are sent to the mailbox identified on the submitter application. • Since the processing systems generate the reports out of CMS and then send to Palmetto for distribution, the systems cannot duplicate reports and send to multiple mailboxes. • MA organizations may request reports in zip format. To avoid difficulties opening zip reports, users should: - Rename the file with the ".zip" extension. - Change the command to binary when using the FTP command line.
Report Retention	• The processing systems, FERAS and RAPS, send the reports to the submitter's mailbox, where they remain for 14 days. • The systems automatically delete reports from the mailbox after 14 days, but MA organizations can access reports through the Customer Service and Support Center (CSSC). • For Gentran users CSSC restores reports from the date of mailbox setup to the current date only.
Printing Reports	
	• All risk adjustment reports are delivered as text reports, with the exception of the RAPS Return File. • Organizations may download reports in Note Pad and should change the print orientation to landscape to ensure that all information on the report prints on one page. • Reports opened in Note Pad, automatically include page breaks for printing. • Users should avoid opening reports in Microsoft Word to avoid the default programming that occurs.



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TABLE 5B – REPORTS OVERVIEW

FERAS Report	
FERAS Response Report	- Indicates file is accepted or rejected - Identifies reasons for rejection - Report layout - FTP users receive reports the same business day - Connect:Direct and Gentran users receive reports the next business day
RAPS Reports	
RAPS Return File	- Contains the entire submitted transaction - Identifies 300-, 400-, and 500-level errors - Flat file layout - Received the next business day after submission
RAPS Transaction Error Report	- Communicates errors found in CCC records during processing - Displays only 300-, 400-, and 500-level error codes - Report layout - Received the next business day after submission
RAPS Transaction Summary Report	- Summarizes the disposition of diagnosis clusters - Report layout - Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	- Identifies diagnosis clusters with 502-error message - Clusters accepted, but not stored - Report layout - Received the next business day after submission
RAPS Management Reports	
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 Report	- 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 Report	- 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



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5.2 FERAS System

MA organizations submit data to FERAS, which performs the format and integrity checks.

- FERAS performs format and integrity checks on file- and batch-level data.
- FERAS checks the first and last detail records in each batch.
- FERAS accepts or rejects the entire file.
- FERAS ensures that all accepted transactions contain the following correct data:
 - AAA and ZZZ record.
 - At least one BBB record for each YYY record.
 - Following each BBB record, at least one CCC record with at least one diagnosis cluster populated.
 - Valid submitter ID and plan numbers.
 - Valid record and file totals.
 - The first and last CCC record will be edited to ensure that the submitted data are in the correct location on the record (i.e., spaces are where they should be located).
 - Record Type CCC must be present in the first field.
 - The first sequence number must equal 0000001.
 - The last sequence number must equal the total CCC record count in the YYY record.
 - The "HIC (Health Insurance Claim) Error Code" and "Diagnosis Code – Filler" fields contain spaces. Do not fill fields with zeros.

If all checks pass, the transaction processing continues in RAPS. If any of the data fail, FERAS rejects the complete file and generates the FERAS Response Report. The FERAS Response Report identifies the errors discovered during the edit check.



Example: 1

Scenario: The MA organization submitted a file and entered "AA1" in record type AAA, field 1.

Results: FERAS will reject the entire file with error message 100. The field must always be populated with "AAA".

Generally, FERAS errors occur during the initial establishment of the system and risk adjustment process in MA organizations. After data are processed, automated formats are programmed, and FERAS errors occur less frequently.

5.2.1 FERAS Error Code Logic

When a FERAS check fails, an associated error code is created. Table 5C describes the error code logic. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all checks are completed.



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TABLE 5C – FERAS ERROR CODE LOGIC

SERIES	EXPLANATION
100	File-level errors on the AAA or ZZZ records.
200	Batch-level errors on the BBB or YYY records.
300-400	Check performed on first and last CCC records.

- The 100- and 200- series error codes are assigned based on the level of checks that are performed, as well as the location of the edit.
- The entire file is returned to the submitter.

5.2.2 FERAS Error Code Ranges

Error code ranges are explained in Table 5D.

TABLE 5D - ERROR CODE RANGES

SERIES	EXPLANATION
100	Indicates that the system could not determine the record type; all editing stopped at that point.
101-109	Indicates a failure of a face-validity edit on the AAA record (file-level header). The last digit indicates the specific field in which the error was found. For example, the 10 <u>1</u> -error code refers to an error found in field <u>1</u> on the AAA record.
111-125	Indicates a failure of a cross-reference edit between a field on the AAA (file-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific AAA field against which the cross-check was performed. For example, the 11 <u>2</u> -error code indicates that the submitter ID in field <u>2</u> did not appear on a look-up table of valid submitter IDs.
151-159	Indicates a failure of a face-validity edit on the ZZZ record (file-level trailer). The last digit indicates the specific field in which the error was found. For example, the 15 <u>1</u> -error code refers to an error found in field <u>1</u> on the ZZZ record.
161-175	Indicates a failure of a cross-reference edit between a field on the ZZZ (file-level trailer) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific ZZZ field against which the cross-check was performed. For example, the 16 <u>2</u> -error code indicates that the submitter ID, field <u>2</u> in ZZZ record, does not match the submitter ID on the AAA record.
201-209	Indicates a failure of a face-validity edit on the BBB (batch-level header) record. The last digit indicates the specific field in which the error was found. For example, the 20 <u>1</u> -error code refers to an error found in field <u>1</u> on the BBB record.



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TABLE 5D - ERROR CODE RANGES (CONTINUED)

211-225	Indicates a failure of a cross-reference edit between a field on the BBB (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific BBB field against which the cross-check was performed. For example, the 213-error code indicates that the submitter ID, field 3 in BBB record, is not authorized to submit for the plan ID.
251-259	Indicates a failure of a face-validity edit on the YYY (batch-level trailer) record. The last digit indicates the specific field in which the error was found. For example, the 251-error code refers to an error found in field 1 in the YYY record.
261- 275	Indicates a failure of a cross-reference edit between a field on the YYY (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific YYY field against which the cross-check was performed. For example, the 262-error code indicates that the sequence number in the YYY record field 2 does not match the sequence number in field 2.
301-489	Indicates a format problem with the first or last CCC record. The problem is either with the face validity of the data in specific fields or the presence of data in fields that are required to be blank. In either circumstance, the basic CCC record format is assumed to be in error and the entire file is rejected.

Note: FERAS checks the validity and format of an individual field before performing checks between fields. For example, the system first checks that there is a valid submitter ID on the AAA record before it checks that the submitter ID reported in the YYY record is identical. Table 5E describes FERAS file-level, batch-level, and detail-level error codes.

TABLE 5E – FERAS ERROR CODES
FILE-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
100	AAA	INVALID RECORD TYPE
101	AAA	AAA RECORD MISSING FROM TRANSACTION
102	AAA	MISSING / INVALID SUBMITTER-ID ON AAA RECORD
103	AAA	MISSING FILE-ID ON AAA RECORD
104	AAA	MISSING / INVALID TRANSACTION DATE ON AAA RECORD
105	AAA	MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD
112	AAA	SUBMITTER ID NOT ON FILE
113	AAA	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
114	AAA	TRANSACTION DATE IS GREATER THAN CURRENT DATE
151	ZZZ	ZZZ RECORD MISSING FROM TRANSACTION
152	ZZZ	MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD
153	ZZZ	MISSING / INVALID FILE-ID ON ZZZ RECORD
154	ZZZ	MISSING / INVALID BBB-RECORD-TOTAL
162	ZZZ	ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD
163	ZZZ	FILE ID DOES NOT MATCH FILE ID ON AAA RECORD
164	ZZZ	ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS



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TABLE 5E – FERAS ERROR CODES (CONTINUED)

BATCH-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
201	BBB	BBB RECORD MISSING FROM TRANSACTION
202	BBB	MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD
203	BBB	MISSING / INVALID PLAN NUMBER ON BBB RECORD
212	BBB	SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE
213	BBB	SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID
251	YYY	YYY RECORD MISSING FROM TRANSACTION
252	YYY	MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD
253	YYY	MISSING / INVALID PLAN NUMBER ON YYY RECORD
254	YYY	MISSING / INVALID CCC-RECORD-TOTAL
262	YYY	LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS
263	YYY	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD
264	YYY	YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS
272	YYY	SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE

DETAIL-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQ-NO ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NO ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST BE BLANK OR EQUAL TO "D"
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
400	CCC	MISSING / INVALID PROVIDER-TYPE ON CCC RECORD
401	CCC	INVALID FROM-DATE ON CCC RECORD
402	CCC	INVALID THRU-DATE ON CCC RECORD



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Example: 2

Scenario: The MA organization submitted a file with a 2.0 in the "Diagnosis Code – Filler" field on the first CCC record.

Results: FERAS would reject the complete file due to data being placed in the "Diagnosis Code – Filler" field of the diagnosis cluster, because the "Diagnosis Code – Filler" must be populated with spaces. FERAS would identify this error, since it occurred in the first CCC



FERAS errors rarely occur after MA organizations program file layouts and adequately test the formats before submission to CMS.

5.2.3 FERAS Response Report

The FERAS Response Report reflects FERAS checks (format, integrity, and validity) that occur in the file, batch, and first and last detail-level records. It indicates if the file has been accepted or rejected by the front-end system. If accepted, the report specifies that the file is completely accepted. If the file is rejected, the report identifies the reason(s) for the rejection. Figure 5B illustrates the fields on the FERAS Response Report and describes these fields.



The report is available in a report layout file in each submitter's mailbox. FTP users typically receive their reports within 15 minutes of submission. Connect:Direct and Gentran users receive their reports the next business day.



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Figure 5B – Rejected FERAS Response Report

[1]REPORT: FERAS-RESP		[2]FRONT END RISK ADJUSTMENT SYSTEM	
[3]RUN DATE: 20030407		FERAS RESPONSE REPORT	
[4]SUBMITTER ID: SH7777			
[5]FILE ID: 0000000001			
[6]FILE STATUS: REJECTED PROD			
[7]	[8]	[9]	[10]
RECORD	SEQ	ERROR	ERROR DESCRIPTION
TYPE	NO	CODE	
AAA		113	DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS
END OF REPORT			

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Report Run Date	Date the report was generated by Palmetto (CCYYMMDD format).
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one plan. A different report is generated for each plan.
5	File ID	The 10-character alphanumeric field identifying the specific file submitted.
6	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST or PRODUCTION.
7	Record Type	Identifies the level of the error (file-, batch-, or detail-record level).
8	Sequence Number	Identifies the batch or detail-level record where the error occurred.
9	Error Code	Identifies the 3-digit number error message that caused the file to reject.
10	Error Code Description	Explains the error code.

NOTE: There are three reasons why users would not receive the FERAS Response Report:

- The AAA record is not included on the file. Submitters receive an "INVALID_FILE_HDR" message.
- No Submitter ID on the AAA record.
- The login ID used to submit data to FERAS does not match the submitter ID. Submitters receive a "SUBMITTER ID IN FILE DOES NOT MATCH THE LOGIN ID" message (FTP and Secure Website users only).



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Example: 3

The MA organization submitted a file containing a File ID already used within the last twelve months. The second batch did not include a plan number i.e., an H number. The first detail record was missing a Health Insurance Claim (HIC) number, and the fourth YYY batch trailer plan number did not match the plan number in the fourth BBB batch header. Figure 5C illustrates this example.

Figure 5C – FERAS Response Report

REPORT: FERAS-RESP		FRONT END RISK ADJUSTMENT SYSTEM	
RUN DATE: 20040304		FERAS RESPONSE REPORT	
SUBMITTER ID: SH9999			
FILE-ID: 0000000001		REJECTED PROD	
RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
AAA		113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
BBB	0000002	203	MISSING/INVALID PLAN NUMBER ON BBB RECORD
CCC	0000001	310	MISSING/INVALID HIC NUMBER ON CCC RECORD
YYY	0000004	263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD



The FERAS Response Report indicates errors in the first and last detail-level (CCC) record.

5.3 RAPS System

After data pass the FERAS checks, the file is sent via Connect:Direct to the CMS data center for RAPS processing.

- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from Palmetto prior to editing data.
- The RAPS system performs editing on the CCC transactions.
- The data elements edited include HIC Number, Provider Type, Diagnosis Code, From Date, and Through Date.
- If Date of Birth is submitted, RAPS performs an edit on that field.



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5.3.1 RAPS Edits Rules

The RAPS editing process takes place in four logical stages.

Stage 1- Field Validity and Integrity Edits

RAPS performs format and integrity checks on all CCC-level fields as a first level of editing. If there are data in the "HIC Error Code" or "Diagnosis Code - Filler" fields, the entire detail record is rejected with no further editing performed. If a record fails this stage of editing, it is assumed that the data are corrupt.

The dates also are checked at this stage. If the dates within a diagnosis cluster are not valid dates, then RAPS stops the editing process for that diagnosis cluster because all other data edits within a diagnosis cluster depend upon the validity of the dates.

Stage 2 - Field-to-Field Edits

After RAPS checks format and integrity of the fields, the field-to-field editing takes place.

- RAPS ensures that the from date is equal or prior to the through date.
- RAPS also checks all diagnosis clusters for hospital outpatient and physician provider types to ensure compliance with the 31-day span rule.
- RAPS checks all data to make certain that MA organizations submit the reconciliation data properly. See Submission Timetable in Module 2 (Risk Adjustment Process Overview) for dates of service included in each data submission period.

Stage 3 - Eligibility Edits

The next stage of editing cross-checks the appropriate fields against the common tables in MBD and MARx. MA organizations may access MBD through the common user interface, Medicare Advantage & Part D Inquiry System. For risk adjustment purposes, these common tables are the authoritative source of beneficiary information, and supports managed care enrollments to MA organizations.

In this editing stage, the HIC number, date of birth, and Medicare entitlement are checked. For example, in Stage 1 editing, the system ensured that a valid HIC number was present in field 5 of the CCC record. In Stage 3 editing, the system makes certain that the HIC number exists on the common tables.

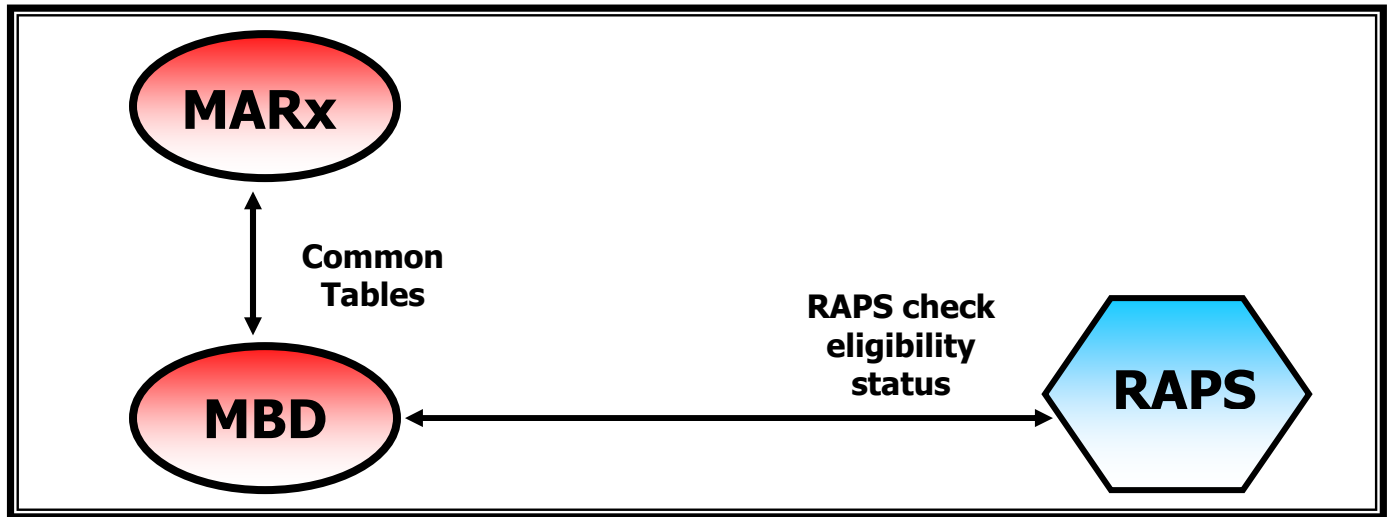


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Figure 5D illustrates the flow of data between MARx and MBD and RAPS.

Figure 5D –Flow of Data for Eligibility Checks



The HIC number is a common way to begin researching data in the common tables.

- The common tables store historical data on file, so if a beneficiary's HIC number changed, the common tables will cross-reference the old and new numbers.
- Railroad Retirement Board (RRB) beneficiary numbers are cross-referenced automatically. This allows users to research demographic and eligibility information for beneficiaries with RRB and HIC numbers.

Stage 4 - Diagnosis Code Edits

After RAPS edits the integrity of the individual fields and validates the HIC number and eligibility, it edits the diagnosis code against the Diagnosis Lookup Table in RAPS. In this stage, the system first ensures that each diagnosis code is valid. Then the system checks each diagnosis code against service dates and gender. If any of these edits fail, the diagnosis cluster is not stored in the RAPS database. The edits at this stage also include an edit to check if the diagnosis code is in the risk adjustment model. If the diagnosis code is not in the model, an information error is returned. The diagnosis cluster is stored if an information-only error is returned, and no further action by the MA organization is required.

Explanations of error codes and their consequences, RAPS error codes, informational edits, and duplicate diagnosis cluster edit are presented in Tables 5F, 5G, 5H, and 5I, respectively.



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TABLE 5F – EXPLANATION OF ERROR AND CONSEQUENCES

SERIES	EXPLANATION OF ERROR AND CONSEQUENCES
300-349	Record-level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record-level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
400-489	Diagnosis cluster error. All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error; diagnosis was not deleted.
500-599	Informational message, all edits were performed; diagnosis cluster was stored unless some other error is noted.

TABLE 5G – RAPS ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NUMBER ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST EQUAL SPACE OR "D" FOR DELETE
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
353	CCC	HIC NUMBER DOES NOT EXIST ON MBD
354	CCC	PATIENT DOB DOES NOT MATCH WITH MBD DOB



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TABLE 5G – RAPS ERROR CODES (CONTINUED)

ERROR CODE	RECORD ID	ERROR DESCRIPTION
400	CCC	MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD
401	CCC	INVALID SERVICE FROM-DATE ON CCC RECORD
402	CCC	INVALID SERVICE THROUGH-DATE ON CCC RECORD
403	CCC	SERVICE THROUGH-DATE MUST BE GREATER THAN 12/31/2004
404	CCC	SERVICE FROM-DATE MUST BE LESS THAN OR EQUAL TO THROUGH-DATE
405	CCC	DOB IS GREATER THAN SERVICE FROM-DATE
406	CCC	SERVICE FROM-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
407	CCC	SERVICE THROUGH-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
408	CCC	SERVICE FROM-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD
409	CCC	SERVICE THROUGH-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD
410	CCC	BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM-DATE
411	CCC	SERVICE THROUGH-DATE IS GREATER THAN DATE OF DEATH
412	CCC	SERVICE FROM-DATE GREATER THAN TRANSACTION DATE
413	CCC	SERVICE THROUGH-DATE GREATER THAN TRANSACTION DATE
450	CCC	DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH-DATE
451	CCC	SERVICE THROUGH-DATE IS GREATER THAN DIAGNOSIS END DATE
453	CCC	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX
454	CCC	DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING
455	CCC	DIAGNOSIS CLUSTER NOT EDITED DUE TO RECORD FORMAT ERROR
460	CCC	SERVICE FROM- AND THROUGH-DATE SPAN IS GREATER THAN 31 DAYS
490	CCC	COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD
491	CCC	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED
492	CCC	DELETE ERROR, DIAGNOSIS CLUSTER WAS NOT DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE

TABLE 5H – INFORMATIONAL EDITS

ERROR CODE	RECORD ID	ERROR DESCRIPTION
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS
501	CCC	VALID DIAGNOSIS BUT NOT INCLUDED IN THE CURRENT RISK ADJUSTMENT MODEL DURING THIS SERVICE PERIOD



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TABLE 5I – DUPLICATE DIAGNOSIS CLUSTER EDIT

ERROR CODE	RECORD ID	ERROR DESCRIPTION
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE



Example: 4

Scenario: The Low Rest Insurance Company submitted a risk adjustment transaction for Susan Doe who was admitted into the hospital. The principal diagnosis submitted was 601.0 for acute prostatitis.

Results: The error code 453 would occur. The system checked that the diagnosis field was complete. Next, the system verified that the HIC number was entered. RAPS then verified that the HIC number was on the common tables and the beneficiary was eligible. The diagnosis was determined to be a valid diagnosis. However, the diagnosis was not valid for the sex. This diagnosis cluster was rejected and not stored in the RAPS database.

5.3.2 RAPS Processing Reports

Generally, the RAPS processing reports allow MA organizations to see all records and diagnosis clusters submitted. They also communicate existing errors and report any exact duplicate clusters. Organizations use these reports to determine if they need to correct and resubmit their data.

5.3.2.1 RAPS Return File

The RAPS Return File contains all transactions submitted by the MA organization. If there are errors or informational edits, they appear next to the field in which the error was found. The file is delivered in the same flat file format used for the RAPS input. It may be downloaded and imported into Microsoft Access or Excel. The data can then be converted to display the necessary fields.



MA organizations receive the RAPS Return File the next business day following a submission.

Table 5J represents the RAPS record layout and the information contained in a flat file format for the RAPS Return File. The shaded areas on the CCC record represent fields where RAPS can report error information.



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**Table 5J – RAPS Record Layout
RECORD AAA – FILE HEADER**

FIELD NO	FIELD NAME
1	Record ID
2	Submitter ID
3	File-ID
4	Transaction Date
5	Production-Test-Indicator
6	Filler

RECORD BBB – BATCH HEADER

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Plan Number
4	Filler

RECORD CCC – DETAIL LEVEL

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Sequence Number Error Code
4	Patient Control Number
5	HICN
6	HICN Error Code
7	Patient DOB
8	DOB Error Code
9.0	Provider Type
9.1	From Date
9.2	Through Date
9.3	Delete-Indicator
9.4	Diagnosis Code
9.5	Diagnosis Code Filler
9.6	Diagnosis Cluster Error 1
9.7	Diagnosis Cluster Error 2
19	Corrected HICN
20	Filler



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TABLE 5J – RAPS RECORD LAYOUT (CONTINUED)

RECORD YY – BATCH TRAILER

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Plan Number
4	CCC-Record-Total
5	Filler

RECORD ZZZ – FILE TRAILER

FIELD NO	FIELD NAME
1	Record ID
2	Submitter ID
3	File-ID
4	BBB Record Total
5	Filler



Example: 5

The MA organization submitted a file and included the date of birth (DOB) for the beneficiary. RAPS determined a discrepancy between the DOB submitted on the file and what is stored in the Medicare Advantage Prescription Drug System (MARx). The submitter received a RAPS Return File. Figure 5E illustrates the portion of the RAPS Return File that contains the DOB, as well as an error code indicating that the submitted DOB is incorrect.

Figure 5E – RAPS Return File

AAASH7777000000000120030411PROD			
BBB0000001H9999			
CCC0000001 7321430	123456789A	193503053540	12003031420030318 4359
YYY0000001H99990000003			
ZZZSH777700000000010000003			

DOB and



RAPS reports include the sequence number of the file, batch, and detailed record as submitted by the organization.

5.3.2.2 RAPS Transaction Error Report

The RAPS Transaction Error Report displays only those detail-level (CCC) records where errors were found during RAPS processing. Every record with errors is displayed in full with the appropriate error code next to the field in error. The report is available in a report layout file in each submitter's mailbox. It is organized by H number, and may prove useful to MA organizations that use a manual tracking process. Figure 5F illustrates the RAPS Transaction Error Report and describes the report's fields.



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Submitters receive a RAPS Transaction Error Report the next business day after submitting a file.

Figure 5F – RAPS Transaction Error Report

[1]REPORT : RAPS002				[2]RISK ADJUSTMENT PROCESSING SYSTEM						[3]PAGE: 1				
[4]RUN DATE : 20030411				TRANSACTION ERROR REPORT						[5]TRANS DATE: 20030411				
[6]SUBMITTER ID SH7777		[7]FILE ID: 0000000005		[8]PLAN ID: H7777		[9]BATCH NUMBER: 0000001								
[10]	[11]	[12]	[13]	[14]	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]
SEQ	SEQ	PATIENT CONTROL	HIC	HIC	DOB	DOB	PVDR	FROM	THRU	DEL	DGNS	DGNS	DGNS	CORRECTED
NUM	ERR	NUM		ERR		ERR	TYPE	DATE	DATE	IND	CODE	ERR1	ERR2	HIC
0000002		123456789A		19350305 354		01	20030314		20030318		4359		501	
		12345676878812347654165464515												
END OF FILE														

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the Submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Page Number	Page number of the report.
4	Report Run Date	Date CMS generated the report (CCYYMMDD).
5	MCO Transmit Date	Date the MA organization created the transaction.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
7	File ID	The 10-character alphanumeric field identifying the specific file submitted.
8	Plan Number	The H-number assigned by CMS; A different report is printed for each organization (H-number).
9	Batch ID	The 7-digit batch identification number.
10	Sequence Number	Detail-level record where the error occurred.
11	Sequence Number Error Code	The 3-digit error code associated with the sequence number.
12	MCO Patient Control Number	Patient control number assigned by the MA organization, if any.
13	HIC Number	The 10-character (alpha-numeric) Health Insurance Claim (HIC) Number of the beneficiary.
14	HIC Number Error Code	The 3-digit error code associated with the HIC Number.
15	Date of Birth	Patient's date of birth (CCYYMMDD format).
16	Date of Birth Error Code	The 3-digit error code associated with the patient's date of birth.
17	Provider Type	The 2-digit code identifying the provider type (01, 02, 10, or 20).
18	Service From Date	Date of admission (inpatient) or date of treatment (outpatient facility or physician).
19	Service Through Date	Date of discharge (inpatient) or date of treatment (outpatient facility or physician).
20	Delete Indicator	The 1-character place holder that identifies diagnosis clusters that will be or are deleted. This field is populated with a "D" if the cluster was deleted. If no deletion has occurred, the space will be blank.
21	Diagnosis Code	The 5-character ICD-9-CM diagnosis code.
22	Diagnosis Code Error 1	Error code associated with submitted diagnosis code, if any.
23	Diagnosis Code Error 2	Error code associated with submitted diagnosis code, if any.
24	Corrected HIC Number	If an error code indicates there is a corrected HIC number, it is listed here.



When RAPS identifies no errors, the system sends a Transaction Error Report with the message "ALL DIAGNOSES PROCESSED WITHOUT ERRORS."

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Figure 5H – RAPS Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM TRANSACTION SUMMARY REPORT							
[1]REPORT: RAPS001							
[2]RUN DATE: 20030412		[3]TRANS DATE:20030411					
[4]SUBMITTER ID SH7777		[5]PLAN ID: H7777		[6]FILE ID: 0000000001			
[7]PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	[8]UNIDENTIFIED	TOTAL	
[9]TOTAL SUBMITTED	207	1,213	0	0	0	1,420	
[10]TOTAL REJECTED	9	49	0	0	0	58	
[11]TOTAL ACCEPTED	198	1,164	0	0	0	1,362	
[12]TOTAL STORED	189	1,099	0	0	0	1,288	
[13]TOTAL MODEL STORED	103	368	0	0	0	471	
[14]TOTAL DELETE ACPTD	0	0	0	0	0	0	
[15]TOTAL DELETE RJCTD	0	0	0	0	0	0	

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the submitter's mailbox.
2	Report Run Date	Date CMS generated the report.
3	MCO Transmit Date	Date the submitter created the transmission.
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
5	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
6	File ID	The 10-character alphanumeric field identifying the specific file submitted.
7	Provider Type	This header row identifies the provider sources for which data are listed: principal inpatient, other inpatient, outpatient, physician, unidentified, and total.
8	Unidentified Provider Type	Indicates the number of diagnosis clusters in transactions that did not include a valid provider type. Valid provider types are "01," "02," "10," and "20."
9	Total Submitted	The total number of clusters submitted in the file.
10	Total Rejected	The total number of clusters submitted in the file and rejected.
11	Total Accepted	The total number of clusters submitted in the file and accepted.
12	Total Stored	The total number of clusters stored in the risk adjustment database – includes all accepted clusters that are non-duplicates.
13	Total Model Stored	The total number of required clusters that were stored, and are included in the CMS-HCC model)
14	Total Delete Accepted	The total number of deletes submitted for the file that were accepted in the database.
15	Total Delete Rejected	The total number of deletes submitted, but rejected, for the file.



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5.3.2.4 Relationships Between Values in Report

The relationships between values found on various lines of the report are illustrated using the following formulas:

- The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected equal total submitted. $\text{Line 10} + \text{Line 11} + \text{Line 14} + \text{Line 15} = \text{Line 9}$.
- The total stored (Line 12) is less than or equal to the total accepted (Line 11). The Risk Adjustment Database stores all required diagnosis clusters, including diagnoses that are not used in the current risk adjustment model. The difference between total accepted and total stored reflects the number of exact duplicate diagnosis clusters.
- The total stored in the model (Line 13) is less than or equal to the total diagnosis clusters stored (Line 12).



Example: 7

Based on the information displayed in Figure 5H, the MA organization can make the following conclusions:

- About four percent of the clusters were rejected due to error.
- Seventy-four duplicates were submitted (total accepted minus total stored).
- About one-third of the diagnoses submitted were in the model.



MA organizations can use the reports not only to correct errors, but to track the errors and implement automated or manual systems to prevent the same errors from occurring in the future.



Example: 8

In Figure 5I, the MA organization submitted a file that included 72 duplicate diagnosis clusters, and 3,299 diagnosis codes that were not relevant. The RAPS Transaction Summary Report also indicates that clusters were submitted with missing or invalid provider types. In addition, the organization had 12 deletes rejected, meaning the organization attempted to perform the delete function against a diagnosis cluster that was already deleted, or tried to delete a cluster that never stored. The RAPS Return File or the RAPS Transaction Error Report communicates the specific reason for each rejection.



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Figure 5I – Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM						
TRANSACTION SUMMARY REPORT						
REPORT: RAPS001						
RUN DATE: 20040503		TRANS DATE:20040430				
SUBMITTER ID SH7777		PLAN ID: H9999		FILE ID: 0000000001		
PROVIDER TYPE	Principal Inpatient	Other Inpatient	Outpatient	Physician	Unidentified	Total
TOTAL SUBMITTED	870	3480	629	348	2	5329
TOTAL REJECTED	26	104	18	13	2	163
TOTAL ACCEPTED	842	3367	606	333	0	5148
TOTAL STORED	840	3335	581	320	0	5076
TOTAL MODEL STORED	295	1167	203	112	0	1777
TOTAL DELETE ACPTD	2	2	0	2	0	6
TOTAL DELETE RJCTD	0	7	5	0	0	12



The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected is equal to the total submitted.



The values in the "Unidentified" column on the report represent the number of clusters for which RAPS is unable to identify a provider type. These clusters are reflected only in the "Total Submitted" and "Total Rejected" rows of the report.

5.3.2.5 Informational Error Messages

RAPS generates informational messages that do not stop processing of data, i.e., no immediate action is necessary. However, these messages, illustrated in Table 5K, provide MA organizations with information to improve future submissions.

TABLE 5K – INFORMATIONAL MESSAGE CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION	PROCESS IMPROVEMENT
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS.	USE UPDATED HIC NUMBER ON ALL FUTURE SUBMISSIONS FOR THIS BENEFICIARY.
501	CCC	VALID DIAGNOSIS BUT NOT INCLUDED IN THE CURRENT RISK ADJUSTMENT MODEL DURING THIS SERVICE PERIOD.	DETERMINE IF FILTERING SHOULD BE INCORPORATED INTO SUBMISSION PROCESS TO REDUCE NUMBER OF 501 MESSAGES.



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5.3.2.5.1 Duplicate Diagnosis Cluster Error and 5 Percent Benchmark

CMS has put a 5 percent benchmark requirement in place for 502 errors, "Diagnosis cluster was accepted but not stored. A diagnosis cluster with the same attributes is already stored in the RAPS database," CMS monitors plans with error rates that exceed the benchmark. CMS defines a duplicate submission as a diagnosis cluster with the same attributes (provider type, from date, through date, diagnosis code, and HIC number) that are already stored in the RAPS database.

Each duplicate cluster that receives a 502-error code counts toward the 5 percent benchmark. For example, if a record included 10 diagnosis clusters and each one was a duplicate of another cluster, there would be 10 502-error codes and all 10 would count towards the 5 percent benchmark.

CMS will look at the overall metrics per file, as this is the easiest way to measure the benchmark. CMS will look at files on a weekly basis to determine volume and the number of duplicates the plan receives to determine if a compliance letter needs to be sent.

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 5L provides examples of how CMS reviews plan submissions against the benchmark.

TABLE 5L – 502 BENCHMARK COMPARISON EXAMPLES

EXAMPLE NUMBER	EXAMPLE DESCRIPTION
1	If a plan submitted one file in a given week with two records and they were duplicates, the plan would have a 100% duplicate rate, but with only two records.
2	Afterwards, the plan submitted additional files that had 10,000 records and a 2% duplicate rate. In this case, CMS would not send this plan a compliance letter.
3	If, on the other hand, a plan submitted a file with 2 million records and 1 million of them were duplicates, CMS would send a compliance letter.

5.3.2.6 RAPS Duplicate Diagnosis Cluster Report

This report lists diagnosis clusters with a 502-error information message (diagnosis cluster was accepted but not stored) appearing on the RAPS Return File and the RAPS Transaction Error Report. Clusters appearing on this report had been submitted previously to CMS; that is, a cluster with the same HIC number, provider type, from and through dates, and diagnosis are already stored in the RAPS database. Figure 5J illustrates the file layout and provides a key to the fields.

Organizations are notified through a www.csscooperations.com update when this report is available.



MA organizations that submit using Connect:Direct do not have to obtain the Duplicate Diagnosis Cluster Report. Connect:Direct submitters are usually large-volume users, and they can reference the RAPS Return File to review 502 informational messages.

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(1) REPORT: RAPS002		(2) RISK ADJUSTMENT PROCESSING SYSTEM DUPLICATE DIAGNOSIS CLUSTER REPORT										(3) PAGE: 22		
(4) RUN DATE: 20030523												(5) TRANS DATE: 20030521		
(6) SUBMITTER ID:SH9999		(7) FILE ID: 0000000001		(8) PLAN: H9999		(9) BATCH NUMBER: 0000001								
(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)
SEQ	SEQ	PATIENT CONTROL	HIC	HIC	DOB	DOB	PVDR	FROM	THRU	DEL	DGNS	DGNS	DGNS	CORRECTED
NO	ERR	NUMBER	NUMBER	ERR		ERR	TYPE	DATE	DATE	IND	CODE	ERR1	ERR2	HIC
0000003			999999999A		19301206		01	20030101	20030105		4823	502		
00000000000000000012345678901234567890														

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Submitters should consider establishing an automated system or a process that checks previously submitted files for accepted diagnosis clusters in order to minimize or eliminate the resubmission of duplicate diagnosis clusters.

While this is an informational error and does not require action in terms of correcting an error, it is critical that plans self-monitor their submissions so that they do not exceed the 5 percent benchmark requirement on 502 errors. Table 5M provides tips to ensure plans are compliant with the guidance on the 5 percent benchmark for duplicate diagnosis cluster errors.

**TABLE 5M – TIPS FOR ENSURING COMPLIANCE WITH THE 5 PERCENT BENCHMARK
FOR DUPLICATE DIAGNOSIS CLUSTER ERROR GUIDANCE**

TIP	DESCRIPTION
Tip 1: 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.
Tip 2: Review Your Reports	Review your current and previous RAPS Return Files to determine which clusters were stored. If the cluster was stored, do not resubmit.
Tip 3: Understand Error Resolution	If you are resolving an error, you do not necessarily need to resubmit all clusters included in the record. If you are resolving a 300-level error, this indicates that none of the diagnosis clusters were stored because there was a record level error. If this is the case, you will need to resubmit all clusters associated with the record. This would not create a duplicate diagnosis because none of the records were previously stored. If you are resolving a 400-level error, this indicates that a specific diagnosis cluster was not stored. You should only resubmit the specific cluster that resulted in the 400-level error message. <i>Do not</i> resubmit all clusters within the record. If there were ten clusters within the record, but you received a 400-level error message on only two of the clusters, you should only resubmit the two clusters where the error occurred.
Tip 4: Understanding Modifying Data	In the case of self-identified errors, those not reported as an error on the RAPS reports, you should be careful to only resubmit the diagnosis clusters that require a modification. If you submit a record with eight clusters, but the following week you realize that the date of service was incorrect in one of the clusters, you would 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.

Use the tips above to assist your plan in reducing or eliminating the submission of duplicate diagnosis clusters to avoid implications that may result in suspension of data submission privileges and ultimately impact your payments.



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Example: 9

Scenario:

Blue Health Plan submitted a CCC record with seven diagnosis clusters in which the sixth diagnosis cluster received an error indicating the diagnosis was not appropriate for the patient sex.

Results:

The CCC record with the seven diagnosis clusters received a cluster level error, error code 453 on the sixth cluster. The only cluster not accepted and stored from this CCC record is the sixth cluster. Therefore, the only cluster that should be resubmitted by Blue Health Plan is the sixth cluster, the one that received the error. Resubmitting the other diagnosis clusters that were accepted and stored would result in the Blue Health Plan receiving error code 502 for submitting duplicate diagnosis clusters. This would count against the plan's 5% benchmark.

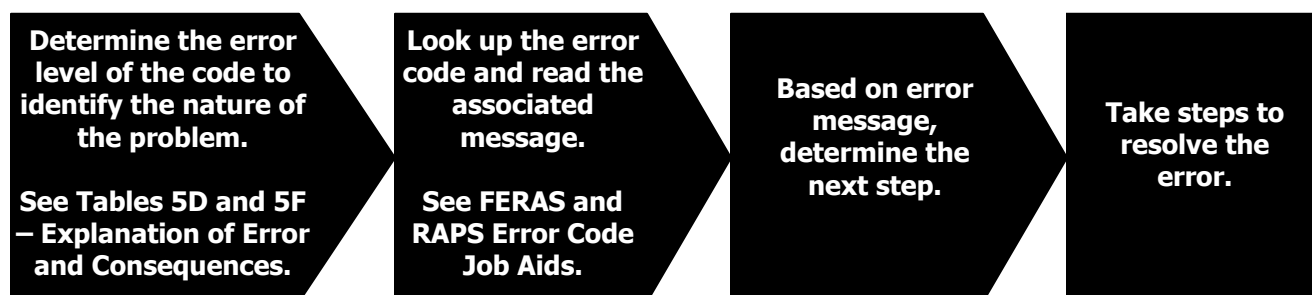
5.4 Resolving Errors

CMS began accepting risk adjustment data in FERAS and processing data through RAPS in October 2002. While the error rate is less than one percent, there are several errors that represent the majority of the common errors seen.

5.4.1 Resolution Steps

It is the MA organization's responsibility to resolve errors that CMS identifies. Described below in Figure 5K are the basic steps required to resolve errors. If inaccurate data are the cause of the error, the organization must submit a new record with corrected information to resolve the error.

Figure 5K – Resolution Steps



System problems may occur when MA organizations submit and delete the same diagnosis cluster several times on the same day. Error code 492 occurs if the organization tries to delete the same cluster more than once.



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Example: 10

Scenario: John Smart at BaseCare Health Plan deleted a diagnosis cluster. Later the same day, he mistakenly added the same cluster using Direct Data Entry (DDE). Realizing his mistake, John immediately attempted to delete this cluster using DDE.

Results: The error code 492 occurs, indicating that (1) the diagnosis cluster was not successfully deleted and (2) that the cluster is already stored as a delete and another delete is not necessary.

Effective January 3, 2006, CMS added error code 455 to the RAPS Error Codes list. The message reads "Diagnosis cluster not edited due to record format error." The diagnosis cluster is not stored. A plan will receive this error if the plan leaves a cluster blank within a CCC record, and then populates the next cluster. Error code 455 clusters may occur with, or after, the first blank diagnosis cluster. Blank clusters will not receive a 455 error.

When a submitter receives a 455-error code, "Diagnosis Cluster Not Edited Due to Record Format Error," apply the resolution steps outlined in Figure 5K:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The error code series 400-489 indicates that all possible diagnosis edits were performed but the diagnosis cluster is not stored.
- The submitter should ensure that the CCC record contains valid clusters, left justified in the record, followed by blank clusters.
- Resubmit following correction.



Example: 11

Scenario: Horizon Valley Health Plan submitted eight diagnosis clusters. However, the fifth diagnosis cluster was a blank cluster.

Results: Error code 455 occurs. All of the diagnosis clusters following the blank cluster received the error code 455. All possible diagnosis edits were performed, but the diagnosis clusters were not stored.



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5.4.2 Common Errors

In an effort to prevent common errors, the next section describes the errors and steps that MA organizations may take to minimize their occurrence.

5.4.2.1 File Name Duplicates Another File Accepted Within Last 12 Months

To identify the unique file that has been accepted, CMS requires that all files include a 10-digit alpha-numeric file ID. This file ID is required when submitting test or production data. Once a file ID has been submitted and accepted in test or production, the same file ID may not be submitted on any other files within 12 months.



Example: 12

SenCare Health Plan submitted a risk adjustment inpatient transaction file in August 2002 and a risk adjustment physician transaction test file in August 2002. The plan cannot submit both files with the same file ID within 12 consecutive months (between August 2002 and August 2003).

Prevention

Submitters should consider establishing an automated system to assign a file sequence number during the establishment of the data file.

Correction

When a submitter receives a 113-error code, "File name duplicates another file accepted within the last 12 months", the following steps should be taken:

- Since this is a 100-level error code message, the submitter will refer to the AAA record.
- The error code 113, describes the field within the AAA record that must be corrected.
- The submitter must enter a valid 10-digit file ID in AAA 3.
- The file must be resubmitted following correction.



Since this file was rejected by FERAS, it will not be processed in RAPS until the data are corrected.

5.4.2.2 Delete Error, Diagnosis Cluster Previously Deleted

When a plan submits a delete and RAPS accepts it, the cluster is not physically deleted from the RAPS database. The RAPS database stores a "D" in the delete indicator and enters a delete date to indicate when the diagnosis was deleted. If a plan tries to delete the exact same diagnosis cluster at a later time, the system will generate a 491-error code, informing the plan that the cluster was already deleted.



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Prevention

This issue normally occurs when plans delete all clusters from a previously submitted file, and the original file included duplicate diagnosis clusters. One way to prevent the errors is to check for duplicate diagnosis clusters prior to submitting the file with the deletes on it.

Correction

There is no corrective action necessary because the 491-error code indicates that the cluster has already been deleted.

5.4.2.3 Diagnosis Cluster Not Successfully Deleted. Another Diagnosis Cluster With the Same Attributes Was Already Deleted From the RAPS Database On This Date

When plans submit delete records, the "D" indicator and the delete date become part of the unique database key for the diagnosis cluster. Diagnosis clusters must have one unique attribute in the database key in order to be stored. The 492-error code occurs when a plan deletes, adds, and then attempts to delete the exact same cluster during a single processing day. The delete will successfully process, as will the following add transaction. The add transaction will create a new record for this diagnosis cluster. The second delete cannot process, since accepting the second delete will cause the creation of a duplicate record in the RAPS database. This error is different from the 491 in that the last record on file will be the add record; that is, the diagnosis cluster has not been successfully deleted.

Prevention

Again, this error normally occurs when plans submit large files of correction records. Plans should check when deleting records that they are not adding the exact same cluster in the same file, or on different files on the same day. If a plan detects multiple submissions of the same diagnosis cluster, the plan should determine the final status of the cluster, deleted or active, and take appropriate action.

Correction

When a submitter receives a 492-error code, "Diagnosis Cluster Not Successfully Deleted", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the CCC record.
- The error code series 490-499 indicates that it is a deletion problem.
- The submitter must determine if the diagnosis cluster should be deleted or active as a final action.
- If the cluster should be active, no further action is required.
- If the diagnosis is supposed to be deleted, the plan must submit one delete record. Since any future submissions will have a different delete date than any other clusters on file, a single delete record will successfully process.



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5.4.2.4 Service From Date Is Not Within MA Organization Enrollment

MA organizations can reduce the numbers of errors that are returned due to invalid eligibility by accessing the common user interface to determine eligibility and other demographic information stored on the common tables. Implementing the following procedures can reduce time spent on resolving errors.

- Develop a monthly validation protocol verifying eligibility of MA organization enrollees.
- Program internal information systems that cross check the common tables before submitting data to FERAS.

The Beneficiary Eligibility and Beneficiary Detail screens in the common user interface provide information that supports the MA risk adjustment requirements. The information includes:

- Date of birth.
- HIC Number.
- Medicare effective date.
- Medicare termination date.

Note: MA organizations can manually research each beneficiary online or electronically research beneficiaries in batches using the Batch Eligibility Query Request File.

The beneficiary receiving services under the MA program must be enrolled in Medicare during the service period. The dates of service reported in the diagnosis clusters must be within the enrollment dates that are posted on the common tables. RAPS cross-references the common tables to verify that the beneficiary was covered during the identified from and through dates of service. Prior to March 2003, MA organizations received the 408- and 409-error codes to reflect data inconsistencies between various CMS systems.



The 408-error code occurs with all data. The 409-error code occurs only with hospital outpatient and physician data.

Prevention

Submitters should check the from and through dates of service against internal enrollment records. Remember that for hospital outpatient and physician data, both the from and through dates must be within MA enrollment periods. For hospital inpatient data, only the from dates must be within MA enrollment periods. Performing these pre-edits will minimize the number of errors received regarding enrollment information.

Correction

When a submitter receives a 408-error code "Service from date is not within MA organization enrollment period", or a 409-error code "Service through date is not within MA organization enrollment period", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.



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- The submitter must ensure that the correct service through date was entered in CCC 9.2.
- The submitter should check these dates against the plan enrollment dates in the common tables.
- If the submitter determines that there are discrepancies in the data in CMS systems, contact CSSC.
- If the CSSC determines that the common tables require updated plan enrollment data, contact the MMA Help Desk.
- After the data have been corrected, resubmit.



Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

5.4.2.5 Beneficiary Is Not Enrolled In Plan On or After Service From Date

Beneficiaries must be enrolled in the plan on or after the date of the service provided.

Prevention

Using information from the monthly membership report and internal enrollment files, submitters should be knowledgeable regarding the enrollment and eligibility of their beneficiaries. Establishing a systematic beneficiary enrollment tracking system will reduce the number of errors associated with this edit.



The 408- and 409-error code messages indicate that the service occurred while the beneficiary was not participating in *any* MA program. The 410-error code message indicates that the service occurred while the beneficiary was not enrolled in *your* organization.

Correction

When a submitter receives a 410-error code "Beneficiary is not enrolled in 'your' plan on or after service from date", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter should check the service from date against the plan enrollment dates to confirm that the beneficiary was enrolled in their plan on or after the from date.
- If the submitter determines that there are discrepancies in the beneficiary's enrollment data in CMS systems, contact the MMA Help Desk.
- After the data have been corrected, resubmit.





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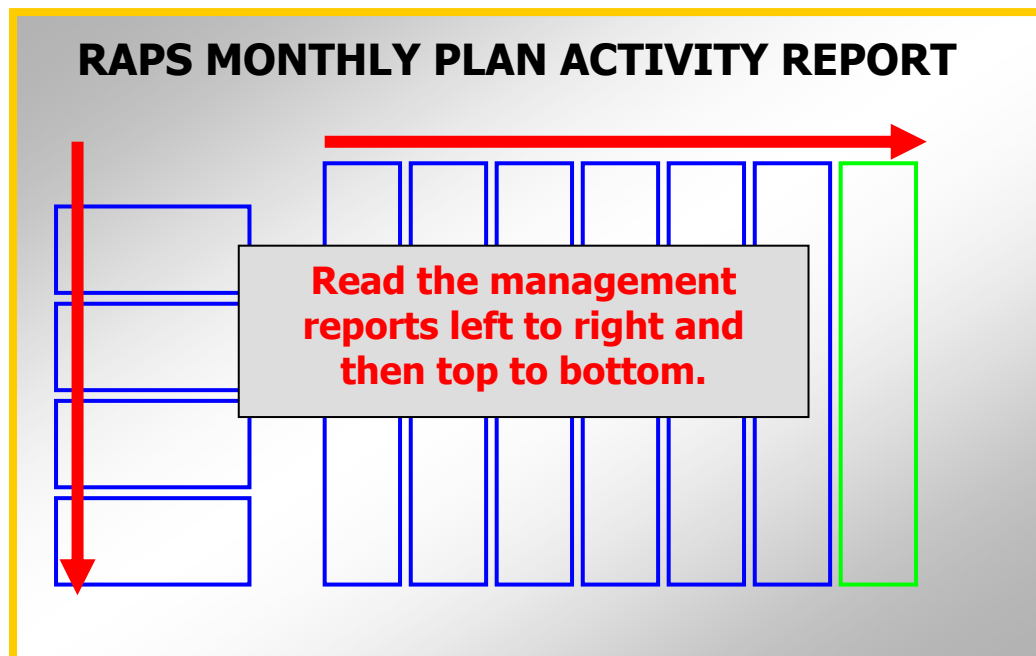
Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

5.5 RAPS Management Reports

CMS developed four management reports that provide detail on the amount of data submitted and stored for each provider type and any error codes associated with processing. The reports are delivered to the user on the second business day of the month.

When reviewing the management reports, it is helpful to read the report from left to right and then from top to bottom as illustrated in Figure 5L.

Figure 5L – Analysis of Management Reports



5.5.1 RAPS Monthly Plan Activity Report

The RAPS Monthly Plan Activity Report provides a summary of the status of all submissions by the submitter ID and plan number (H number). It allows MA organizations to validate the diagnoses submitted for a 1-month period. The report is arrayed by provider type and month (determined by through date of service). The report displays information by submitter ID and H number, and displays six months of data on each page. Figure 5M illustrates the report and its fields.



Delivered to users on the second business day of the month.

This report allows MA organizations to validate submitted diagnoses during a 1-month period, based on the date of service (through date). MA organizations can determine the number of clusters sent and



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processed during the month, and the status of that data (accepted, rejected, stored, model stored, and accepted and rejected deletes) by source. By analyzing this report, the MA organization can determine if they are receiving and submitting sufficient data from sources, and the rejection rates for each data source. All this information is helpful in managing the data collection, data submission, and error resolution processes.



The total diagnosis clusters stored includes all non-duplicate clusters accepted, while the total model stored includes only diagnosis clusters identified in the CMS-Hierarchical Condition Category (HCC) model.

Figure 5M – RAPS Monthly Plan Activity Report Layout

[1]REPORT: RAPS0010		CMS RAPS ADMINISTRATION					[2]PAGE: 2	
[3]RUN DATE: 20040503		[4] RAPS MONTHLY PLAN ACTIVITY REPORT					[5] SERVICE YEAR: 2003	
[6]SUBMITTER ID: SH7777		[7]FOR THE MONTH OF APRIL, 2004						
[8]PLAN ID: H7777								
PROVIDER TYPE/TOTALS	[9]	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT								
[10]TOTAL SUBMITTED		19	25	28	73	404	1704	2253
[11]TOTAL REJECTED		10	7	11	19	106	426	579
[12]TOTAL ACCEPTED		9	18	17	54	298	1248	1674
[13]TOTAL STORED		9	18	17	54	298	1248	1674
[14]TOTAL MODEL STORED		5	8	12	27	158	646	856
[15]TOTAL DELETE ACPTD		0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD		0	0	0	0	0	0	0
OTHER INPATIENT								
[10]TOTAL SUBMITTED		103	113	143	407	244	10561	13774
[11]TOTAL REJECTED		49	44	55	112	638	2634	3532
[12]TOTAL ACCEPTED		54	69	88	295	1809	7927	10242
[13]TOTAL STORED		54	69	88	295	1809	7927	10242
[14]TOTAL MODEL STORED		18	24	26	95	575	2574	3312
[15]TOTAL DELETE ACPTD		0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD		0	0	0	0	0	0	0
OUTAPTIENT								
[10]TOTAL SUBMITTED		329	490	761	1691	9526	33693	46490
[11]TOTAL REJECTED		115	179	219	531	2523	8769	12336
[12]TOTAL ACCEPTED		214	311	542	1160	7003	24924	34154
[13]TOTAL STORED		214	311	542	1160	7003	24924	34154
[14]TOTAL MODEL STORED		35	82	135	244	1779	5305	7580
[15]TOTAL DELETE ACPTD		0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD		0	0	0	0	0	0	0
PHYSICIAN								
[10]TOTAL SUBMITTED		2450	3221	4812	12429	31573	130564	185049
[11]TOTAL REJECTED		224	206	527	928	2039	6026	9950
[12]TOTAL ACCEPTED		2226	3015	4285	11501	29534	124538	175099
[13]TOTAL STORED		2226	3015	4285	11501	29534	124538	175099
[14]TOTAL MODEL STORED		608	721	1116	2797	7426	29413	42117
[15]TOTAL DELETE ACPTD		0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD		0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE



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Figure 5M– RAPS Monthly Plan Activity Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Page Number	Page number of the report. Six months arrayed per page.
3	Report Run Date	Date CMS generated the report.
4	Report Full Name	Full name of the report.
5	Service Year	The year of the service through date.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization (H number).
7	Report Year and Date	Month and year of the submission.
8	Plan Number	H number assigned by CMS; a different report is printed for each organization (H number).
9	Month	The month of the service through date.
10	Total Submitted	The total number of clusters submitted during the report period by the MA organization.
11	Total Rejected	The total number of clusters submitted during the report period by the MA organization rejected due to errors.
12	Total Accepted	The total number of clusters submitted during the report period by the MA organization accepted without errors.
13	Total Stored	The total number of clusters submitted by the MA organization and accepted by RAPS during the report period, and stored in the database (does not include duplicates if identical clusters already stored in the database).
14	Total Model Stored	The total number of required diagnosis clusters submitted by the MA organization and accepted by RAPS during the report period, and stored in the database.
15	Total Deletes Accepted	The total number of deleted clusters submitted by the MA organization during the report period that were accepted with no errors.
16	Total Deletes Rejected	The total number of deleted clusters submitted by the MA organization during the report period that were rejected with errors.



Example: 13

An MA organization's management can determine how effectively it has submitted data by reviewing the number of clusters submitted and stored on a monthly basis. Figure 5N illustrates that the submissions for service year 2004 are going relatively well. There is an error rate of approximately three percent during the period identified on page 2 of the April 2004 report. The error rate is calculated by dividing the total records rejected into the total submitted; for example, April 2004 principal inpatient has 26 rejected out of 824 submitted, a three percent error rate. There is very little lag between the date of the visit or stay and the date those data were collected and submitted. For every inpatient principal diagnosis on page 2 of the March 2004 report, there are four secondary diagnoses, which is appropriate.

An area of concern may be the number of physician services. In the April 2004 report, no data for physicians were submitted with dates of service between July 2003 and December 2003. However, 350 clusters with dates of service between January 2004 and April 2004 were submitted. For all data with dates of service between January 2004 and April 2004, only seven percent of the data were from physicians. It is typical for about three-quarters of the data submitted to be from physicians, so this finding might be indicative of a problem. However, this may be explainable if the organization simply



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submitted its physician data before April 1 or after April 30, (i.e., the organization is submitting sufficient data, but did not send any physician data in April). Management should compare the data submitted during the previous month and take the MA organization's enrollment into account when interpreting this report and resolving potential issues.

During the month of April there was a group of clusters submitted for services performed in September 2003. One explanation for this could be difficulty collecting from particular providers. The error rate for the September 2003 data was 92 percent. Management should consider identifying the sources of that data and offering outreach or training to prevent this problem from occurring in the future.



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Figure 5N – RAPS Monthly Plan Activity Report

REPORT: RAPS0010
RUN DATE: 20040402

CMS RAPS ADMINISTRATION
RAPS MONTHLY PLAN ACTIVITY REPORT

PAGE: 2
SERVICE YEAR: 2003

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF MARCH, 2004

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	20915	17891	1739	1365	1721	2837	46468
TOTAL REJECTED	209	93	33	27	35	55	452
TOTAL ACCEPTED	20706	17798	1706	1338	1686	2782	46016
TOTAL STORED	20706	17798	1706	1338	1686	2782	46016
TOTAL MODEL STORED	17186	14772	599	455	573	946	34531
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	69458	47939	19020	14618	14264	20945	186244
TOTAL REJECTED	695	240	381	293	274	419	2302
TOTAL ACCEPTED	68763	47699	18639	14325	13990	20526	183942
TOTAL STORED	68763	47699	18639	14325	13990	20526	183942
TOTAL MODEL STORED	57073	39114	5965	4584	4285	6568	117589
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	60838	59543	11621	21381	23879	47758	225020
TOTAL REJECTED	61	30	175	321	359	717	1663
TOTAL ACCEPTED	60777	59513	11446	21060	23520	47041	223357
TOTAL STORED	60777	59513	11446	21060	23520	47041	223357
TOTAL MODEL STORED	50445	48801	3892	7161	7997	15994	134290
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	172301	101277	179713	173688	214495	129995	971469
TOTAL REJECTED	1723	1013	3595	3474	4290	2600	16695
TOTAL ACCEPTED	170578	100264	176118	170214	210205	127395	954774
TOTAL STORED	170578	100264	176118	170214	210205	127395	954774
TOTAL MODEL STORED	141580	83219	61642	59575	73572	44589	464177
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010
RUN DATE: 20040402

CMS RAPS ADMINISTRATION
RAPS MONTHLY PLAN ACTIVITY REPORT

PAGE: 1
SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF MARCH, 2004

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1297	1301	293	0	0	0	2891
TOTAL REJECTED	26	26	0	0	0	0	52
TOTAL ACCEPTED	1261	1275	288	0	0	0	2824
TOTAL STORED	1235	1269	283	0	0	0	2787
TOTAL MODEL STORED	432	444	99	0	0	0	975
TOTAL DELE ACPTD	10	0	5	0	0	0	15
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	8431	13489	411	0	0	0	22331
TOTAL REJECTED	169	270	3	0	0	0	442
TOTAL ACCEPTED	8262	13219	405	0	0	0	21886
TOTAL STORED	8261	13216	404	0	0	0	21881
TOTAL MODEL STORED	2891	4625	141	0	0	0	7657
TOTAL DELE ACPTD	0	0	1	0	0	0	1
TOTAL DELE RJCTD	0	0	2	0	0	0	2
OUTPATIENT							
TOTAL SUBMITTED	23415	17342	84	0	0	0	40841
TOTAL REJECTED	351	260	3	0	0	0	614
TOTAL ACCEPTED	23064	17081	81	0	0	0	40226
TOTAL STORED	20989	15199	77	0	0	0	36265
TOTAL MODEL STORED	7346	5320	27	0	0	0	12693
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	1	0	0	0	0	1
PHYSICIAN							
TOTAL SUBMITTED	111207	189171	0	0	0	0	300378
TOTAL REJECTED	2224	3783	0	0	0	0	6007
TOTAL ACCEPTED	108983	185388	0	0	0	0	294371
TOTAL STORED	108978	164995	0	0	0	0	273973
TOTAL MODEL STORED	38142	57748	0	0	0	0	95890
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010
RUN DATE: 20040503

CMS RAPS ADMINISTRATION
RAPS MONTHLY PLAN ACTIVITY REPORT

PAGE: 2
SERVICE YEAR: 2003

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF APRIL, 2004

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	0	0	74	0	0	0	74
TOTAL REJECTED	0	0	60	0	0	0	60
TOTAL ACCEPTED	0	0	14	0	0	0	14
TOTAL STORED	0	0	14	0	0	0	14
TOTAL MODEL STORED	0	0	6	0	0	0	6
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	0	0	296	0	0	0	296
TOTAL REJECTED	0	0	280	0	0	0	280
TOTAL ACCEPTED	0	0	16	0	0	0	16
TOTAL STORED	0	0	7	0	0	0	7
TOTAL MODEL STORED	0	0	2	0	0	0	2
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010
RUN DATE: 20040503

CMS RAPS ADMINISTRATION
RAPS MONTHLY PLAN ACTIVITY REPORT

PAGE: 1
SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF APRIL, 2004

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	100	435	200	89	0	0	824
TOTAL REJECTED	0	4	20	2	0	0	26
TOTAL ACCEPTED	100	429	180	87	0	0	796
TOTAL STORED	90	420	180	80	0	0	770
TOTAL MODEL STORED	30	152	52	26	0	0	260
TOTAL DELE ACPTD	0	2	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	400	1740	696	348	0	0	3184
TOTAL REJECTED	12	52	21	10	0	0	95
TOTAL ACCEPTED	388	1688	666	338	0	0	3080
TOTAL STORED	386	1668	661	333	0	0	3048
TOTAL MODEL STORED	135	583	232	117	0	0	1067
TOTAL DELE ACPTD	0	0	2	0	0	0	2
TOTAL DELE RJCTD	0	0	7	0	0	0	7
OUTPATIENT							
TOTAL SUBMITTED	0	377	252	0	0	0	629
TOTAL REJECTED	0	10	8	0	0	0	18
TOTAL ACCEPTED	0	362	244	0	0	0	606
TOTAL STORED	0	350	231	0	0	0	581
TOTAL MODEL STORED	0	123	80	0	0	0	203
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	5	0	0	0	0	5
PHYSICIAN							
TOTAL SUBMITTED	308	40	0	0	0	0	350
TOTAL REJECTED	9	4	0	0	0	0	13
TOTAL ACCEPTED	299	36	0	0	0	0	335
TOTAL STORED	284	36	0	0	0	0	320
TOTAL MODEL STORED	99	13	0	0	0	0	112
TOTAL DELE ACPTD	2	0	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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5.5.2 RAPS Cumulative Plan Activity Report

The RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions. The report is arrayed by provider type and month (determined by through date of service), and reports information by submitter ID and H number. Figure 50 illustrates the report and its fields.



The Cumulative Plan Activity Report is delivered to users on the second business day of each month.

Figure 50 – RAPS Cumulative Plan Activity Report Layout

[1]REPORT: RAPS0010		CMS RAPS ADMINISTRATION				[2]PAGE: 2	
[3]RUN REPORT: DATE: 20040503		[4] RAPS CUMULATIVE PLAN ACTIVITY REPORT				[5]SERVICE YEAR: 2003	
[6]SUBMITTER ID: SH7777		[7]FOR PERIOD ENDING APRIL 30, 2004					
[8]PLAN NO: H7777							
PROVIDER TYPE/TOTALS	[9]JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
[10]TOTAL SUBMITTED	22	25	40	29	39	61	216
[11]TOTAL REJECTED	0	0	2	0	3	1	6
[12]TOTAL ACCEPTED	22	25	38	29	36	60	210
[13]TOTAL STORED	22	25	38	29	36	60	210
[14]TOTAL MODEL STORED	18	24	26	23	33	44	168
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
[10]TOTAL SUBMITTED	56	92	157	108	99	178	690
[11]TOTAL REJECTED	0	0	8	0	15	4	27
[12]TOTAL ACCEPTED	56	92	149	108	84	174	663
[13]TOTAL STORED	56	92	149	108	84	174	663
[14]TOTAL MODEL STORED	29	67	66	58	51	104	375
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
[10]TOTAL SUBMITTED	7	4	3	19	8	16	57
[11]TOTAL REJECTED	0	0	0	0	0	0	0
[12]TOTAL ACCEPTED	7	4	3	19	8	16	57
[13]TOTAL STORED	7	4	3	19	8	16	57
[14]TOTAL MODEL STORED	7	4	3	19	8	16	57
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
[10]TOTAL SUBMITTED	14	28	14	13	37	16	122
[11]TOTAL REJECTED	0	0	4	6	1	0	11
[12]TOTAL ACCEPTED	14	28	10	7	36	16	111
[13]TOTAL STORED	13	26	10	7	31	14	101
[14]TOTAL MODEL STORED	13	26	10	7	31	14	101
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE



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Figure 50 – RAPS Cumulative Plan Activity Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Page Number	Page number of the report. Six months arrayed per page.
3	Report Run Date	Date CMS generated the report.
4	Report Full Name	Full name of the report.
5	Service Year	The year of the service through date.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one MA organization (H-number).
7	Report Year and Date	Month and year of the submission.
8	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
9	Month	The month of the service through date.
10	Total Submitted	The total number of clusters submitted during the report period.
11	Total Rejected	The total number of clusters submitted during the report period that were rejected due to errors.
12	Total Accepted	The total number of clusters submitted during the report period that were accepted without errors.
13	Total Stored	The total number of required diagnosis clusters submitted, accepted, and stored and were not duplicates.
14	Total Model Stored	The total number of required , diagnosis clusters submitted, accepted stored and included in the current risk adjustment model during the report period.
15	Total Deletes Accepted	The total number of deleted clusters submitted during the report period that were accepted without errors.
16	Total Deletes Rejected	The total number of deleted clusters submitted during the report period that were rejected with errors.

A service year of 9999 on a Monthly or Cumulative Plan Activity Report indicates that the data submitted have not been appropriately stored and have been rejected. The RAPS Return File will list error codes 402 (invalid service through date on CCC record) and 403 (service through date must be greater than December 31, 2002). With each of these error codes, the system cannot recognize and properly file the rejected data since the dates of service are either outside of the reporting period or unrecognizable. Data that cannot be associated with one of the years on the Monthly and Cumulative Plan Activity Reports must be filed in the service year of 9999.



Example: 14

Using the RAPS Cumulative Plan Activity Report, the MA organization can effectively monitor the quantity of data submitted for each provider type. The submission numbers are higher for previous months than the more current dates of service months, which indicate a lag between the dates of service provided, collected, and submitted. Comparing Figure 8K to the Cumulative Plan Activity Report (Figure 8M) illustrates April transactions accounted for very few of the January, February, and March numbers indicating collection and submission problems in the month of April. This can be explained by new staff, competing internal priorities, or system implications. Management should consider the root cause of this decline to prevent this in the future.

The third page of this report indicates diagnosis clusters submitted where the service dates could not be identified. These are reported on the service year 9999.



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Figure 5P – RAPS Cumulative Plan Activity Report

RAPS0020	CMS RAPS ADMINISTRATION					PAGE:	2
RUN REPORT:	DATE: 20040503	RAPS CUMULATIVE PLAN ACTIVITY REPORT				SERVICE YEAR:	2003
SUBMITTER ID:	SH7777	FOR PERIOD ENDING APRIL 30, 2004					
PLAN NO:	H7777						
PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	62747	53673	5389	4096	5162	8517	139584
TOTAL REJECTED	627	278	108	82	103	170	1368
TOTAL ACCEPTED	62120	53395	5281	4014	5059	8347	138216
TOTAL STORED	62120	53395	5281	4014	5059	8347	138216
TOTAL MODEL STORED	51560	44316	1796	1365	1720	2838	103595
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	208372	143816	57058	43852	40989	62833	556920
TOTAL REJECTED	2084	719	1141	877	820	1257	6898
TOTAL ACCEPTED	206288	143097	55917	42975	40169	61576	550022
TOTAL STORED	206288	143097	55917	42975	40169	61576	550022
TOTAL MODEL STORED	171219	117340	17893	13752	12854	19704	352762
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	182512	178628	34860	64142	71635	143270	675047
TOTAL REJECTED	183	89	523	962	1075	2149	4981
TOTAL ACCEPTED	182329	178539	34337	63180	70560	141121	670066
TOTAL STORED	182329	178539	34337	63180	70560	141121	670066
TOTAL MODEL STORED	151333	146402	11675	21481	23990	47981	402862
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	516903	303829	539136	521062	643485	389984	2914399
TOTAL REJECTED	5169	3038	10783	10421	12870	7799	50080
TOTAL ACCEPTED	511734	300791	528353	510641	630615	382185	2864319
TOTAL STORED	511734	300791	528353	510641	630615	382185	2864319
TOTAL MODEL STORED	424739	249657	184924	178724	220715	133765	1392524
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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Figure 5P – RAPS Cumulative Plan Activity Report (continued)

REPORT: RAPS0020	CMS RAPS ADMINISTRATION						PAGE: 1
RUN DATE: 20040503	RAPS CUMULATIVE PLAN ACTIVITY REPORT						SERVICE YEAR: 2004
SUBMITTER ID: SH7777	FOR PERIOD ENDING APRIL 30, 2004						
PLAN NO: H7777							
PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	3891	3905	879	91	0	0	8766
TOTAL REJECTED	77	78	2	2	0	0	159
TOTAL ACCEPTED	3784	3825	863	89	0	0	8561
TOTAL STORED	3704	3808	849	80	0	0	8441
TOTAL MODEL STORED	1296	1333	297	26	0	0	2952
TOTAL DELE ACPTD	30	2	14	0	0	0	46
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	25292	40467	1234	348	0	0	67341
TOTAL REJECTED	506	809	9	10	0	0	1334
TOTAL ACCEPTED	24786	39658	1216	338	0	0	65998
TOTAL STORED	24784	39648	1211	333	0	0	65976
TOTAL MODEL STORED	8674	13876	423	117	0	0	23090
TOTAL DELE ACPTD	0	0	2	0	0	0	2
TOTAL DELE RJCTD	0	0	7	0	0	0	7
OUTPATIENT							
TOTAL SUBMITTED	70246	52027	252	0	0	0	122525
TOTAL REJECTED	1053	780	8	0	0	0	1841
TOTAL ACCEPTED	69193	51242	244	0	0	0	120679
TOTAL STORED	62966	45598	231	0	0	0	108795
TOTAL MODEL STORED	22038	15959	80	0	0	0	38077
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	5	0	0	0	0	5
PHYSICIAN							
TOTAL SUBMITTED	333621	567512	0	0	0	0	901133
TOTAL REJECTED	6672	11350	0	0	0	0	18022
TOTAL ACCEPTED	326949	556162	0	0	0	0	883111
TOTAL STORED	326934	494984	0	0	0	0	821918
TOTAL MODEL STORED	114426	173244	0	0	0	0	287670
TOTAL DELE ACPTD	2	0	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0

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```
REPORT:   RAPS0020                CMS RAPS ADMINISTRATION                PAGE:   1
RUN DATE: 20040503                RAPS CUMULATIVE PLAN ACTIVITY REPORT    SERVICE YEAR: 9999

SUBMITTER ID:   SH7777                FOR PERIOD ENDING APRIL 30, 2004
PLAN NO:        H7777
```

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	25	0	0	0	0	0	25
TOTAL REJECTED	25	0	0	0	0	0	25
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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5.5.3 Correcting Rejected Data

When MA organizations correct data that originally received errors in RAPS, the originally rejected data are still reflected on the cumulative totals for the appropriate month, and in the number of total rejections. After a diagnosis cluster is counted as stored, it remains part of the stored count on the RAPS Cumulative Plan Activity Report even if it is later deleted. When MA organizations delete a cluster, the number is included in the total stored as well as the total deleted.



Example: 15

The April RAPS Cumulative Plan Activity Report (Figure 5P) displays a high reject rate in the data submitted for dates of service July – September (page 2 of the report). The report shows the plan corrected the previously submitted errors and began submitting data more accurately. The April Cumulative Report reflects that the rate of rejection (Total Rejected) remained high for July – September, but decreased for October – December.

5.5.4 RAPS Error Frequency Reports

The two RAPS Error Frequency Reports, Monthly and Quarterly, provide a summary of the number of errors submitted during the reporting period. This includes files submitted in test and production arrayed by error code and provider type. The reports are generated by submitter ID and plan number (H number). These reports are an effective tool that MA organizations can use to analyze error codes and frequency and reconcile data submissions. In addition, the reports include the total number of CCC records, total diagnoses, and total accepted and rejected diagnosis clusters.

Both the Monthly and Quarterly RAPS Error Frequency Reports utilize the report layout illustrated in Figure 5Q, however the report names differ as follows:

- RAPS Monthly Error Frequency Report: RAPS04M
- RAPS Quarterly Error Frequency Report: RAPS04Q

The monthly report provides summary information for a month; the quarterly report provides summary information for a 3-month period.



The Monthly RAPS Error Frequency Report is delivered to users on the second business day of the month.



The Quarterly RAPS Error Frequency Report is delivered to users on the second business day of the month following each quarter's end date.



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Figure 5Q - RAPS Monthly Error Frequency Report Layout

```

[1] REPORT:      RAPS04M
[3] RUN TIME:    10.06.09
[6] SUBMITTER ID: SH9999
[8] PLAN NO:     H9999

                                PALMETO GBA
                                [4] RISK ADJUSTMENT PROCESSING
                                ERROR FREQUENCY SUMMARY
                                [5] RUN DATE: 20050502
                                [2] PAGE:      1
                                [7] FOR THE MONTH OF APRIL, 2005

[9] TOTAL CCC RECORDS: 7,831 [10] TOTAL DIAGNOSIS: 16,465 [11] TOTAL ACCEPTED: 14,517 [12] TOTAL REJECTED: 1,948

[13]      [14]      [15]      [16]      [17]      [18]
ERROR <==PROVIDER TYPE XX==><==PROVIDER TYPE 01==><==PROVIDER TYPE 02==><==PROVIDER TYPE 10==><==PROVIDER TYPE 20==>
CODE <=UNKNOWN PROV TYPE=> <PRINCIPAL INPATIENT> <==OTHER INPATIENT==> <=====OUTPATIENT=====> <=====PHYSICIAN =====>
353      81          0          0          0          0
354      0           4          32         105         581
408      0          10          73         120         883
409      0           0           0         120         883
410      0          10          73         114         845
460      0           0           0           1          14
500      6           0           0           0           0
501      0          17         140         875         3,927
502      0           7           51         79         1,272

```

FIELD DESCRIPTIONS ON NEXT PAGE



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Figure 5Q – RAPS Monthly Error Frequency Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the Submitter's mailbox.
2	Page Number	Page number of the report.
3	Run Time	Time report was generated.
4	Full Name	Full name of the report.
5	Report Run Date	Date CMS generated the report.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
7	Month	The month of the service through date.
8	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
9	Total CCC Records	Total number of detailed records submitted during the report period.
10	Total Diagnosis	Total number of diagnosis clusters submitted during the report period
11	Total Accepted	The total number of diagnosis clusters submitted during the report period and accepted without errors.
12	Total Rejected	The total number of diagnosis clusters submitted during the report period and rejected with errors.
13	Error Code	Message sent back by CMS indicating there is an error in the data submitted during the report period.
14	Provider Type – Unknown	Indicates the number of errors associated with an unknown provider type. The transactions did not include a valid provider type. Valid provider types are "01", "02", "10", and "20".
15	Provider Type – Principal Inpatient	Identifies the principal inpatient provider source and the quantity of each error code associated with principal inpatient during the report period.
16	Provider Type – Other Inpatient	Identifies the other inpatient provider source and the quantity of each error code associated with other inpatient during the report period.
17	Provider Type – Outpatient	Identifies the outpatient provider source and the quantity of each error code associated with outpatient during the report period.
18	Provider Type – Physician	Identifies the physician provider source and the quantity of each error code associated with physician during the report period.



Example: 16

The sample RAPS Monthly Error Frequency Report (Figure 5R) indicates that the error occurring most frequently was an informational error code (501). However, error code, 410 accounted for the most rejected clusters. There were also high counts of rejected clusters associated with error codes 408 and 409. These error codes are all related to beneficiary enrollment in a specific MA plan or any MA plan in Medicare. Management should investigate possible discrepancies between their internal enrollment systems and the common tables.



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Figure 5R – RAPS Monthly Error Frequency Report

REPORT: RAPS004M

PALMETO GBA

] PAGE: 1

RUN TIME: 13.31.06

RISK ADJUSTMENT PROCESSING
ERROR FREQUENCY SUMMARY

RUN DATE:20050219

SUBMITTER ID: SH9999
PLAN NO: H9999

FOR THE MONTH OF APRIL, 2005

TOTAL CCC RECORDS: 4,647 TOTAL DIAGNOSIS: 17,660 TOTAL ACCEPTED: 15,403 TOTAL REJECTED:2,257

ERROR CODE	<==PROVIDER TYPE XX==> <=UNKNOWN PROV TYPE=>	<==PROVIDER TYPE 01==> <PRINCIPAL INPATIENT>	<==PROVIDER TYPE 02==> <==OTHER INPATIENT==>	<==PROVIDER TYPE 10==> <=====OUTPATIENT=====>	<==PROVIDER TYPE 20==> <=====PHYSICIAN =====>
353	75	0	0	0	0
354	0	7	38	108	618
403	0	1	0	0	0
408	0	14	79	132	859
409	0	0	0	116	782
410	0	12	67	110	980
460	0	0	0	5	12
500	6	0	0	0	0
501	0	18	148	578	2,297
502	0	5	63	97	1,741



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5.6 Analysis of Reports

When analyzing the monthly RAPS management reports, CMS urges MA organizations to consider the following questions:

- "Is my organization collecting enough data from physicians and providers?"
- "Is my organization collecting the correct data from physicians and providers?"
- "Are external issues affecting data collection?"
- "Are internal processes supporting data submissions?"

Each question is discussed below.

5.6.1 Collecting Sufficient Accurate Data

The Monthly Plan Activity Report is a good place to start the analysis. Because this report provides a summary of the status of data submitted for each month, it allows organizations to check, on a monthly basis, the number of diagnosis clusters submitted overall, the number of clusters submitted by data source (hospital inpatient, hospital outpatient, and physician), and the status of those clusters.

Reading the report from left to right, the report identifies the number of clusters submitted in the reporting month (April 2004 in Figure 5P) for every month in the data collection period.



Example: 17

Figure 5S on the next page illustrates a Cumulative Plan Activity Report for April 2004. It reports the number of diagnoses submitted from July 2003 through March 2004. Analysis of this report might begin with a review of the number of clusters submitted by provider (source) type. This plan is doing well because it is submitting the vast majority of its hospital inpatient data for service through dates within 90 days of the report date. If the organization is submitting data at about the same pace received, then the number of clusters seems appropriate, at least for hospital inpatient.



CMS recommends MA organizations collect data from providers and physicians within 90 days of the service through date. Consistent collection lags of more than 90 days may cause problems in submitting data in a timely manner.

The average rate of rejected data is below one percent for MA organizations. The plan in this example has a rejection rate for hospital inpatient services at about nine percent during April. If the other provider type information reflects a similar rate of rejected data, it is higher than it should be and a cause for investigation.



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Figure 5S – Analysis of Cumulative Plan Activity Report

REPORT: RAPS0010	CMS RAPS ADMINISTRATION						PAGE: 1
RUN DATE: 20040501	RAPS CUMULATIVE PLAN ACTIVITY REPORT						SERVICE YEAR: 2003
SUBMITTER ID: SH8888	FOR THE MONTH OF APRIL, 2004						
PLAN NO: H8888							
PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	12	30	21	43	58	101	265
TOTAL REJECTED	5	3	4	5	2	8	27
TOTAL ACCEPTED	7	27	17	38	56	93	238

REPORT: RAPS0010	CMS RAPS ADMINISTRATION						PAGE: 2
RUN DATE: 20040501	RAPS CUMULATIVE PLAN ACTIVITY REPORT						SERVICE YEAR: 2004
SUBMITTER ID: SH8888	FOR THE MONTH OF APRIL, 2004						
PLAN NO: H8888							
PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1940	1944	643	50	0	0	577
TOTAL REJECTED	158	203	54	5	0	0	415
TOTAL ACCEPTED	1782	1741	589	45	0	0	4157

On the Cumulative Report, MA organizations should review the data across the collection period, ensuring that the number of data for each month is consistent. Low submission months or significant spikes in the data submitted for a month may indicate a problem in either data collection from providers and physicians, or issues related to data submission. Generally, each quarter of data should reflect about 25 percent of the expected data for the collection period.

5.6.2 External Issues Affecting Data Collection

When reviewing the management reports, MA organizations should consider external issues that affect data collection. The Cumulative Report is a good place to start analysis because it gauges the number of data collected and submitted over the course of the collection year. For an organization just starting operations, a steady increase in data submissions from month to month is expected. However, an MA organization that has a relatively stable population should have consistent numbers from month to month. Significant fluctuations from month to month may be cause for investigation.

The risk adjustment rules require that for each quarter MA organizations submit approximately 25 percent of the total expected data for the year for each provider type (source). Meeting or exceeding this standard (e.g., submitting monthly or weekly) helps organizations avoid “playing catch up” at the end of the collection year and helps ensure accurate risk adjustment calculation. If data are not submitted in a timely and consistent manner, there may be a data collection issue. Provider education may be necessary to remedy the problem. Also, it may be necessary to check that third party billers used by providers (especially large volume providers) are current on risk adjustment procedures and the importance of timely filing.



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5.6.3 Internal Processes Supporting Data Submissions

The RAPS management reports can help MA organizations identify internal processes negatively affecting data collection and submission. Organizations should check to make certain that data, as it is collected, is properly translated for submission.

MA organizations should take steps to ensure they have, or have access to, the proper medical documentation to support diagnoses being submitted for risk adjustment. MA organizations are responsible for the accuracy of the data submitted to CMS. When necessary, they should obtain the proper documentation to support diagnoses and maintain an efficient system for tracking diagnoses back to medical records.



Example: 18

If the appropriate amount of data are collected from providers and physicians for a month or quarter, but only a fraction of the data are submitted, there may be an over filtering issue, i.e., the plan may not be submitting all required data. Also, the plan should check for higher than normal rejection rates, possibly indicating a problem with the data submission system (bad formatting, assigning the wrong HIC, etc.).

If an organization is submitting well above the benchmark levels, it should check to see if proper filtering occurred before submission. Many plans collect data from provider types not covered by the risk adjustment instructions. Submitting data from these non-covered provider types violates the instructions and will probably cause the diagnostic-to-beneficiary ratios to be high.

5.7 Report Naming Conventions

Table 5N provides the naming conventions for reports placed in the submitter's mailbox.



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TABLE 5N – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
FERAS Response Report	RSP#9999.RSP.FERAS_RESP_ RSP#9999.ZIP.FERAS RESP (zip format)
RAPS Return File	RPT#9999.RPT.RAPS_RETURN_FLAT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Error Report	RPT#9999.RPT.RAPS_ERROR_RPT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Summary Report	RPT#9999.RPT.RAPS_SUMMARY_ RPT#9999.ZIP.RAPS SUMMARY (zip format)
RAPS Duplicate Diagnosis Cluster Report	RPT#9999.RPT.RAPS_DUPDX_RPT_ RPT#9999.ZIP.RAPS DUPDX RPT (zip format)
RAPS Monthly Plan Activity Report	RPT#9999.RPT.RAPS_MONTHLY_ RPT#9999.ZIP.RAPS MONTHLY (zip format)
RAPS Cumulative Plan Activity Report	RPT#9999.RPT.RAPS_CUMULATIVE_ RPT#9999.ZIP.RAPS CUMULATIVE (zip format)
RAPS Monthly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_MNTH_ RPT#9999.ZIP.RAPS ERRFREQ MNTH (zip format)
RAPS Quarterly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_QTR_ RPT#9999.ZIP.RAPS ERRFREQ QTR (zip format)

5.8 Plan Monitoring Process

The Plan Monitoring Process allows CMS to monitor MA organization submission rates and ensure that they are submitted accurately and paid appropriately. The process is designed to assist MA organizations and to provide guidance to meet risk adjustment data collection and submission requirements. The process is administered as follows:

- CSSC contacts the identified MA organizations to address problems, discuss specific issues, offer technical assistance, and develop an action plan.
- The CMS Compliance Division may contact MA organizations that are not responsive to the risk adjustment team's assistance.



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DIAGNOSIS CODES & RISK ADJUSTMENT

MODULE 6 – DIAGNOSIS CODES & RISK ADJUSTMENT

Purpose

It is neither the intention of this module nor the purpose of this training to provide diagnostic coding training. However, this module does provide Risk Adjustment organizations with an introduction to diagnosis coding and stresses the importance of accurate diagnosis documentation and coding for risk adjustment. The module first explains the structure and layout of the official Centers for Medicare & Medicaid Services (CMS) diagnosis coding set-- the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The module also discusses the diagnosis coding guidelines that apply to the ICD-9-CM, and how following these guidelines ensures accurate risk adjustment payments. The module demonstrates how verification of compliance with coding guidelines depends upon accurate documentation in the medical record. Finally, the module provides information to assist MA organizations in communicating with their physicians regarding proper documentation and diagnosis coding.

Learning Objectives

At the completion of this module, participants will be able to:

- Identify the background, key terms, and organization of ICD-9-CM.
- Describe the coding update process, recent and proposed changes impacting risk adjustment, and the status of ICD-10-CM.
- Apply official coding guidelines to common Medicare diagnoses and understand the impact on associated Hierarchical Condition Category (HCC) assignment.
- Define and identify V codes and E codes in the HCC model.
- Describe the importance of ICD-9-CM and medical record documentation to risk adjustment.
- Identify resources available for additional training and policy formation regarding documentation and coding.

ICON KEY

Example



Reminder



Resource



6.1 Introduction

Medicare uses ICD-9-CM as the official diagnosis code set for all lines of business including determination of risk adjustment factors. MA organizations must:

- Implement procedures to ensure that diagnoses are coming from physician, hospital inpatient, or hospital outpatient provider types.
- Submit all required ICD-9-CM diagnosis codes for each beneficiary.
- Submit required diagnoses at least once during the risk adjustment data reporting period.



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DIAGNOSIS CODES & RISK ADJUSTMENT

The source medical record documentation that supports each coded diagnosis must be obtainable and demonstrate adherence to official coding guidelines.



Required diagnoses are defined as those diagnoses collected from one of the three provider types that are used in the Risk Adjustment models (i.e., CMS-HCC, ESRD, and RxHCC models), and those diagnoses required for payment simulation.

This module emphasizes physician documentation and reporting of diagnosis codes. Historically, physician reimbursement in fee-for-service is primarily based on procedures or services rather than diagnoses, and physicians are very familiar with documentation guidelines for procedures and services. Physicians generally are not as familiar with diagnosis codes and their associated documentation guidelines as they are with procedure coding rules. The Risk Adjustment models depend upon accurate diagnosis coding, which means that physicians must fully understand and comply with documentation and coding guidelines for reporting diagnoses.

6.1.1 Benefit to the MA Organization and Physician

Benefits to the MA organization and physician are illustrated in Table 6A.

TABLE 6A – BENEFITS TO MA ORGANIZATIONS AND PHYSICIANS

A basic understanding of ICD-9-CM process and guidelines assists MA organizations in: • Interpreting and designing management reports. • Determining possible causes of ICD-9-CM errors. • Communicating diagnosis-related collection issues to the provider staff. • Developing and maintaining information systems that meet the clinical data collection needs of the organization. • Understanding clinical issues important to beneficiaries. • Planning for future MA organization services.
Medical record documentation and coding impact several issues important to the physician and MA organization including: • Accurate reimbursement. – ICD-9-CM codes are the basis of the Risk Adjustment models. – Accurate diagnosis codes are a result of clear, consistent, and complete documentation. – CMS may verify the accuracy of the diagnoses submitted relative to the medical record documentation. • Communication among all members of the health care team. • Evaluation of the care provided. • Research and education. • Practice patterns.

6.2 Structure and Terminology of ICD-9-CM

ICD-9-CM diagnosis codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. They do not describe the service performed, just the patient's medical condition. For any

DIAGNOSIS CODES & RISK ADJUSTMENT

6-3



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DIAGNOSIS CODES & RISK ADJUSTMENT

- **E codes** are a supplemental classification included in ICD-9-CM and are used for reporting external causes of injuries and poisonings. The Risk Adjustment models include codes E950-E959, describing suicide or self-inflicted injuries.
- **Neoplasm Table** located in the Alphabetic Index (see *Neoplasm*) lists all cancer codes by site and nature of the disease (e.g. malignant primary or secondary, benign, or unspecified behavior).
- **Table of Drugs and Chemicals** is located at the end of the Alphabetic Index. It lists drug classifications; as well as specific names of drugs; identifies the code for poisoning by that drug; and the associated E code to specify if the poisoning was accidental, an adverse effect (therapeutic use), suicide attempt, assault, or undetermined.

6.3 ICD-9-CM Updates

To assist users of ICD-9-CM in interpreting and clarifying the guidelines, as well as publishing updated codes and applications, the AHA Central Office on ICD-9-CM publishes quarterly official code advice in *Coding Clinic for ICD-9-CM*. The *Coding Clinic for ICD-9-CM* is the approved resource to update and clarify the use of ICD-9-CM. The small volumes (typically about 20 pages) include clarifications of previous advice and guidelines, or new information on a specific diagnosis coding practice by means of articles and a question and answer section.

The ICD-9-CM diagnosis code listing is updated on October 1 and April 1 (beginning April 2005). The ICD-9-CM Coordination and Maintenance Committee holds a public forum for requested updates and publishes a transcript of their recommendations on the CMS website and in the *Federal Register*. Revisions discussed at the April and December meetings generally become effective in October the following year. A complete listing and description of annual updates are available in *Coding Clinic for ICD-9-CM* during the fourth quarter of each year. More information on the process for updating ICD-9 codes may be found at <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/>.



Note: The annual ICD-9-CM diagnosis codes update may result in updates to the list of diagnosis codes used in the Risk Adjustment models. CMS posts a list of new codes in the CMS-HCC model annually, prior to the codes taking effect on October 1.



The ICD-9-CM coding guidelines are not updated as frequently as the list of diagnosis codes. The most recent official guideline revision is published on the National Center for Health Statistics website (<http://www.cdc.gov/nchs/datawh/ftp/ftp/cd9/icdguide07.pdf>) and is effective October 2007.

6.3.1 Valid Diagnosis Codes Phase-in Schedule

Prior to 2009, CMS did not impose strict validity checks on diagnosis codes submitted for risk adjustment.

As described in Table 6B below, starting with 2008 payment, the list of acceptable ICD-9-CM codes for the CMS-HCC, ESRD, and RxHCC risk adjustment models for risk adjustment for any given payment year will comprise the list of published NCHS/CMS codes that are valid for the payment year.



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DIAGNOSIS CODES & RISK ADJUSTMENT

**TABLE 6B – RISK ADJUSTMENT PHASE-IN SCHEDULE FOR
NEW LISTS OF DIAGNOSIS CODES**

YEAR OF PAYMENT	DATE COLLECTION PERIOD	DESCRIPTION/SOURCE OF CODES
2007	1/06 – 12/06	The list of codes is published on our website at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage , which lists acceptable codes by years.
2008	1/07 – 12/07	The list of codes is published on our website at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2008, 2009
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2009, 2010
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2010, 2011

6.3.2 International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM)

ICD-10-CM is the clinical modification of ICD-10, which was adopted by the World Health Organization in July 2000. In 1994, the NCHS began a comprehensive evaluation of ICD-10-CM to determine if it is a significant improvement over ICD-9-CM and should be implemented in the United States. The new system was tested and results were favorable. In November 2003, the National Committee on Vital and Health Statistics recommended that the Secretary of the Department of Health and Human Services (HHS) approve ICD-10-CM for all lines of business. The Secretary of HHS is currently studying this recommendation. To implement this new coding system as part of the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a notice of proposed rule-making, and requested public comment on the new policy.

6.4 Coding Guidelines Impacting the CMS-HCC Model

Standard ICD-9-CM coding practices support the CMS-HCC model. In all cases, the documentation must support the code selected and substantiate that the proper coding guidelines were followed. Data validation ensures that both are appropriate. Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider. Several guidelines that impact physician documentation and reporting of diagnosis data are listed in the following sections.

6.4.1 Co-Existing and Related Conditions

The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM, published at www.cdc.gov/nchs/icd9.htm and in the *Coding Clinic*. Physicians should code all documented conditions that co-exist 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



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codes (V10-V19 not in HCC model) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.

Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.



MA organizations must submit each required diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.

Another type of co-existing conditions is symptoms. Symptoms that are integral to an underlying condition should not be coded.



Example: 1

Initial myocardial infarction (410.91, HCC 81) is a specific condition that, when coded, would eliminate the need to code symptoms of that condition. For example, unstable angina (411.1, HCC 82) or angina pectoris (413.9, HCC 83) are symptoms of initial myocardial infarction and various other cardiovascular conditions and would not typically be coded in addition to the underlying problem.

6.4.1.1 Combination Codes

Often ICD-9-CM combines two or more conditions into one code when both conditions occur together or when one is a manifestation of the other. When a combination code fully describes the encounter, the combination code is reported, not the separate component codes. However, when ICD-9-CM instructions include "Code also" notes, follow the directions to fully describe the encounter.



Example: 2

Hypertension (401.9) is not in the risk adjustment model; however it may be associated with other conditions resulting in combination codes that are in the model. The documentation must specifically and directly connect the conditions using terms such as "due to" or "associated with" hypertension. The mere listing of the diseases in the same paragraph or diagnosis list does not assume the connection. For example "congestive heart failure *due to* hypertension" is coded 402.91 (hypertensive heart disease with CHF, HCC 80). Other examples include hypertensive renal disease with renal failure (403.91, HCC 131) and hypertensive heart and renal disease with heart failure and renal failure (404.93, HCC 131 & 80).



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Code also combinations - some codes have suggestions of related codes that might further explain the exact nature of the condition. While these codes are not required to be present, in many cases a second code is appropriate and should be utilized.



Example: 3

Some diabetes codes carry “Code also” instructions that impact directly on the Risk Adjustment models.

- If a patient has diabetic retinopathy (250.50, HCC 18), the tabular section requires a code for also the manifestation (if known). The ICD-9-CM offers several different manifestations, such as blindness (369.00-369.9, not in the CMS-HCC model) or proliferative diabetic retinopathy (362.02, HCC 119). Here, coding the correct manifestation is essential to correct HCC assignment.
- Diabetic ulcers are one of the conditions covered under diabetes with other specified manifestations (250.80, HCC 16). If ulcers are the specific manifestation, the guidelines say to code also the site of the ulcer, such as lower extremity (707.10, HCC 149). If the specific manifestation is diabetic bone changes (731.8), that code is not in the CMS-HCC model, but should be coded as instructed in the tabular section. Again, coding the correct specific manifestation ensures appropriate HCC assignment.

6.4.2 Unconfirmed Diagnoses

Physicians and hospital outpatient departments shall not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working.” Rather, the condition(s) shall be coded to the highest degree of certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. CMS recognizes that this is an area where the physician-reported diagnosis and hospital inpatient diagnosis for the same encounter may disagree, particularly since hospital inpatient rules allow for coding of suspected conditions as if they were confirmed.

It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.



Example: 4

A physician removes a mole during an office visit and sends the specimen for pathology. The diagnoses documented are “suspicious skin lesion” (709.9, not in model) and “rule out melanoma.” At this point, the diagnosis 709.9 may be submitted, but the diagnosis of melanoma may not. The pathology report is returned several days later and confirms malignant melanoma (172.9, HCC 10). The physician reviews the findings, initials the report, and documents in the record the results and notification to the patient. Since the removal of the mole was done during the office visit, the new code (172.9, melanoma) should be submitted with that date of service.



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6.4.3 Clinical Specificity in Documentation

Clinical specificity involves having a diagnosis fully documented in the source medical record instead of routinely defaulting to a general term for the diagnosis. It is important to understand medical terminology in order to identify terms in the medical record that may be a more specific description of a general term. Communication with the physician is perhaps one of the key elements in improving documentation skills that allow for more specific coding. The following examples are guidelines and specific conditions selected from various chapters of ICD-9-CM (e.g., Circulatory, Respiratory, Neoplasm, etc.) that are representative of documentation and coding decisions that impact HCCs.

The first three examples involve situations in which a physician may use the most common code for all forms of a disease and conditions. Remember, this practice has had no impact in the past on physician reimbursement. With the Risk Adjustment models, physicians must be careful to code the correct forms and manifestations of diseases and conditions.



Example: 5

Anemia (285.9) is the most commonly coded form of anemia in physician offices. However, there are many types of anemia. Some are in the models and some are not. If the term “neutropenia” is used to describe the anemia, it must be coded to the more specific diagnosis code 288.0 (agranulocytosis), which groups to HCC 45. “Refractory” anemia is coded 238.7 (HCC 44). It is important that physicians code these types of anemia accurately.



Example: 6

Pneumonia (486) unspecified is not in the model. If the organism responsible for the pneumonia (HCC 111-112) is known or if the physician documents that the patient aspirated prior to developing pneumonia (507.0 HCC 111), the more specific code should be reported.



Example: 7

Mental disorders in the HCC models require particular attention to specific wording in documentation and coding. Episodic mood disorders (296.XX, HCC 55) are mental diseases that include mood disturbances such as major depression (296.2X-296.3X). Physicians are encouraged to carefully document the characteristics of the mood disturbance (e.g., mania, depression, single episode, recurrent episode, circular) and use specific mental disorder terminology in the final diagnosis. The coder is cautioned to exactly code only the narrative provided by the physician in the final diagnosis and not make any further assumptions based on the patient work-up. For example, in coding depression, careful use of the ICD-9-CM index directs the coder to the correct type documented. If the physician does not document specific descriptor terms such as “major” or “recurrent”, then code 311 (depression, not otherwise specified, not in the model) is used.

Use of “history of.” In ICD-9-CM, “history of” means the patient no longer has the condition and the diagnosis often indexes to a V code not in the HCC models. A physician can make errors in one of two ways with respect to these codes. One error is to code a past condition as active. The opposite error is to code as “history of” a condition when that condition is still active. Both of these errors can impact risk adjustment.



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Example: 8

The diagnosis statement “history of hip fracture” is not coded as a current hip fracture (820.8, HCC 158), but with a V code for orthopedic aftercare (V54.XX) or history of injury (V15.5), if appropriate. Neither “history of” code is in the HCC models. If a patient has a current acute condition, then the “history of” wording should not be used to describe the recent occurrence.



Example: 9

The physician may actually intend to communicate that a condition is ongoing, but note the “history of” a condition. An example of this is “history of Hepatitis C” (V12.09 personal history of other infectious disease). Hepatitis C generally presents as a chronic condition (070.54, HCC 27) that is rarely fully eradicated. While assigning V12.09 is not necessarily an example of incorrect coding, it may indicate that the physician office is not coding correctly. Again, communication and clear documentation are essential to make the appropriate determination.

Correct use of associated terms. Some conditions are described by more than one term depending on the clinical presentation and medical terminology practices of the physician. Coders must be careful not to assign a diagnosis to conditions that are not specified by the physician and cannot be validated by the medical record.



Example: 10

Cancer coding requires detailed specificity. Several different HCCs exist for cancer, and assigning the appropriate HCC requires closely following the cancer coding guidelines. The HCC varies depending on whether the cancer is a primary site or a secondary site. Coding guidelines state that if the malignant status is not specified, then code to the primary site, except for the following: bone, brain, diaphragm, heart, liver, lymph nodes, mediastinum, meninges, peritoneum, pleura, retro peritoneum, and spinal cord. Applying this rule assures that the correct HCC for secondary malignant neoplasm is assigned rather than an HCC for primary malignant neoplasms. [For example, bone cancer (primary) (170.9, HCC 9) vs. bone cancer (secondary) (198.5, HCC 7). Since the cancer is not specified as primary or secondary, and bone is one of the sites listed above, the correct HCC is 7.]



Cancer codes are part of a multi-category HCC hierarchy. It is not unusual for a patient to have more than one type of cancer. However, only the most severe and costly form of cancer is recognized in the HCC models. Even if the type of cancer included in HCC 7 is of a different site or origin than any other cancer the patient has and is included in HCCs 8, 9, and 10, the HCC models drop it.



Complete Neoplasm guidelines are included in the Resource Guide.

6.4.3.1 History and Physical (H&P), and Lab and Pathology Reports – Guidance

Some organizations have inquired about the use of the History and Physical (H&P), and Lab and Pathology Reports for data submission and medical record review. If an organization decides to use either as a source for justify ICD-9-CM code submission and/or subsequent medical record review, the



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following guidance must be taken into account when considering the appropriate ICD-9-CM coding guidelines to be used.

Inpatient Documentation – History and Physical (H&P) Guidance

CMS recommends submitting diagnoses and medical records documentation based on a complete inpatient medical record for a hospital inpatient stay. If an organization chooses to use H&P as stand-alone documentation for submitting ICD-9 codes or medical record documentation for validation, the following guidance applies:

- **H&P as part of the inpatient full medical record**

- Will **not** contain reportable final/confirmed diagnoses
- Typically contains
 - Admission symptoms and co-existing conditions as well as
 - Admission/working diagnoses, which may or may not be one of the final diagnoses for the inpatient admission

Note that upon medical record review, discharge/final diagnoses– not the H&P alone –will be reviewed in accordance with the Inpatient ICD-9 coding guidelines

- H&P representing an independent physician visit from an inpatient stay
If a physician submits a separate claim/encounter to the organization based on his/her evaluation of the patient as reflected on the H&P
 - H&P (face-to-face encounter) is viewed as a physician visit
 - Reportable diagnoses documented in the H&P
 - Could be used as final
 - Could be used for risk adjustment; HOWEVER,
 - The medical record documentation will be reviewed in accordance with the Outpatient ICD-9 coding guidelines
- H&P Conclusion
The following applies for both data submission and data validation requirements
 - Risk Adjustment is based on final/confirmed diagnoses.
 - Risk adjustment diagnoses should only be submitted based on the H&P alone when there is an independent physician claim associated with the diagnosis.
 - Upon validation, if an organization submits an H&P as stand-alone documentation, the Outpatient guidelines will be applied to determine if there is a confirmed diagnosis.

Lab and Pathology Reports

The following guidance must be taken into account when considering data or medical record submission from lab and pathology sources.

- Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings)
- “Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicated their clinical significance.”
- Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding
- Written interpretation (alone) of a tissue biopsy is not equivalent to the attending/referring physician’s complete clinical assessment used to assign a diagnosis.
- If submitting risk adjustment data or medical records based on pathology, note the following:
 - Outpatient pathology facilities are unacceptable risk adjustment provider sources



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- Physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting risk adjustment diagnoses or medical records based on physician specialty code 22 refer to the guidance stated in this section.

AND

- Medical records submitted as stand-alone documentation from these sources will be reviewed in accordance with the Outpatient guidelines and will likely result in a risk adjustment discrepancy since these source do not typically render confirmed diagnoses.

6.4.4 Coding to the Highest Specificity-Fourth and Fifth Digits

ICD-9-CM codes have three, four, or five digits. Diagnoses should be reported to the highest level of code available for that category. In selected cases, the fifth digit may impact whether the code is in the models, but at a different HCC level, which may impact reimbursement.



Example: 11

Myocardial infarction (MI) (heart attack, 410.XX) is unspecified or subsequent episode fifth digits 0 and 2 are in HCC 82. All initial care for a new MI (from physician office to emergency room to hospital) should have the fifth digit of "1" and group to HCC 81.



Example: 12

Diabetes (250.XX) codes group into HCCs 15, 16, 17, 18, or 19 depending on the fourth digit applied. The fourth digit designates manifestations or complications of diabetes such as neurological conditions, eye disorders, or diabetic ulcers.



At a minimum, the submitted ICD-9-CM codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. CMS encourages MA organizations to use the full level of specificity in submitting data to provide the most accurate coding and grouping of codes in the model.

6.4.5 V Codes

Health status situations that should be described by V codes are common in physician documentation. Those that impact risk adjustment include HIV status, transplant status, artificial opening status or maintenance, dialysis status or encounter, and amputation status. These V codes are used in several HCCs.

6.4.6 E Codes

The HCC models include codes E950-E959 describing suicide or self inflicted injuries (HCC 55, Major Depressive Disorders). Therefore, it is important that the physician documents and codes the appropriate external cause of all self-inflicted injuries and poisonings so the MA organization can report them as diagnoses appropriately.



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6.5 Supporting Documentation Summary

Accurate coding begins with complete documentation. Characteristics of effective documentation include quality documentation as a team effort that may require some intervention by the MA organization. Table 6C lists documentation considerations.

TABLE 6C – DOCUMENTATION CONSIDERATIONS

Documentation Guidelines
• Reported diagnoses must be supported with medical record documentation. • Medical records and codes are subject to CMS validation. • Characteristics of acceptable documentation include: – Clear. – Concise. – Consistent. – Complete. – Legible.
Physician Documentation and Communication Tips
• Document and report co-existing diagnoses. • Communicate issues regarding inadequate documentation. • Adhere to proper methods for appending (late entries) or correcting inaccurate data entries. – Lab/Radiology results. – Strike through, initial, and date. Do not obliterate. • Use only standard abbreviations. • Identify patient and date on each page of the record.
SOAP Notes
• SOAP note format assists both the physician and record reviewer/coder in identifying key documentation elements. SOAP stands for: – Subjective: How the patients describe their problem or illness. – Objective: Data obtained from examinations, lab results, vital signs, etc. – Assessment: Listing of the patient's current condition and status of all chronic conditions. How the objective data relate to the patient's acute problem. – Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for followup.

6.6 Provider and Staff Training

Remaining current on medical record documentation and coding guidelines is important to ensure accurate risk adjustment payment. Table 6D provides examples of resources available for medical record documentation and coding guidelines.



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TABLE 6D – DOCUMENTATION AND CODING RESOURCES

TRAINING SOURCES	DESCRIPTION
Official Coding Guidelines on CDC Website Available at www.cdc.gov/nchs/icd9.htm	The Official ICD-9-CM Coding Guidelines are available as an Adobe .pdf file, or as a CD-ROM. The CDC site has the .pdf file for download, as well as information to order the CD-ROM from the Government Printing Office.
Coding Clinic for ICD-9-CM Available through AHA.	Published quarterly by the AHA. It is the official publication for ICD-9-CM coding guidelines and advice as designated by the AHA, AHIMA, CMS, and the NCHS.
American Health Information Management Association (AHIMA) www.ahima.org	AHIMA is a professional association for health information management professionals. Members make information accessible to healthcare providers and work in the healthcare industry and in the public sector by managing, analyzing, and using data that are critical to patient care. The AHIMA Catalog online offers tools for coders such as audio seminars, books, and continuing education courses.
American Academy of Professional Coders (AAPC) www.aapc.com	AAPC provides education and certification for professional medical coders. Certifications focus on physician practice (CPC) and hospital outpatient facility (CPC-H) coding. Students learn Current Procedural Terminology (CPT) Codes, diagnosis codes (ICD-9-CM), and Healthcare Common Procedure Coding System (HCPCS) while focusing on HIPAA, Office of Inspector General (OIG), and Medicare compliance.
American Medical Association (AMA) www.ama-assn.org	AMA is an advocate of physician and patient rights. Coders may access the AMA Press Online Catalog to find current resources on medical record documentation and the medical record review process.
American Hospital Association (AHA) www.aha.org	AHA is a national organization that serves and represents hospitals, healthcare networks, and their patients. The AHA Online Store offers coders online reference materials including ICD-9-CM, HCPCS, and testing and certification for HIPAA.
Local Colleges Check local community and 4-year colleges for courses.	These provide online courses in clinical coding and guidelines.



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MODULE 7 – RISK ADJUSTMENT DATA VALIDATION (MEDICAL RECORD REVIEW)

Presentation Purpose (Slide 2)

To provide participants with an understanding of:

- The risk adjustment data validation (RADV) process AND
- CMS' approaches for:
 - Identifying risk adjustment discrepancies,
 - Estimating payment error, and
 - Conducting contract-level payment adjustments

Presentation Objectives (Slide 3)

Define

- Purpose and objectives of risk adjustment data validation (RADV)
- New RADV policies and parameters
- RADV stages and requirements
- Documentation Dispute
- Payment adjustment implementation approach
- Appeals

ICON KEY

Example



Reminder



Resource



7.1 Risk Adjustment Data Validation (RADV)

7.1.1 RADV – Purpose, Method, and Objectives (Slide 4)

Risk adjustment data validation (RADV) occurs after the final risk adjustment data submission deadline for the MA contract payment year. The purpose of RADV is to ensure risk adjusted payment integrity and accuracy. CMS reviews medical records from hospital (inpatient and outpatient) and physician providers to validate enrollee CMS-HCCs that were assigned based on risk adjustment diagnoses submitted by MA organizations for payment. As a basic risk adjustment rule, all risk adjustment diagnosis codes submitted by MA organizations must be supported by medical record documentation.

The primary objectives of RADV are to:

- Verify enrollee CMS-HCCs used for payment
- Identify risk adjustment discrepancies
- Calculate enrollee-level payment error
- Estimate national and contract-level payment errors
- Implement contract-level payment adjustments



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7.1.2 RADV - New Approaches (Slide 5)

In its *Announcement of Calendar Year (CY) 2009 Medicare Advantage (MA) Capitation Rates and Medicare Advantage and Part D Payment Policies* (available at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage>), CMS informed Part C sponsors of its decision to establish payment adjustment policies based on RADV findings beginning with CY 2007 payments.

The following new approaches will be incorporated into the RADV activities beginning with CY 2007 payments:

- CMS will make contract-level payment adjustments based on statistical findings from enrollee samples. This is a change from previous years when, although statistically valid samples were selected, CMS adjusted payments only for those sampled enrollees whose risk scores were not supported by medical record review
- Medical records will not be accepted after CMS' official deadline
- A Documentation Dispute process will be available for organizations to dispute enrollee-level HCC findings
- New documentation for missing medical records will not be allowed during the Documentation Dispute process
- An Appeals process will be facilitated by the CMS Office of Hearings and will occur after the Documentation Dispute process

7.1.3 RADV – 2007 Parameters (Slide 6)

The 2007 RADV project parameters will be based on the following:

- Eligible contracts will include all MA Contracts, PACE, and dual demonstration organizations that were active in January 2007 (all of which received risk adjustment payments for 2007). CMS may exclude contracts (from these groups) that terminated prior to the start of the 2007 RADV process.
- Within each eligible contract a statistical enrollee sample will be selected from all eligible enrollees – defined as enrollees with at least one HCC. Eligible enrollees are identified as either “continuously enrolled” or “non-continuously enrolled”. Continuously enrolled beneficiaries are those who were in the same eligible contract from January 2006 through January 2007. Non-continuously enrolled beneficiaries are those who switched between contracts and/or MA and Medicare fee-for-service (FFS) between January 2006 and January 2007. Note the non-continuously enrolled beneficiaries will not be included in the contract-level payment error estimate that will be used for contract-level payment adjustments.
- Data collection period will include dates of service that occurred from January 2006 through December 2006 for the eligible enrollee population.



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7.1.4 RADV – Core Concept (Slide 7)

The guidelines for risk adjustment data validation reflect the purpose and objectives described above. Beginning with CY2007 payments, the RADV functions will expand to include contract-level payment adjustments.

RADV Core Concept – Enrollee HCCs are assigned based on risk adjustment diagnoses that were present on FFS claims, or submitted by MA organizations via RAPS. The CMS-HCCs contribute to payment increases for enrollees. As a principal risk adjustment rule, risk adjustment diagnoses submitted for enrollees must be supported by medical record documentation and based on a face-to-face encounter. CMS uses RADV activities to confirm the presence of risk adjustment conditions (i.e., diagnoses that map to HCCs) for enrollees. Therefore, all CMS-HCCs for sampled enrollees will be reviewed and for these HCCs, CMS will review medical record records and abstract ICD-9-CM codes to confirm HCCs that contributed to enrollee payments.

7.1.5 RADV – Guiding Principle (Slide 8)

The risk adjustment guiding principle states that all diagnoses submitted for payment (i.e., used for HCCs) must be:

- Documented in a medical record that was based on a face-to-face health service encounter between a patient and a healthcare provider
- Coded in accordance with the *ICD-9-CM Guidelines for Coding and Reporting*
- Assigned based on dates of service within the data collection period AND
- From an acceptable RA provider type and RA physician specialty

This guiding principle is what's used as the key guideline for medical records review.

7.1.6 Risk Adjustment Discrepancy (Slides 9)

The primary focus of medical record review is on the HCC because any change to an enrollee's HCC profile will impact payment at the enrollee-level. For medical record review, ICD-9 codes abstracted from the medical record are mapped to HCCs. The HCCs based on medical record review are then compared to the HCCs based on submitted risk adjustment data.

Risk adjustment discrepancies are identified when the HCC(s) assigned based on risk adjustment data submitted by the MA organization differs from the HCC(s) assigned after validation. Risk adjustment discrepancies affect the beneficiary risk score because of the change in the HCC(s).

7.1.7 Medical Record Review Overview (Slide 10)

The RADV process involves coordination between multiple entities such as CMS, MA organizations, and CMS contractors. CMS will use a number of contractors to support the RADV efforts. These contractors will have defined roles for the RADV project, and will collaborate, and work in cooperation with CMS to achieve the overall project goals.



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The Core Project Contractors include:

- A Lead Analytic Contractor (LAC) to coordinate the overall analytic approach and process for the RADV activities. This will involve facilitating all project mechanisms to accomplish sampling, analysis reporting, estimating national and contract-level payment errors, policy and process decision tracking, and overall tracking and management of the RADV project data.
- Medical Record Review Contractors (MRRCs) to conduct the initial and second independent reviews to confirm risk adjustment discrepancies. Both MRRC processes include inter-rater reliability (IRR) reviews to ensure coding consistency and accuracy. The MRRCs use certified coders to abstract diagnosis codes and validate provider type, physician specialty, and date(s) of service.

The MRRCs will serve as CMS' primary entity responsible for communicating with the MA organizations throughout the RADV process, and limited communication will take place between the LAC and the MA contracts. The MRRC will facilitate the medical record requests, reviews, and Documentation Disputes processes (Stages 1, 2, and 4), while the LAC will facilitate the sampling and payment analysis for payment adjustments (Stages 3, and 5). Note that the LAC and the MRRCs will have shared functions for the MRR findings under Stage 3. CMS also uses other support contractors throughout the RADV process for purposes of reviewing statistical, analytic, and technical data approaches.

7.1.8 RADV- Process (Slide 11)

The core RADV process begins with MA organizations and enrollee selection, and ends with a second round of payment adjustments after MA organization submission of HCC-level disputes for sampled enrollees. After the core process, an Appeals stage will be implemented by the CMS Office of Hearings. Figure 7A illustrates the overall data validation process. The RADV process stages are as follows and described in detail in this module:

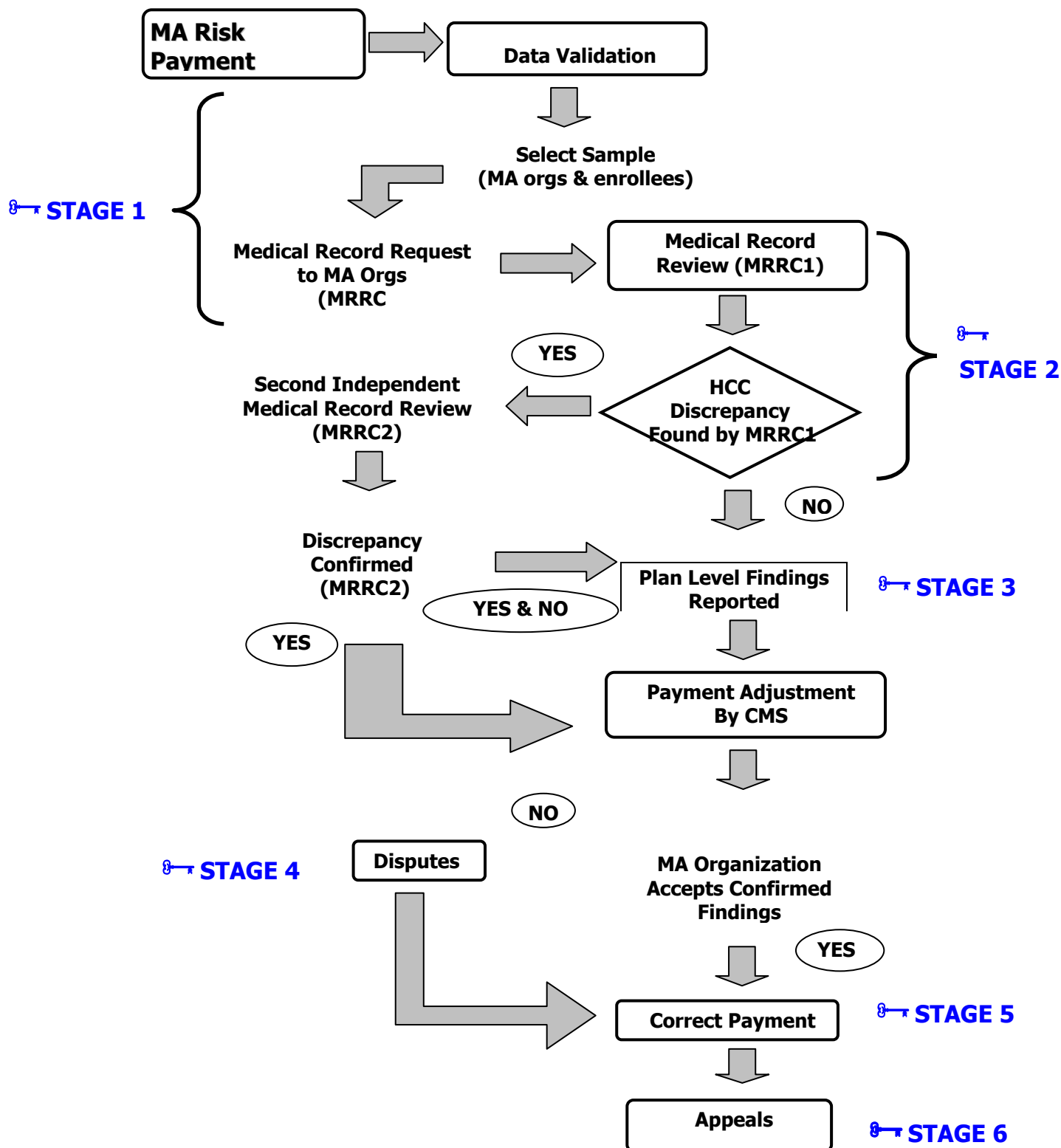
- ➔ **STAGE 1 Sampling and Medical Record Request**
- ➔ **STAGE 2 Medical Record Review (MRR)**
- ➔ **STAGE 3 MRR Findings and Contract-level Payment Adjustments**
- ➔ **STAGE 4 Documentation Dispute**
- ➔ **STAGE 5 Post Documentation Dispute Payment Adjustments**
- ➔ **STAGE 6 Appeals**



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Figure 7A – Data Validation Process





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7.2 RADV Stages

7.2.1 Sampling Selection and Medical Record Request -- STAGE 1 (Slides 12-19)

7.2.1.1 Sampling

Organizations and enrollees will be sampled for national and contract-specific payment error estimates. The **national** enrollee sample will be used to estimate national annual payment error. For 2007, CMS will select the national sample from the eligible January 2007 contracts (based on the RADV parameters). The sample will consist of continuously and non-continuously enrolled beneficiaries with at least one CMS-HCC.

Contract-specific enrollee samples will be used to estimate annual payment error at the contract level. CMS will target or randomly select contracts. The group of targeted contracts will be chosen from among MA contracts included in the MA Coding Intensity Study, which was conducted to analyze differences in risk score changes (and risk score disease component changes) over time between MA and FFS. The group of randomly selected contracts will be chosen from all active eligible contracts. Contracts selected via the targeting criteria will not be eligible for random selection. Statistical enrollee samples will be selected from among the continuously-enrolled populations within each targeted and randomly selected contract.

All active contracts will be eligible for contributing enrollees to the national sample. CMS is considering a stratified random enrollee sampling approach for the national and contract-specific samples. Note that some organizations may be requested to contribute medical records for only the national sample.

7.2.1.2 Medical Record Request

Upon completion of the sampling, the MRRCs will request medical records from the selected organizations. The Medical Record Request is defined by three distinct segments: 1) medical record request; 2) medical record submission (contract response); and 3) medical record receipt.

1. The medical record request includes the initial notification of RADV selection, the enrollee list, and the official medical record request instructions.
2. Medical record submission refers to the MA organization's response to the medical record request and addresses medical record obtainment and submission requirements.
3. Medical record receipt refers to the process used by the MRRC for receiving, logging and tracking of medical records.

Medical Record Request - Initial Contact Letter

The MRRC will send a CMS Notification Letter to the Medicare Compliance Officer (MCO) for each MA organization selected for validation. The purpose of the initial contact letter is to: 1) inform the MCO that its contract was selected for data validation; and 2) request primary and secondary points of contact (either the compliance officer or a designee) to be responsible for facilitating the medical record request process for the organization. The Compliance Officer is given approximately 5-days to respond to the initial request.



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Medical Record Request - Enrollee List

A list of enrollees selected from each organization will be sent to the confirmed primary and secondary contact persons for the MA organization. The list will be provided to MA organizations either in advance of or in conjunction with the medical record request instructions package. The purpose of the list is to provide organizations the opportunity to easily identify the selected enrollees in their systems, and start establishing contact with the specific provider(s) of services for those enrollees. CMS does not require or store provider identification numbers as part of risk adjustment data. Therefore, the MA organization must use its data systems that can:

- Track and locate dates of service.
- Link a specific diagnosis to a specific provider.

The enrollee list is provided in an electronic spreadsheet format, which displays:

- Organization's name,
- Enrollee ID,
- Current Contract ID (H-number), and
- Previous Contract ID (H-number)—this information is furnished if the contract ID used during the data collection period differs from the current contract ID.

For each selected enrollee the following information is included in the beneficiary list:

- Coversheet ID number (A masked ID tracking number that can be found on the bottom left of each HCC coversheet)
- Enrollee Last Name
- Enrollee First Name
- Enrollee Date of Birth
- Enrollee HIC Number
- Validation HCC
- ICD-9-CM code(s) related to the validation HCC

ABOUT YOUR LISTED ENROLLEES

The enrollee list will contain a line for each enrollee's unique HCC. This means that if an enrollee has multiple different HCCs, each line for the enrollee will comprise a unique HCC and all associated risk adjustment diagnoses that were stored for that HCC. Therefore, a complete enrollee HCC profile could comprise multiple lines on the beneficiary list. Table 7A displays an example request sample beneficiary list. The information shown on the line with each beneficiary HCC reflects all ICD-9 codes stored that HCC. Each enrollee will have at least one HCC and one corresponding risk adjustment ICD-9 code(s) stored for that HCC.

The listed enrollees are those who spent at least one month in your contract during the data collection period.

- If your organization is selected for one of the contract-specific samples, your list will contain all enrollees with continuous enrollment status (i.e., continuously enrolled) who were selected for your contract-level estimate.



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- If your organization has enrollees selected from the national sample, your list may include enrollees with continuous enrollment status and/or enrollees with non-continuous enrollment status (i.e. non-continuously enrolled).

Enrollees with non-continuous enrollment status are those who were either 1) enrolled in your contract in January 2007, but were not enrolled (in your contract) for all twelve (12) months during the data collection period, or 2) not enrolled in your contract in January 2007, but were enrolled (in your contract) for at least one month during the data collection period.

The Enrollee List will include the complete HCC and stored risk adjustment diagnosis profile for all selected enrollees. For enrollees with non-continuous enrollment status, the organization must identify, via its internal systems, whether it submitted risk adjustment diagnoses (during the data collection period) for any of the HCCs listed for these enrollees. If the organization submitted diagnoses data for at least one of the HCCs, the organization must identify providers (and date(s) of service) from which the data were collected, and request a medical record for the HCC(s).

If the organization did not submit any risk adjustment data for a non-continuously enrolled enrollee the organization must immediately notify the MRRC of this finding.



Example 1

For beneficiary Joe K. Smith - HCCs 38, 80 and 16 will be validated. For HCC 38, the MA organization may rely on one of the five ICD-9 codes associated with that HCC to identify the date of service, provider, and **"one best medical record"** for review. The organization could also opt to identify a provider that rendered a diagnosis that is not on the list, but will map to HCC 38. Contracts should take advantage of whichever approach yields the most efficient results. Table 7A provides an enrollee list for the example.

TABLE 7A – ENROLLEE LIST

MA Organization Name – Health Plan for People with Medicare												
Current Contract ID: H1111												
Previous Contract ID: H0000												
Coversheet ID #	ENROLLEE ID	LAST NAME	FIRST NAME	MI	DOB	HIC	HCC	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE
H1111-10005-HCC38	6225841	Smith	Joe	K	09/02/1925	12345678A	HCC 38	7101	446	4460	4465	71430
H1111-10005-HCC80							HCC 80	40201	40491	416		
H1111-10005-HCC16							HCC 16	2506	25062	2508	25080	
H1111-10006-HCC16	5457845	Johnson	James		8/16/1937	12345679A	HCC 16	2506	2508			
H1111-10007-HCC2	1545154	Mumford	Anne	A	03/15/1933	12345670A	HCC 2	0382	0389			
H1111-10007-HCC79							HCC 79	42741	51883			

Medical Record Request - Instructions and Coversheets

An instructions package is sent to MA organizations to facilitate the request for submitting medical records. This package will at a minimum include the following:

- Detailed instructions for requesting records from providers and submitting to the MRRC
- Guidance and best practices to further assist organizations with the request process
- A list of the selected enrollees (as previously described) and their HCCs
- CMS-signed cover provider letters
- HIPAA Fact Sheet to discuss HIPAA privacy AND



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- A coversheet for each unique enrollee HCC

7.2.2 Medical Record Submission

MA organizations must submit medical records and all corresponding coversheets for each enrollee HCC to the MRRC. In responding to the medical record request, MA organizations must select the “one best medical record” to support the enrollee HCC.

Medical Record Submission and Coversheets

REQUEST MEDICAL RECORDS FROM PROVIDERS

Organizations must request medical records from hospital inpatient, hospital outpatient, or physician providers. When requesting medical records from your providers, be sure to attach the HIPAA fact sheet, your MA organization contact, and as appropriate, the CMS-signed and sample provider letters. This will facilitate the provider’s contact with your organization in the event the provider has questions with regard to the medical record request.

When requesting medical records from providers, the organization must make every effort to limit disclosure of beneficiary health information to the minimum necessary as it pertains to the specific diagnosis(es) as rendered by the provider. This means that if the organization finds a date of service for which one provider rendered specific diagnoses then the organization should request medical record documentation from that provider for only those specific diagnoses, and the organization must not disclose of any additional health information from the enrollee HCC profile.

SELECT THE “ONE BEST MEDICAL RECORD” AND SUBMIT WITH COMPLETED COVERSHEET(S)

The coversheet is where the concept of the “one best medical record” is applied. The coversheet will at a minimum provide enrollee demographic information and stored risk adjustment data (HCC and ICD-9 codes). The MA organization must select and submit the best medical record and indicate on the coversheet the provider type and date(s) of service to be reviewed for the HCC. The date(s) of service could include a range of consecutive dates if the record is from a hospital inpatient provider or one date if the record is from a hospital outpatient or physician provider.

One coversheet will be generated and provided for each HCC being validated for each selected enrollee. Each coversheet shows every risk adjustment diagnosis that was stored by CMS and generated the HCC. A hierarchy (Y/N) indicator is included on the coversheet to identify if a specific HCC is part of a hierarchy. Where the HCC is part of a hierarchy, the HCC listed on the coversheet will be that which led to the most severe manifestation for the condition based on stored risk adjustment data. Only one coversheet will be issued for the general hierarchy condition, and within that condition only the most severe manifestation based on stored diagnoses will be displayed. Note that there may be other risk adjustment data that were stored and led to less severe manifestations for a condition. Attachment A provides a sample beneficiary HCC coversheet with directions for completion.

If one enrollee has two or more different HCCs, the contract will receive a separate HCC coversheets for each unique enrollee HCC; however, one medical record could be used to support multiple HCCs. If you identify a medical record that supports more than one HCC selected for validation, then complete each HCC coversheet, and attach them to that one medical record. For HCCs that are part of a hierarchy



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(described above), the MA organization could submit a medical record for either the HCC hierarchy level listed on the coversheet, or a different level (higher or lower) within the hierarchy, but only one medical record should be submitted for the general condition.



All coversheets must be returned regardless of whether a medical record is submitted to support the HCC. MA organizations must complete the coversheets to identify the information being submitted. Complete medical record coversheets are essential for timely medical record review.



If an MA organization is unable to submit the required medical record(s) to support the enrollee HCC(s), it must complete the coversheet as per the instructions package prior to submitting the coversheet to the MRRC. This will inform the MRRC that no medical record could be obtained to support the HCC.



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Guidance for Submitting Medical Records to the MRRC

1. Do not submit medical records for date(s) of service that occurred outside of the data collection period.
2. Do not submit medical records without provider signature and credentials.
3. Submit medical records from acceptable risk adjustment providers and physician specialties only.
4. If you select an inpatient discharge to substantiate the HCC(s), submit the entire inpatient medical record. Do not just submit parts of the record that may state the diagnosis; doing so would likely result in the record being reviewed in accordance with outpatient guidelines, which differ from inpatient depending on the type of diagnosis. The organizations should opt to submit the entire inpatient record if it's available.
5. Several organizations choose to submit medical record documentation that reflects only the physician face-to-face portion of an inpatient record when the entire inpatient record is not available. When this is the case, complete the coversheet to reflect a "physician" provider type and the date of service in the medical record for which the physician visit occurred during the inpatient stay. Only submit the medical record page(s) for the selected physician face-to-face.
6. In order to prevent medical record information from inadvertently being attached to the wrong coversheet(s), be sure that all coversheets are attached (e.g., rubber banded, paper clipped, or stapled) to the record. Do not clip together medical records for multiple different enrollees and enrollee HCCs.
7. If you are submitting for multiple organizations (i.e., those with different "H" numbers), separate the records for the different organizations.
8. Submit only one medical record per enrollee HCC being validated. Only one medical record—the first received for each HCC—will be accepted.
9. If you are unsure whether a record substantiates an HCC, you must determine whether to submit it or wait for another record. When in doubt about the clinical documentation in a medical record and you have no viable substitute, send the medical record even if you do not believe the record supports the HCC. We may find that the record does support the HCC being validated.
10. **SUBMIT ALL MEDICAL RECORDS AND COMPLETED COVERSHEETS BY THE OFFICIAL DEADLINE. MEDICAL RECORDS WILL NOT BE ACCEPTED AFTER CMS' OFFICIAL DEADLINE.**



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MEDICAL RECORD SUBMISSION METHODS AND SECURITY REQUIREMENTS

Extreme caution must be utilized when sending medical records and coversheets to the MRRC because of the protected health information (PHI), and/or personal identifiable information (PII) included in these documents. Medical records may be sent via electronic media (e.g., CD or USB), fax, or hardcopy. CMS prefers electronic media whenever feasible for medical record submission. **Do not e-mail medical records to the MRRC.**

All medical record submission packets must include a manifest of its contents, and records being sent via hardcopy or electronic media must be sent in tamper-proof packaging via U.S. Postal Service (USPS) certified mail with return receipt. Electronic media files must be encrypted. Faxed medical records must be sent using secured faxing procedures outline in the Medical Record Request Instructions packet. Organizations must follow all policies defined in the Instructions packet for submitting medical records.

7.2.3 Medical Record Receipt by the MRRC and Reimbursement

Once medical records are selected by the organization, the records must be submitted to the MRRC for medical record review. Upon receipt, the MRRC will log medical records into a chart-tracking database on the basis of the coversheet ID on each medical record coversheet. The date the medical record was received for a given HCC will be recorded.

When the coversheet and medical record are received by the MRRC, the following intake process is initiated:

- Administrative check—confirms beneficiary demographic information, including name, HIC number, and service date within or outside of the collection period.
- Clinical check—determines whether the:
 - Record is from an appropriate provider type.
 - Pertinent components needed for coding are included in the record.
 - Record is dated and signed.

Based on the administrative and clinical checks, the MRRC may elect to contact (telephone call or email message) the MA organization to request clarification or additional information.

CMS reimburses MA organizations for each medical record submitted per beneficiary HCC; however, only one medical record per beneficiary HCC will be accepted for reimbursement. If one record supports more than one beneficiary HCC, then the contract will receive reimbursement for one record. **This rule applies regardless of the method chosen for medical record submission.** Reimbursement checks are sent by the MRRC after completion of data validation activities.

7.2.4. Medical Record Review STAGE 2 (Slides 20-27)

CMS uses medical record review to validate risk adjusted payments. The process involves the review of submitted medical record documentation by a certified coder. The coders abstract all diagnosis codes—in accordance with the *ICD-9-CM Coding Guidelines*—based on the medical record documentation.



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During medical record review, the certified coder specifically checks for the following:

- The service was provided by an acceptable risk adjustment provider type and physician specialty.
- Dates of service are within the data collection period.
- A provider signature and credentials for each note.
- Acceptable documentation based on documentation guidance.
- Diagnoses supported by medical record documentation.

Proper medical record documentation is the key to accurate payment and successful data validation. The accurate assignment of ICD-9-CM diagnosis codes is based on thorough medical record documentation. Therefore, risk adjusted payment accuracy also relies on medical record documentation. Remember, beneficiary HCCs are assigned based on plan reported or FFS submitted risk adjustment diagnoses. Below are some general guidelines for medical record documentation, based on the sources of the documentation.

General Guidelines for Hospital Inpatient Medical Record Documentation

Hospital inpatient medical records are generally considered to be the most reliable source of diagnostic coding because hospitals employ certified professional coders.

CODING

According to the *ICD-9-CM Official Guidelines for Coding and Reporting*, for hospital inpatient stays a medical record reviewer should code the principal diagnosis and:

...all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

The required medical record documentation should include, but is not limited to, the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic (radiology, cardiology, etc.) testing reports
- Discharge summary.

General Guidelines for Hospital Outpatient and Physician Medical Record Documentation

Hospital outpatient and physician office medical records should include, but are not limited to, the following:

- Face sheet
- History and physical exam



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- Physician orders
- Progress notes
- Diagnostic reports (to support documentation)
- Consultation reports



Submit all relevant medical record components needed to validate the date of service, beneficiary, the HCC, and ICD-9 code selected. When you submit medical record documentation to support only the physician face-to-face visit that occurred during an inpatient stay, the same medical components are needed; however, the medical record documentation will be reviewed in accordance with *Diagnostic Coding and Reporting Guidelines for Outpatient Services*.

Only services that occurred on the date of service are reviewed. The overall guidelines for medical record documentation from hospital outpatient sites and physician offices are:

- A coder can determine from the documentation that an evaluation of the patient was performed by a physician or an acceptable physician extender (e.g., physician assistant, nurse practitioner).
- An ICD-9-CM code can be assigned on the basis of the evaluation and clinical findings/treatment.
- Physician signature, physician credentials and date entries are present.

CODING

Per the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

Code all documented conditions that coexist at 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.

Per *Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services*, Part C of the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

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.



"Probable," "suspected," "questionable," "rule out," or "working" diagnoses cannot be reported to CMS as valid diagnoses by a physician.

In some cases, additional guidance is needed when relying on certain types of hospital outpatient and physician office medical record documentation. (For additional information, see the *Guidance for Problem Lists*, *Guidance for Radiology Reports*, and *Guidance for Nursing Home Resident Medical Records* sections of this module.)



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7.2.4.1 Unacceptable Documentation

Several sources of medical records and types of documentation are **not acceptable** for risk adjustment data validation.

Unacceptable Sources of Medical Records

- Skilled nursing facility (SNF) (See *Additional Guidance*)
- Diagnostic Radiology
- Freestanding ambulatory surgical center (ASC)
- Alternative data sources (e.g., pharmacy)
- Unacceptable physician extenders (e.g., nutritionist)
- Durable medical equipment (DME)

Unacceptable Types of Medical Record Documentation

- Superbill
- Physician-signed attestation
- A list of patient conditions
- A diagnostic report that has not been interpreted
- Any documentation for dates of service outside the data collection period

Unacceptable Types of Diagnoses (outpatient hospital and physician settings)

- Probable
- Suspected
- Questionable
- Rule out
- Working

For additional information about unacceptable types of risk adjustment diagnoses, see Module 5 of the Participant's Guide.

7.2.4.2 Physician Signatures, Physician Credentials, and Dates of Service

As stated in CMS' 2008 Call Letter (available on the CMS web site at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>):

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



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specialty. (For additional information on acceptable physician specialties, see the above section titled *Filtering for Acceptable Provider Types and Physician Specialties*.)

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.

Thus, all dates of service that are identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner). The physician must authenticate each note for which services were provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signature. Signature stamps must comply with state regulations for authentication. For example, some states may require provider initials in conjunction with the stamped signature.

If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. **Some examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," or "Validated by," and include the practitioner's name and credentials and the date signed.**



Medical records will be reviewed if there is dated medical record documentation (e.g., handwritten or transcribed consultation report, discharge summary) with a physician signature and credentials.



A medical record that lacks a date or physician signature and credentials is invalid and will not be reviewed.

Tables 7B and 7C identify types of acceptable and unacceptable physician signatures and credentials.

TABLE 7B – TYPES OF ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

TYPE	ACCEPTABLE
• Hand-written signature or initials, including credentials	• Mary C. Smith, MD; or MCS, MD
• Signature stamp, including credentials	• Must comply with state regulations for signature stamp authorization
• Electronic signature, including credentials	• Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by")
	• Must be password protected and used exclusively by the individual physician



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TABLE 7C – TYPES OF UNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

TYPE	UNACCEPTABLE unless...
• Typed name	• Authenticated by the provider
• Non-physician or non-physician extender (e.g., medical student)	• Co-signed by acceptable physician
• Provider of services' signature without credentials	• Name is linked to provider credentials or name on physician stationery

7.2.4.3 Additional Guidance

To further assist MA organizations in determining the “one best medical record”, below is guidance on radiology reports, problem lists, nursing home resident medical records. Information about medical record documentation resources is also furnished.

Guidance for Nursing Home Resident Medical Records

Although CMS does not accept risk adjustment data from nursing home facilities, some beneficiaries who reside in a nursing home will have a nursing home medical record as the only source to support their diagnostic data (i.e., there is no other medical record that documents the diagnosis submitted for risk adjusted payment; the nursing home record is the record of last resort). Only in certain circumstances will CMS accept nursing home medical records for purposes of data validation. We will accept a medical record from a nursing home providing it is the only medical record for the enrollee that documents the diagnosis submitted for risk adjustment and:

1. The provider's encounter must have been face-to-face with the beneficiary;
2. The clinical provider rendering the services must be an acceptable physician specialty for risk adjustment;
3. The medical record must clearly document the provider's signature and credentials; and
4. The beneficiary must be identified in the Minimum Data Set (MDS) as a long-term institutional resident.

Guidance for Problem Lists

Although the term “problem list” is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.



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Inpatient Documentation – History and Physical (H&P) Guidance

As previously mentioned CMS recommends submitting the complete inpatient medical record for a hospital inpatient stay. Some organizations have inquired about the use of the H&P as stand-alone documentation when submitting risk adjustment and medical records. The following guidance must be taken into account if organizations are considering these options.

- H&P submitted as part of the complete inpatient medical record
 - Will **not** contain reportable final/confirmed diagnoses
 - Typically contains
 - Admission symptoms and co-existing conditions as well as
 - Admission/working diagnoses, which may or may not be one of the final diagnoses for the inpatient admission

Note that discharge/final diagnoses– not the H&P alone –will be reviewed in accordance with the Inpatient ICD-9 coding guidelines.
- H&P submitted as an independent physician visit from an inpatient stay

If a physician submits a separate claim/encounter based on his/her evaluation of the patient as reflected on the H&P

 - H&P (face-to-face encounter) is viewed as a physician visit
 - Reportable diagnoses documented in the H&P
 - Could be used as final
 - Could be used for risk adjustment; HOWEVER,
 - The medical record documentation will be reviewed in accordance with the Outpatient ICD-9 coding guidelines
- H&P Conclusion
 - Risk Adjustment is based on final/confirmed diagnoses.
 - Risk adjustment diagnoses should only be submitted based H&P alone when there is an independent physician claim associated with the diagnosis.
 - Upon validation, if an organization submits the H&P as stand-alone documentation, the Outpatient guidelines will be applied to determine if there is a confirmed diagnosis.



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Lab and Pathology Reports – Guidance

Some organizations have inquired about the use of Lab and Pathology Reports for data submission and medical record review. The following guidance must be taken into account when considering data or medical record submission from these sources.

- Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings)
- “Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicated their clinical significance.”
- Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding.
- Written interpretation (alone) of a tissue biopsy is not equivalent to the attending/referring physician’s complete clinical assessment used to assign a diagnosis.
- If submitting risk adjustment data or medical records based on pathology, note the following:
 - Outpatient pathology facilities are unacceptable risk adjustment provider sources.
 - Physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting risk adjustment diagnoses for data submission or as a stand-alone medical record for RADV refer to the guidance stated in this section. AND
 - Medical records submitted as stand-alone documentation from these sources will be reviewed in accordance with the Outpatient guidelines, and will likely result in a risk adjustment discrepancy since these sources do not typically render confirmed diagnoses.

Medical Record Documentation Resources

-  *ICD-9-CM Official Guidelines for Coding and Reporting*, October 1, 2003 (Section IV is specific to ambulatory coding), <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>
-  *ICD-9 Coding Clinic Guidelines*
-  *CMS 2004 Physicians and Medicare Advantage Risk Adjustment CD*
-  American Health Information Management Association, <http://www.ahima.org/>
-  American Medical Association, <http://www.ama-assn.org/>
-  *Bates Guide to the Physical Examination and History Taking*, 7th Edition, Chapter 21 (The Patient’s Record)
-  *Fundamentals of Clinical Practice*, Mengel, Holleman, and Fields (Eds.), Kluwer Academic/Plenum Publishers, Chapter 12 (Record Keeping and Presentation)

7.2.4.4 Risk Adjustment Discrepancies

As previously stated, a risk adjustment discrepancy occurs when the enrollee HCC(s) assigned after medical record review differs from the enrollee HCC(s) assigned based on submitted risk adjustment data. To give a general understanding of the types of discrepancies that may be identified, the following descriptions are provided:

- Invalid
 - The medical record documentation submitted for review is from an unacceptable provider type and physician specialty for risk adjustment (e.g., SNF).
 - The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.



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- The medical record is missing provider signature and credentials.
- Missing
 - Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
 - Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.
- Coding Discrepancies
 - The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.

Some risk adjustment discrepancy examples are provided below.



Example 2

Risk Adjustment Discrepancy – Example (Non-Hierarchical CMS-HCC)

Reported Diagnosis Data: 0031 Septicemia Shock (HCC2)
Data Validation Findings: HCC2 was not supported by the submitted medical record

The CMS-HCC Community Factor for HCC2 is .887. The submitted medical record documentation was reviewed and the abstracted diagnoses **did not** support HCC2. This finding results in a risk adjustment discrepancy because the enrollee HCC was not supported; thus, the associated factor should not be included in the enrollee's risk score. The enrollee's corrected (MRR) risk score will not reflect .887 for HCC2.



Example 3

Risk Adjustment Discrepancy – Example (Hierarchy CMS-HCC)

Reported Diagnosis Data: 4824 Staphylococcal Pneumonia (HCC111)
Data Validation Findings: 4823 Streptococcal Pneumonia (HCC112)

The medical record documentation supports the code 482.3 streptococcal pneumonia, not 482.4 staphylococcal pneumonia. The CMS-HCC Community Factor associated with HCC 111 is .761. The factor associated with HCC112 (the final HCC) is .233. This will result in a risk adjustment discrepancy finding because the enrollee HCC changed levels within the hierarchy. The enrollee's corrected (MRR) risk score will reflect a change from .761 (HCC111) to .233 (HCC112) based on this MRR finding.

All risk adjustment discrepancies identified by the initial MRRC are referred to a second independent MRRC for confirmation. Each independent MRRC implements an inter-rater reliability (IRR) process to ensure coding consistency and accuracy across coders. Risk adjustment discrepancies that are confirmed by both independent MRRCs will contribute to the payment error estimate and resulting contract-level payment adjustment for your organizations. (See *Stage 3* of this module.)



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7.3 MRR Findings and Contract-Level Payment Adjustments STAGE 3 (Slide 28)

Once all enrollee-level HCC findings are confirmed through two independent levels of review, CMS will provide each selected organization with the RADV findings. This communication will be sent as a report to the selected organizations and include 1) detailed enrollee information relating to the enrollee HCC discrepancies, 2) the contract-level payment adjustment amount (in absolute dollars) to be made, 3) an approximate timeframe for the payment adjustment, and 4) the requirements for the Documentation Dispute process if your organization decides to dispute enrollee HCC discrepant findings.

7.4 Documentation Disputes STAGE 4 (Slide 29)

A Documentation Dispute process will be implemented to address organization disputes regarding interpretation of the ICD-9-CM guidelines used by the MRRCs to assigned ICD-9 codes. The process will be facilitated by the MRRC and has some similarities to CMS' prior RADV Appeals processes where:

- Only enrollee HCC-level discrepancy findings will be allowed for dispute.
- MA organizations may dispute the application of the ICD-9-CM guidelines for the particular medical record date of service submitted during the Medical Record Request Stage (Stage 1).
- MA organizations will be given 60 days to submit a documentation dispute.
- An expert coding panel reviews every dispute. The panel is typically comprised of a senior medical reviewer, a senior coder, and a physician. The physician assesses whether any clinical factors may change the outcome of the appeals determination.

The Documentation Dispute process will not be used to address missing medical records of any kind, or additional medical record documentation of any kind. This means that MA organizations cannot use Documentation Dispute as a forum for first time submission of medical records and any additional medical record documentation to support their dispute(s). To clarify, the following information will not be accepted for Documentation Disputes:

- Medical records that were originally missing (i.e., the organization submitted no medical record) for an HCC, which resulted in Risk Adjustment Discrepancy Type = "Missing (never sent)".
- Medical records that resulted in a Risk Adjustment Discrepancy Type = "Missing (invalid)".
- Additional medical record documentation for HCCs that resulted in a Risk Adjustment Discrepancy Type = "Coding Discrepancy". The organization must submit the dispute based solely on the information that was originally submitted for the HCC during the Medical Record Request Stage.
- Additional medical record documentation for HCCs that were not originally assigned for 2007 payments for an enrollee.

When submitting a dispute, an MA organization must offer a clearly documented reason for disagreement with the MRRC regarding the ICD-9 code assignment and a different interpretation of the *ICD-9-CM Coding Guidelines*.



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7.5 Post Documentation Dispute -- Payment Adjustment STAGE 5 (Slide 30)

The enrollee-level findings will be re-calculated based on findings from the Documentation Dispute process (Stage 4) and contract-level level payment error will be re-estimated. Additional payment adjustments will be made based on these findings. Organization will be notified of the revised payment error estimate and resulting payment adjustment.

7.6 Appeals STAGE 6 (Slide 31)

This concludes the CORE Stages of the RADV Process. STAGES 1- 6

Following the core RADV process stages 1-5, CMS will implement a formal Appeals process, which will be facilitated by the CMS Office of Hearings. This process and the requirements will be announced prior to the Appeals process being implemented.

7.7 Recommendations & Lessons Learned to Date (Slides 32-33)

Recommendations and lessons learned about the medical record request process that may assist contracts in planning and implementing their contract's activities include the following:

- **CMS-related Validation Activities**

- Adhere to the submission deadline and plan accordingly.
- Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
- Involve in-house quality assurance staff/medical record reviewers/medical director to identify the "one best medical record."
- Query your data based on the beneficiary list that is furnished by the MRRC.
- Establish communications with the providers prior to sending the medical record request.
- Identify a contact person at the physician's office.
- Send complete request information to providers.
- Use newsletters and CMS training tools to inform physicians about risk adjustment.
- Determine whether providers require payment in advance of sending medical records.
- Follow up with the physician's office after the medical record request is sent.
- Plan accordingly to ensure that you receive the medical records you need. It may require more effort to obtain medical records from—
 - Specialists
 - Non-contracted providers
 - Hospital outpatient or primary care provider settings.
- Ensure that medical record documentation is signed (with physician credentials) and dated by an appropriate provider type and physician specialty.
- Ensure that medical record documentation is complete.
- Submit medical records on an on-going basis as you receive them from providers.

- **Conduct Ongoing Independent (non-CMS) Data Validation Activities**

MA organizations may choose to undertake data validation activities independent of CMS' efforts. When this is the case, CMS encourages organizations to clearly emphasize to their providers that the activity is **not a CMS-sponsored activity**. As a courtesy to providers, we ask that MA organizations limit to distribution of enrollee confidential health information to the minimum information necessary to accomplish the purpose of their activity. This means that an organization should not provide enrollee



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diagnoses data to providers who were not responsible for rendering specific treatment for enrollees. For example, if a provider submitted diabetes on a claim for an enrollee, the MA organization should only disclose diabetes to that provider and no other diagnoses as determined by other providers. In other words, the organization should not provide universal lists of enrollee diagnoses to multiple providers. Doing so, may raise concerns about the organization's compliance with the Privacy Rules.

If undertaking independent data validation activities, below are some additional considerations:

- Conduct ongoing internal processes to confirm the accuracy of risk adjustment diagnoses from providers.
- Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
- Use newsletters and CMS training tools to inform physicians about risk adjustment.

7.8 Technical Assistance

To improve the quality of risk adjustment data, CMS has technical assistance contractors available for any MA organization that needs help with CMS data validation processes, data completeness and accuracy, documentation requirements, and areas of concern identified by medical record review. Technical assistance may include site visits and teleconferences. To discuss your technical assistance needs, please contact the appropriate CMS staff member as identified in the *Current Validation Activities* section below.

7.9 CMS Data Validation Team Contacts (Slide 34)

Table 7D lists the CMS staff for the RADV project.

TABLE 7D – CMS STAFF

CMS CONTACT	CONTACT INFORMATION	ROLE
Jennifer Harlow	jennifer.harlow@cms.hhs.gov	Director, Division of Payment Validation
Lateefah Hughes	lateefah.hughes@cms.hhs.gov	RADV Project Team Lead Project Officer - LAC
Mary Guy	mary.guy@cms.hhs.gov	Project Officer- MRRC

7.10 Next Steps

As risk adjustment data validation activities continue, CMS will consider other techniques for monitoring risk adjustment data submissions to improve the sampling selection and receipt of quality medical record documentation.

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Attachment A –Medical Record Request Coversheet

INSTRUCTIONS: When completing this coversheet, please refer to the *Instructions Packet* that was mailed with your medical record request packet. Complete all applicable sections.

MA Organization Name:	
2008 Contract ID (E- or H-Number):	2006 Contract ID (E- or H-number):

Name of Health Plan

Designee Submitting Coversheet: _____

Date: __ __/__ __/2008

I. ENROLLEE DEMOGRAPHIC INFORMATION—Provide corrected information as necessary.

PRE-POPULATED INFORMATION	CORRECTED INFORMATION
HIC #:	
Last Name:	
First Name:	
DOB:	

II. STORED RISK ADJUSTMENT (RA) DATA¹

ENROLLEE CMS-HCC FOR VALIDATION	ICD-9-CM CODE(S) SUBMITTED FOR PAYMENT THAT MAP TO THE ENROLLEE CMS-HCC FOR VALIDATION	CMS-HCC HIERARCHY (YES/NO)?

III. MEDICAL RECORD NON-SUBMISSION—Prior to completing this section, please thoroughly review the footnote that appears at the bottom of this coversheet regarding hierarchies.

☐ Check here if not submitting a medical record.

IV. MEDICAL RECORD SUBMISSION—If submitting a medical record, complete this section.

SERVICE DATES²		PROVIDER TYPE (CHECK ONLY ONE BOX)
START (MM/DD/YYYY)	END (MM/DD/YYYY)	
__ __/__ __/ 2006	__ __/__ __/ 2006	☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician/Specialist

¹ In Section II we provide:

- Enrollee CMS-HCC for Validation—this is the CMS-HCC that was assigned based on the stored RA data;
- ICD-9-CM Code(s) Submitted for Payment that Map to the Enrollee CMS-HCC for Validation—displays the ICD-9-CM code(s) used to assign the “Enrollee CMS-HCC for Validation”; and
- CMS-HCC Hierarchy (YES/NO)?—identifies whether the “Enrollee CMS-HCC for Validation” is part of a hierarchy. If you cannot provide supporting medical record documentation for the Enrollee CMS-HCC specified, you may submit medical record documentation with this coversheet that supports another CMS-HCC within the same hierarchy. The *Instructions Packet* provides a full list of CMS-HCCs, CMS-HCC hierarchies, and the ICD-9-CM codes.

Note CMS-HCCs that are not supported by medical record documentation will result in a payment adjustment.

² Applicable service dates must have occurred between January 1, 2006 and December 31, 2006.



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MODULE 8– VERIFYING RISK SCORES

Purpose (Slide 2)

The risk score calculation is based on data captured from a variety of systems. To ensure that accurate payments are made, Medicare Advantage (MA) organizations may verify the components of the risk score calculation throughout the year. This module is designed to explain the systems involved in the risk score calculations and introduce MA organizations to a variety of verification tools available to them.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

- Understand the systems and processes used to calculate the risk scores.
- Determine how the organization can use risk adjustment processing and management reports to ensure the accuracy of payment.
- Identify the components and uses of the Non-Drug and Drug Monthly Membership Reports (MMRs).
- Explain the Part C Risk Adjustment and New RXHCC Model Output Report (MOR).

ICON KEY	
Example	
Reminder	
Resource	

8.1 Calculating Risk Scores (Slides 5-7)

The risk score used in calculating payments under the Centers for Medicare & Medicaid Services (CMS)-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The risk score calculation gathers the critical data from a variety of systems, including risk adjustment data from the Risk Adjustment Processing System (RAPS) database, Fee-For-Service (FFS) information from the National Medicare Utilization Database (NMUD), and demographic data captured from the Common Tables.

The risk score calculation considers the following:

- Demographics
- Disease groups
- Disease interactions
- Disease hierarchies
- Disabled indicators
- Residence in a long-term care institution
- End-Stage Renal Disease (ESRD) Status

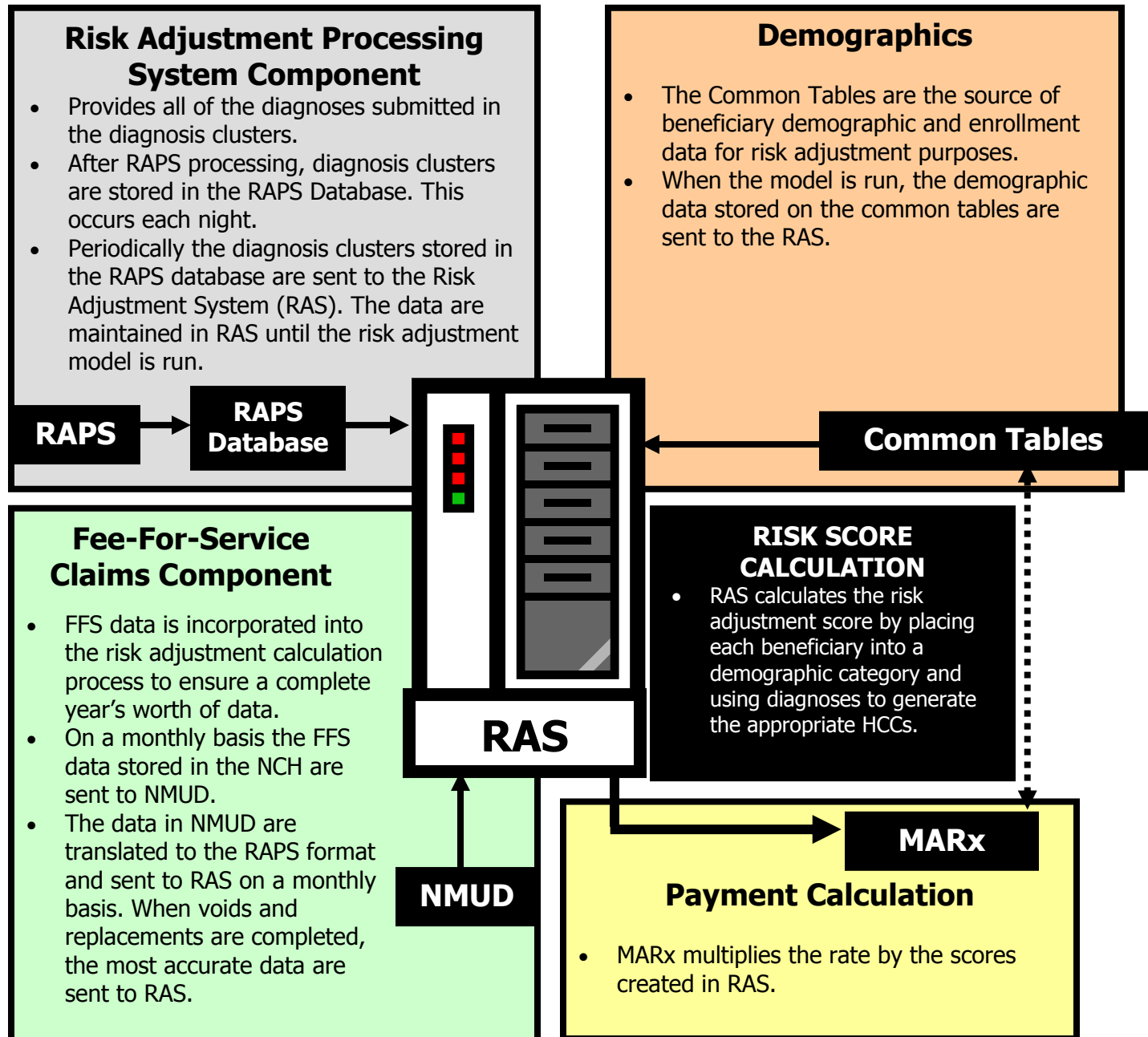


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Figure 8A illustrates the flow of data used to calculate the risk score.

Figure 8A - Risk Score Calculation Process





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Table 8A describes the eight steps in the risk score calculation.

TABLE 8A - RISK SCORE CALCULATION STEPS

STEP	DESCRIPTION
1 Define Cohort	Each year CMS defines a cohort of beneficiaries for whom risk scores will be calculated and used for making payments beginning the following January. Typically, CMS calculates scores for all Medicare beneficiaries.
2 Obtain Beneficiary Specific Information	For this cohort, CMS obtains beneficiary-specific information from Medicare's enrollment databases. Beneficiary information includes the months of enrollment in Part A and Part B, age, sex, original reason for Medicare entitlement, etc. for each beneficiary in the cohort. Medicaid information is obtained from the third party payor file. In addition, plan-submitted Medicaid status information is included and beneficiaries with an ESRD flag are identified. CMS ensures that all Health Insurance Claim (HIC) numbers associated with each individual in the file have been identified. CMS uses all of this information to create a beneficiary demographic input file.
3 Extract Long-term Institutional Information from MDS	Next, for this cohort, CMS extracts assessments from the Minimum Data Set (MDS). CMS identifies the beneficiaries who have resided in a long-term institution for 90 days or more and classifies these individuals as long-term institutional beneficiaries. CMS passes beneficiary long-term institutional file to the RAS system.
4 Obtain Diagnosis Information	Next, CMS obtains all diagnostic information from Medicare data files for the cohort. These data include all diagnoses for the data collection period from the three types of data sources: physician services, hospital outpatient, and hospital inpatient. These diagnoses come from the RAPS database as well as Medicare fee-for-service files. From these data, CMS creates a beneficiary diagnosis input file.
5 Run the Model	The beneficiary demographic and beneficiary diagnosis input files are used to run the CMS-HCC and ESRD models and the Prescription Drug HCC (RxHCC) model. The ESRD model is run only on those beneficiaries with ESRD flags from the Common Tables. Each model determines a new enrollee factor for individuals who had fewer than 12 months of Part B enrollment during the data collection period. The model filters out diagnoses that do not correlate, such as ovarian cancer in a male patient. For individuals with 12 months of Part B enrollment, the software produces two risk scores: one based on the community model and one on the institutional model. In addition, for individuals with ESRD, the ESRD model will create additional risk scores appropriate to that model. The software also shows which HCC group (as well as which demographics, interactions, etc.) is associated with the risk scores. Only the most severe disease classification within a hierarchy is shown in the output. Based on this information, an output file is created and sent to the payment system.



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TABLE 8A – RISK SCORE CALCULATION STEPS (CONTINUED)

STEP	DESCRIPTION
6 Send Model Output to MARx	The output from the CMS-HCC model is provided to MARx for use in making payments to plans. In addition, the model output serves as the basis for the MMR reports provided to plans and the risk adjustment MOR.
7 Apply Additional Payment Factors	Plan-level instructions are provided to MARx to determine which factors should be used in actually making payments.
8 Calculate Payment	MARx identifies individuals enrolled in an organization for a particular month. Then it accesses the risk factor file to retrieve the appropriate risk factor for each individual. MARx uses the individual's state and county code to determine the correct county capitation rate and then multiplies the risk factor by that rate. After calculating the correct demographic payment for the same individual, MARx then calculates the correct payment by blending the appropriate proportion of risk and demographic payments. Then the demographic and risk adjusted amounts are totaled.

Note: For each risk adjustment model run, the process is repeated, updating the data used for the model to include new diagnoses received for the data collection period, as well as changes in any of the demographic factors. During final reconciliation, long-term institutional status is determined for each month during the payment year, and ESRD status is reconciled to obtain the most precise month-by-month status.

8.2 Risk Score Verification Tools (Slide 8)

CMS offers a variety of tools that MA organizations can use at various stages in the risk adjustment process to ensure that the risk score reported by CMS is in close alignment with the score that the organization expects to receive. This section of the training module describes each of the tools, identifies the method of access and timeframe, and provides information on how an organization can use the tool to increase the accuracy of payment projections.

The verification tools include:

- RAPS Return File/RAPS Transaction Error Report
- RAPS Monthly and Cumulative Plan Activity Reports
- SAS CMS-HCC Model Program
- MMR
- Part C MOR (Non-Drug) and the new RAS RxHCC MOR

Information on the tools are illustrated in Table 8B



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TABLE 8B – RISK SCORE VERIFICATION TOOLS

REPORT NAME	ACCESS	AVAILABLE
RAPS Return File/RAPS Transaction Error Report	RAPS Mailbox RPT####.RPT.RAPS_RETURN_FLAT RPT####.ZIP.RAPS_RETURN_FLAT (zip format) RPT####.RPT.RAPS_ERROR_RPT RPT####.ZIP.RAPS_ERROR_RPT (zip format)	Next business day following data submission
RAPS Monthly and Cumulative Plan Activity Reports	RAPS Mailbox RPT####.RPT.RAPS_MONTHLY RPT####.ZIP.RAPS_MONTHLY (zip format) RPT####.RPT.RAPS_CUMULATIVE RPT####.ZIP.RAPS_CUMULATIVE (aip format)	Second business day of the month
Risk Adjustment SAS Programs	http://cms.hhs.gov/MedicareAdvtgSpecRateStats <i>Ratebooks & Supporting Data, 2004 Mar-Dec, Downloads</i>	2003-present
MMR Non-Drug and Drug Reports	Through MARx	Refer to the 2006 MARx Monthly Schedule
MOR HCC Part C and RAS RxHCC MOR	Through MARx	Refer to the 2006 MARx Monthly Schedule



Locate the 2008 MARx Monthly Schedule from: <http://www.cms.hhs.gov/MMAHelp/>.
For applicable diagnoses by payment years (2004-2009) for CMS-HCC and RxHCC models see http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

8.2.1 RAPS Return File/RAPS Transaction Error Report (Slide 9)

The RAPS Return File contains all transactions submitted by the MA organization. Any errors identified during the RAPS process will appear next to the field in which the error was found. This indicates that the diagnosis was not stored. The file is delivered in the same flat file format used for the RAPS input. Unique diagnosis clusters that are 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. Since this report is a flat file, MA organizations may download the file into a Microsoft Access or Excel database, and establish a record of each diagnosis that was stored in the CMS-HCC model for each enrollee. Larger organizations also use this file in mainframe databases. Organizations that employ automated update processes for their databases typically use the Return File.

The RAPS Transaction Error Report contains only those records that contain errors, causing one or more diagnosis clusters to be rejected. The RAPS Transaction Error Report is typically used by organizations that employ a non-automated update process when maintaining their diagnosis files. To use this report, an individual at the health plan normally downloads the report, prints it, and then manually updates their diagnosis records to indicate which diagnoses were rejected.

The database will serve several purposes:



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1. 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.
2. The MA organization will have the data required to determine which diagnoses were stored for each beneficiary for the payment period.
3. CMS requires plans to submit all required diagnoses, and recommends maintaining an accurate record of all data submitted and stored.



MA organizations must submit each required diagnosis at least once during a reporting period for each enrolled beneficiary.



Example: 1

The MA organization received a RAPS Return File that included three records and one cluster within each record. Using the data communicated on the RAPS Return File, the organization captured information that could be used later to verify the risk score. The plan developed an internal database that captured each HIC number and each relevant diagnosis that is stored in the RAPS database for that beneficiary. Based on the RAPS Return File (see Figure 8B), the plan captured the 70710 (ulcer of the lower limb) and 311 (depression) diagnoses, since both were accepted to RAPS. Figure 8C illustrates the database content based on the results of this RAPS Return File.

Note: The plan should maintain 311 in its database. 311 is a required diagnosis that was stored in the RAPS database even though it is not a model diagnosis. 250, in the third CCC record, is a model diagnosis, however it was returned with an error code (i.e., 354). Therefore, the plan should not maintain this diagnosis in its database until the error has been successfully addressed.

Note: Figure 8B is an abbreviated version of the RAPS Return File due to space limitations on the page.

Figure 8B – RAPS Return File

AAASH7777000000000120030411PROD					
70710BBB0000001H9999					
CCC0000001	7321430	123456789A	19350305	012003031420030318	70710
CCC0000002	7321430	123456788A	19350305	012003031420030318	311
CCC0000003	7321430	123456787A	19350305	354012003031420030318	250
YYY0000001H999900000003					
ZZZSH7777000000000120030411					

HIC points to the HIC numbers (123456789A, 123456788A, 123456787A).
Error Code points to the error code 354.
Diagnosis points to the diagnosis codes 70710, 311, and 250.

Figure 8C – Internal Diagnosis Cluster Database

HIC	Dx	From Date	Thru Date	Provider Type	Date Submitted
123456789A	70710	20030314	20030318	01	20030411
123456788A	311	20030314	20030318	01	20030411



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Note: The MA organization may include other fields, such as Patient Control Number (PCN), in the database for a variety of reasons. The PCN can help the plan find the original source document for the diagnosis. This sample database includes only the minimal components required for verifying the accuracy of the number of clusters stored for risk score calculation and elements that define a duplicate cluster.

8.2.2 RAPS Management Reports (Slide 11)

The RAPS Monthly and Cumulative Plan Reports (Figure D) are available the second business day of the month. These reports assist in the confirmation of the total number of diagnoses stored in the CMS-HCC model.

The reports are delivered in report layout format. MA organizations can compare their internal database developed from the RAPS Return File to the number of diagnoses stored on the report. The cumulative report reflects the total number of diagnoses stored to date for the H number. The database should reflect all diagnosis clusters stored for the health plan for the data collection period



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Figure 8D – RAPS Cumulative Plan Activity Report

RAPS0020	CMS RAPS ADMINISTRATION					PAGE:	1
RUN REPORT:	DATE: 20070203	RAPS CUMULATIVE PLAN ACTIVITY REPORT				SERVICE YEAR:	2006
SUBMITTER ID:	SH7777	FOR PERIOD ENDING January 30, 2004					
PLAN NO:	H7777						
PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	22	35	29	19	27	25	157
TOTAL REJECTED	2	4	7	5	3	3	24
TOTAL ACCEPTED	20	31	22	14	24	22	133
TOTAL STORED	20	31	22	16	24	24	137
TOTAL MODEL STORED	0	0	2	0	2	0	4
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	64	83	51	48	40	60	346
TOTAL REJECTED	8	10	11	6	5	4	44
TOTAL ACCEPTED	56	73	40	42	35	56	302
TOTAL STORED	56	73	40	42	35	56	302
TOTAL MODEL STORED	0	0	0	1	0	0	1
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	98	87	43	37	44	76	385
TOTAL REJECTED	7	5	3	4	5	4	28
TOTAL ACCEPTED	91	82	40	33	39	72	357
TOTAL STORED	91	82	40	33	39	72	357
TOTAL MODEL STORED	0	0	3	3	1	0	7
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	99	77	92	90	97	79	534
TOTAL REJECTED	5	5	8	6	8	5	37
TOTAL ACCEPTED	94	72	84	84	89	74	497
TOTAL STORED	94	72	84	84	89	74	497
TOTAL MODEL STORED	0	0	2	1	0	1	4
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0



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8.2.3 CMS-HCC Risk Adjustment Model Software (Slide 12)

The software is a SAS program that allows the organization to verify and predict risk scores. Click on HCC Software (ZIP 49KB), open the zip file, and double click on "hccsoftdescription.rtf." CMS published the ESRD model on the web after publication of the final payment notice for 2005. Users must have a SAS license to use the SAS program.

MA organizations may access the CMS-HCC Risk Model software at <http://cms.hhs.gov/>.

- Select:
 - Medicare
 - Health Plans
 - Medicare Advantage Rates & Statistics
 - Risk Adjustment
 - Downloads
 - 2007 CMS-HCC software (ZIP 53KB)

The software includes an HCCSOFT SAS program that uses several SAS Macros to create HCC 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 MACROSOFT. This macro program takes user-provided files and assigns HCCs for each person. The program follows these major steps when calculating risk scores.

1. The program assigns each beneficiary to an appropriate age/sex grouping, and adds in the interactions for Medicaid, disabled, and previously disabled.
2. The program crosswalks diagnoses to Condition Categories using SAS formats that were previously stored in the FORMAT library.
3. The program then creates HCCs by imposing hierarchies on the Condition Categories.
4. The program creates the interactions.
5. The program computes predicted scores from three regression models.

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



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Table 8C lists the software-provided files.

TABLE 8C – SOFTWARE-PROVIDED FILES

FILE NAME	DESCRIPTIONS
V1206D4P	Main program that supplies user parameters to the main SAS macro program.
V1206D4M	Main macro that creates HCC and Score variables by calling other external macros.
AGESEXVR	Creates age/sex, originally disabled, disabled variables.
EDITICD9	Performs edits to International Classification of Diseases, 9 th Revision, Clinical Modification (ICD-9-CM) code.
V12H70M	Assigns ICD-9-CM diagnosis code to multiple CCs where required.
V12H70L	Assigns labels to HCCs.
V12H70H	Sets HCC=0 according to hierarchies.
SCOREVR	Calculates a score variable.
F1206D4Y	Format library that has a crosswalk from ICD-9-CM codes to CC categories that are transformed to HCC categories by the software.
C1206D4Y	Coefficients for three regression models.

Table 8D provides a list of user supplied files.

TABLE 8D – USER SUPPLIED FILES

FILE NAME	DESCRIPTION
Person File	A person-level file of demographic and enrollment information
Diagnosis File	A diagnosis-level input file of diagnoses

8.2.4 Monthly Membership Reports (MMR) (Slides 13-16)

The MMR provides information to reconcile the Medicare membership and payment record to the records maintained by CMS. The MMR is available in two formats – report and data file, which are posted monthly. The report and data file formats provide summary and detail-level information on beneficiaries belonging to the MA organization.

Summary: This format presents a summary of the payments and adjustments applicable to the MA organization's Medicare membership. This format shows the total number of beneficiaries for whom a hospice, ESRD, or institutionalized payment was received.

Detail: This format contains a detailed list of beneficiaries for whom a payment was made to the MA organization for that month: either a monthly or an adjustment payment. This allows the MA organization to compare its beneficiary records with those maintained by CMS.



The MMR Reports communicate information on a beneficiary level.

Questions regarding accessing and understanding the MMR should be directed to the plan's regional contact at the CMS Central Office.



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8.2.4.1 Monthly Membership Summary Reports (Slide 13)

The MMR Summary is available in both data file and report layout format. Both the data file and the report include summaries of drug and non-drug data.

8.2.4.2 Monthly Membership Detail Reports (Slide 13)

The MMR Detail is available in a data file that includes both drug and non-drug data. CMS extracts data from the data file and generates two formatted reports, one for drug data and one for non-drug data. The reports display payment information as it relates to the appropriate payment model. The two detail reports are described below.

8.2.4.2.1 Non-Drug Monthly Membership Report (Slide 14)

The Non-Drug MMR 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.

8.2.4.2.2 Drug Monthly Membership Report (Slide 15)

The Drug MMR 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.

Table 8E describes the MMR field ranges. Table 8F provides the complete record layout for the MMR.

TABLE 8E – SUMMARY OF THE MMR DETAIL RECORD LAYOUT FIELD RANGES

FIELD RANGE	GENERAL DESCRIPTION OF FIELD RANGE
1-3	Managed Care Organization Information
4-11	Beneficiary Identification
12-13	Entitlement
14-21	Health Status
22-34	Risk Adjustment/Demographic Payment Adjustment Information
35	Low Income Subsidy Premium Amount
36	ESRD MSP Flag
37-46	Additional Indicators
47	Risk Adjustment Factor Type Code
48	Frailty Indicator
49	Original Reason for Entitlement Code (OREC)
50	Lag Indicator
51	Segment ID for Part D
52	Enrollment Resource
53	EGHP Flag
54-66	Risk Adjustment Premium/Rebate/Payment Information
67	Part D Risk Factor
68-78	Fields supporting the Part D Benefit
79-80	PACE related fields

Note: In 2006, CMS added a Low-Income Subsidy (LIS) Premium Amount field to filler field #35. This field contains the amount of Part D premium paid to MA organizations on behalf of affected members.



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TABLE 8F – MONTHLY MEMBERSHIP REPORT (MMR) (DRUG AND NON-DRUG FIELDS)

MMR FLAT FILE LAYOUT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	First 7 letters of the member's surname
6	First Initial	1	39-39	First initial of the member's first name
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Aged/Disabled MSP	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional (monthly)
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid Beneficiary Medicaid Status Flag	1	66-66	Y = Default Part C risk factor used, Medicaid Beneficiary N = Default Part C risk factor used, non-Medicaid beneficiary Blank = No Part C default factor used or the beneficiary is Part D only
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	Y = Medicaid Add-on to beneficiary RAS factor Blank = No Medicaid Add-on
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a 'Y' indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a 'Y' indicates that a default factor was generated by the system due to lack of a RA factor.



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MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29	Paymt/Adjustmt Start Date	8	92-99	FORMAT: YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	FORMAT: YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	FORMAT: -99999.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	FORMAT: -99999.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35	LIS Premium Subsidy	8	144-151	FORMAT: -9999.99
36	ESRD MSP Flag	1	152-152	Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer for an ESRD member
37	MSA Part A Deposit/Recovery Amount	8	153-160	Medicare Savings Account (MSA) lump sum Part A dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
38	MSA Part B Deposit/Recovery Amount	8	161-168	Medicare Savings Account (MSA) lump sum Part B dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
39	MSA Deposit/Recovery Months	2	169-170	Number of months associated with MSA deposit or recovery dollars



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MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
40	FILLER	1	171-171	SPACES
41	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
42	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43	De Minimis	1	183-183	'N' = "de minimis" does not apply 'Y' = "de minimis" applies
44	FILLER	2	184-184	SPACES
45	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
46	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
47	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD)
48	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
49	Original Reason for Entitlement Code (OREC)	1	192-192	0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD



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MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
50	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months.
51	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.
52	Enrollment Source	1	197	The source of the enrollment. Values are A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover), E = Auto-enrolled by Plans, F = Facilitated enrollment by Plans, G = POS submitted enrollment, H = Re-assignment enrollment by CMS or Plans and I = Enrollments submitted by Plans with enrollment source other than B, E, F, G, H and blank.
53	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
54	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
55	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
56	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
57	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
58	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
59	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99



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MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
60	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non- ESRD members and it is subtracted from ESRD member's payments. -9999.99
61	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non- ESRD members and it is subtracted from ESRD member's payments. -9999.99
62	Rebate for Part D Supplemental Benefits – Part A Amount	8	263-270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63	Rebate for Part D Supplemental Benefits – Part B Amount	8	271-278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
64	Total Part A MA Payment	10	279-288	The total Part A MA payment. -999999.99
65	Total Part B MA Payment	10	289-298	The total Part B MA payment. -999999.99
66	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -9999999.99
67	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD
68	Part D Low-Income Indicator	1	317	An indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank.
69	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD
70	Part D Long Term Institutional Indicator	1	325	An indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank.
71	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD
72	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99



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MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
73	Part D Basic Premium Amount	8	341-348	The plan's Part D premium amount. -9999.99
74	Part D Direct Subsidy Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. -999999.99
75	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
76	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
77	Total Part D Payment	11	379-389	The total Part D payment for the member -999999.99.
78	Number of Paymt/Adjustmt Months Part D	2	390-391	99
79	PACE Premium Add On	10	392-401	Total Part D PACE Premium Add-on amount -999999.99
80	PACE Cost Sharing Add on	10	402-411	Total Part D PACE Cost Sharing Add-on amount -999999.99



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Plans may access the MMR Report format. Figure 8E illustrates an example of the MMR for Non-Drug.

Figure 8E –MMR REPORT FORMAT – NON-DRUG

RUN DATE:20050115			MONTHLY MEMBERSHIP REPORT - NON DRUG										PAGE:		1								
PAYMENT MONTH:200502			PLAN(H4444) PBP(nnn) SEGMENT(mmm) IRIS INSURANCE OF INDIANA																				
----- REBATES -----																							
BASIC PREMIUM			COST SHR		REDUC		MAND SUPP		BENEFIT		PART D SUPP		BENEFIT		PART B BAS PRM		REDUC		PART D BAS PRM		REDUC		
PART A		\$8889.99			N/A				N/A				N/A				N/A				N/A		
PART B		\$8889.99			N/A				N/A				N/A				N/A				N/A		
S			----- FLAGS -----												----- PAYMENTS/ADJUSTMENTS -----								
CLAIM		E AGE	STATE	P P		M F		A D		S A		MTHS		DATES		LAG		FTYPE					
NUMBER		X GRP	CNTY	A A H E I		C R O D E E O D A B		START		END													
-----			O R R O S N N A A R D F G U M												-----								
SURNAME		F	DMG	BIRTH		O T T S R S H I I E O A H R S		PIP		ADJ													
I		RA	DATE	A A B P D T C D L C N U P C P DCG		REA		FCTR-A		FCTR-B		PART A		PART B		TOTAL PAYMENT							
-----			-----												-----								
1234567890AB		F	8084	33800				200405		200405		Y		C									
LEONARD		G	8084	19200206		Y Y N		Y		Z929		ZZ		1.0650		1.0650		\$8888889.99		\$8888889.99		\$8888889.99	
0987654321AB		M	8084	33800				200405		200405		Y		C									
MARION		H	8084	19251008		Y Y Y		N		Z929		ZZ		1.0650		1.0650		\$8888889.99		\$8888889.99		\$8888889.99	

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.

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Figure 8F –MMR REPORT FORMAT – DRUG

1RUN DATE:20061027				MONTHLY MEMBERSHIP REPORT - DRUG												PAGE:1			
PAYMENT MONTH:200601				PLAN(H9999) PBP(999) SEGMENT(000) ACME HEALTH SERVICES															
0				BASIC PREMIUM ESTIMATED REINSURANCE															
				PART D		\$10.60				\$0.00									
0				S		---		FLAGS		---		----- PAYMENTS/ADJUSTMENTS -----							
CLAIM		E	AGE	STATE	P	P	S	L	L	D	ADJ	RA	FCTR	DATES		LOW-INCOME COST		LOW-INCOME COST	
NUMBER		X	GRP	CNTY	A	A	E	O	O	I	E	REA		START	END	SHARING PERCENTAGE		SHARING SUBSIDY	
-----				-		O		R		R		G		U		I		N	
SURNAME		F	DMG	BIRTH	O	T	T	H	R	N	S	I	MTHS	DIRECT SUBSIDY		PACE		PACE COST	
		I	RA	DATE	A	A	B	P	C	C	T	N	D	PAYMENT AMT		PREMIUM ADD-ON		SHARING ADD-ON	
-----				-		-		-		-		-		-----		-----		-----	
123456789A		F	5559	33700										1.9770	200601	200601	000		\$0.00
FIRST		S	5559	19491130					B			N	1	\$129.17			\$0.00	\$0.00	\$129.17
987654321A		F	8084	10050										1.0300	200601	200601	000		\$0.00
SECOND		M	8084	19240306					B			Y	1	\$62.22			\$0.00	\$0.00	\$62.22

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8.2.5 Risk Adjustment Model Output Reports (MOR) (Slides 17-19)

CMS has developed two reports to support the MMR – the Part C Risk Adjustment MOR and the new RxHCC MOR. The MORs are used in conjunction with the MMR and beneficiary-specific information (residence-community vs. institution, Medicaid status, disability, etc.) to verify risk scores.

The reports are available monthly through MARx in flat file and report layout.

8.2.5.1 Part C Risk Adjustment MOR (Slide 18)

The Part C Risk Adjustment MOR displays the HCCs used by RAS to calculate risk adjustment factors for each beneficiary. This report displays the HCC Disease Groups used by the CMS-HCC model and disease and demographic interactions.

The Part C Risk Adjustment MOR provides detailed beneficiary level information on:

- Enrollee identifiers (HICs, name, date of birth).
- The appropriate sex and age group, as well as other demographic factors for an individual (if applicable).
- The specific disease groups (HCCs) triggered.
- Disease interactions.

The Part C Risk Adjustment MOR 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.



Example: 3

If a beneficiary triggered HCC 7 (Metastatic Cancer and Acute Leukemia) and HCC 9 (Lymphatic, Head and Neck, Brain, and Other Major Cancers), the report will reflect HCC 7, not HCC 9 because HCC7 is the most severe manifestation of the disease.

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 plan level frailty score on HPMS. PACE organizations must then determine whether the score is a new enrollee or institutional score and determine which factors on a given HCC apply. The report includes Medicaid information, individual HCCs, and the interaction of HCCs. PACE organizations should also review the values associated with each individual condition and the appropriate community or institutional numbers. A final reconciliation of HCCs may prove useful in the analysis.

Table 8G provides descriptions of the fields in the Part C MOR, and Table 8I provides the complete record layout for the Part C MOR.



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TABLE 8G – PART C RISK ADJUSTMENT MOR FIELD SUMMARY

REPORT BODY = 162 bytes	
Fields	Description
1	Record Type
2-8	Beneficiary Identifying Information.
9-20	The sex and age group for the female beneficiary.
21-32	The sex and age group for the male beneficiary.
33-34	Medicaid indicators for Female Beneficiary.
35-36	Medicaid indicators for Male Beneficiary.
37	Originally Disabled Female.
38	Originally Disabled Male.
39-108	Disease Coefficients. Field 38 represents HCC 1. Field 107 represents HCC 177.
109-113	Disabled Disease HCC. Field 108 represents HCC 5. Field 112 represents HCC 107.
114-119	Disease Interactions.

8.2.5.2 RAS RxHCC MOR (Slide 19)

With the implementation of Part D, CMS created the RxHCC model for Prescription Drug Plans. The Part D model predicts plan liability for prescription drugs, uses different diseases to predict drug costs, and includes multipliers for incremental costs related to low-income and long term institutional beneficiaries.

The Part D model, like the CMS-HCC model, provides for some disease groups to fall into hierarchies. Diseases with higher levels of severity may include intensified drug regimens or additional drug needs for treatment. The hierarchies for the Part D model are triggered by the highest cost category of the related diseases. Lower cost categories do not increase the Part D risk score.

The RAS RxHCC MOR displays the RxHCCs for each beneficiary. The report is formatted similarly to the Part C Risk Adjustment MOR. The RxHCCs can be used by plans to verify the beneficiaries risk factors provided in the MMR. Summing the risk factors for an individual beneficiary yields a total risk adjustment factor.

Table 8H provides a sample description of the fields in the RxHCC MOR, and Table 8J provides the complete record layout for the RxHCC MOR.

TABLE 8H – RXHCC MOR FIELD SUMMARY

REPORT BODY = 164 bytes	
Fields	Description
1	Record Type
2-8	Beneficiary Identifying Information.
9-20	The sex and age group for the female beneficiary.
21-32	The sex and age group for the male beneficiary.
33	Originally Disabled Female.
34	Originally Disabled Male.
35-119	Disease Coefficients RxHCCs. Field 35 represents RxHCC1. Field 119 represents RxHCC 187.
120-122	Disabled Disease RxHCC. Field 120 represents RxHCC 65. Field 122 represents RxHCC 108.



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TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE

Header Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '1'
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Run Date	8	7 – 14	Date when file was created, YYYYMMDD
4	Payment Year and Month	6	15 – 20	Identifies the risk adjustment payment year and month for the model run
5	Filler	142	21 – 162	Spaces

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '2'
2	Health Insurance Claim Number	12	2 – 13	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12 bytes account number.
3	Beneficiary Last Name	12	14 – 25	First 12 bytes of the Beneficiary Last Name
4	Beneficiary First Name	7	26 – 32	First 7 bytes of the Beneficiary First Name
5	Beneficiary Initial	1	33	Beneficiary Initial
6	Date of Birth	8	34 – 41	The date of birth of the Medicare Beneficiary. Format as YYYYMMDD.
7	Sex	1	42	Represents the sex of the Medicare Beneficiary. Examples include Male and Female. 0=unknown, 1=male, 2=female
8	Social Security Number	9	43 – 51	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female0_34	1	51	The sex and age group for the beneficiary base on a given as of date. Female between ages of 0 through 34. Set to "1" if existed, otherwise "0".
10	Age Group Female35_44	1	52	The sex and age group for the beneficiary base on a given as of date. Female between ages of 35 through 44. Set to "1" if existed, otherwise "0".



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TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
11	Age Group Female45_54	1	54	The sex and age group for the beneficiary base on a given as of date. Female between ages of 45 through 54. Set to "1" if existed, otherwise "0".
12	Age Group Female55_59	1	55	The sex and age group for the beneficiary base on a given as of date. Female between ages of 55 through 59. Set to "1" if existed, otherwise "0".
13	Age Group Female60_64	1	56	The sex and age group for the beneficiary base on a given as of date. Female between ages of 60 through 64. Set to "1" if existed, otherwise "0".
14	Age Group Female65_69	1	57	The sex and age group for the beneficiary base on a given as of date. Female between ages of 65 through 69. Set to "1" if existed, otherwise "0".
15	Age Group Female70_74	1	58	The sex and age group for the beneficiary base on a given as of date. Female between ages of 70 through 74. Set to "1" if existed, otherwise "0".
16	Age Group Female75_79	1	59	The sex and age group for the beneficiary base on a given as of date. Female between ages of 75 through 79. Set to "1" if existed, otherwise "0".
17	Age Group Female80_84	1	60	The sex and age group for the beneficiary base on a given as of date. Female between ages of 80 through 84. Set to "1" if existed, otherwise "0".
18	Age Group Female85_89	1	61	The sex and age group for the beneficiary base on a given as of date. Female between ages of 85 through 89. Set to "1" if existed, otherwise "0".
19	Age Group Female90_94	1	62	The sex and age group for the beneficiary base on a given as of date. Female between ages of 90 through 94. Set to "1" if existed, otherwise "0".
20	Age Group Female95_GT	1	63	The sex and age group for the beneficiary base on a given as of date. Female between age of 95 and greater. Set to "1" if existed, otherwise "0".
21	Age Group Male0_34	1	64	The sex and age group for the beneficiary base on a given as of date. Male between ages of 0 through 34. Set to "1" if existed, otherwise "0".
22	Age Group Male35_44	1	65	The sex and age group for the beneficiary base on a given as of date. Male between ages of 35 through 44. Set to "1" if existed, otherwise "0".
23	Age Group Male45_54	1	66	The sex and age group for the beneficiary base on a given as of date. Male between ages of 45 through 54. Set to "1" if existed, otherwise "0".



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TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
24	Age Group Male55_59	1	67	The sex and age group for the beneficiary base on a given as of date. Male between ages of 55 through 59. Set to "1" if existed, otherwise "0".
25	Age Group Male60_64	1	68	The sex and age group for the beneficiary base on a given as of date. Male between ages of 60 through 64. Set to "1" if existed, otherwise "0".
26	Age Group Male65_69	1	69	The sex and age group for the beneficiary base on a given as of date. Male between ages of 65 through 69. Set to "1" if existed, otherwise "0".
27	Age Group Male70_74	1	70	The sex and age group for the beneficiary base on a given as of date. Male between ages of 70 through 74. Set to "1" if existed, otherwise "0".
28	Age Group Male75_79	1	71	The sex and age group for the beneficiary base on a given as of date. Male between ages of 75 through 79. Set to "1" if existed, otherwise "0".
29	Age Group Male80_84	1	72	The sex and age group for the beneficiary base on a given as of date. Male between ages of 80 through 84. Set to "1" if existed, otherwise "0".
30	Age Group Male85_89	1	73	The sex and age group for the beneficiary base on a given as of date. Male between ages of 85 through 89. Set to "1" if existed, otherwise "0".
31	Age Group Male90_94	1	74	The sex and age group for the beneficiary base on a given as of date. Male between ages of 90 through 94. Set to "1" if existed, otherwise "0".
32	Age Group Male95_GT	1	75	The sex and age group for the beneficiary base on a given as of date. Male between age of 95 and greater. Set to "1" if existed, otherwise "0".
33	Medicaid Female Disabled	1	76	Beneficiary is a female disabled and also entitled to Medicaid. Set to "1" if existed, otherwise "0".
34	Medicaid Female Aged	1	77	Beneficiary is a female aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise "0".
35	Medicaid Male Disabled	1	78	Beneficiary is a male disabled and also entitled to Medicaid. Set to "1" if existed, otherwise "0".
36	Medicaid Male Aged	1	79	Beneficiary is a male aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise "0".



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TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
37	Originally Disabled Female	1	80	Beneficiary is a female and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise "0".
38	Originally Disabled Male	1	81	Beneficiary is a male and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise "0".
39	Disease Coefficients HCC1	1	82	HIV/AIDS. Set to "1" if existed, otherwise "0".
40	Disease Coefficients HCC2	1	83	Septicemia/Shock. Set to "1" if existed, otherwise "0".
41	Disease Coefficients HCC5	1	84	Opportunistic Infections. Set to "1" if existed, otherwise "0".
42	Disease Coefficients HCC7	1	85	Metastatic Cancer and Acute Leukemia. Set to "1" if existed, otherwise "0".
43	Disease Coefficients HCC8	1	86	Lung, Upper Digestive Tract, and Other Severe Cancers. Set to "1" if existed, otherwise "0".
44	Disease Coefficients HCC9	1	87	Lymphatic, Head and Neck, Brain, and Other Major Cancers. Set to "1" if existed, otherwise "0".
45	Disease Coefficients HCC10	1	88	Breast, Prostate, Colorectal and Other Cancers and Tumors. Set to "1" if existed, otherwise "0".
46	Disease Coefficients HCC15	1	89	Diabetes with Renal or Peripheral Circulatory Manifestation. Set to "1" if existed, otherwise "0".
47	Disease Coefficients HCC16	1	90	Diabetes with Neurologic or Other Specified Manifestation. Set to "1" if existed, otherwise "0".
48	Disease Coefficients HCC17	1	91	Diabetes with Acute Complications. Set to "1" if existed, otherwise "0".
49	Disease Coefficients HCC18	1	92	Diabetes with Ophthalmologic or Unspecified Manifestation. Set to "1" if existed, otherwise "0".



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#	Field Name	Len	Pos	Description
50	Disease Coefficients HCC19	1	93	Diabetes without Complication. Set to "1" if existed, otherwise "0".
51	Disease Coefficients HCC21	1	94	Protein-Calorie Malnutrition. Set to "1" if existed, otherwise "0".
52	Disease Coefficients HCC25	1	95	End-Stage Liver Disease. Set to "1" if existed, otherwise "0".
53	Disease Coefficients HCC26	1	96	Cirrhosis of Liver Set to "1" if existed, otherwise "0".
54	Disease Coefficients HCC27	1	97	Chronic Hepatitis. Set to "1" if existed, otherwise "0".
55	Disease Coefficients HCC31	1	98	Intestinal Obstruction/Perforation. Set to "1" if existed, otherwise "0".
56	Disease Coefficients HCC32	1	99	Pancreatic Disease. Set to "1" if existed, otherwise "0".
57	Disease Coefficients HCC33	1	100	Inflammatory Bowel Disease. Set to "1" if existed, otherwise "0".
58	Disease Coefficients HCC37	1	101	Bone/Joint/Muscle Infections/Necrosis. Set to "1" if existed, otherwise "0".
59	Disease Coefficients HCC38	1	102	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease. Set to "1" if existed, otherwise "0".
60	Disease Coefficients HCC44	1	103	Severe Hematological Disorders. Set to "1" if existed, otherwise "0".
61	Disease Coefficients HCC45	1	104	Disorders of Immunity. Set to "1" if existed, otherwise "0".
62	Disease Coefficients HCC51	1	105	Drug/Alcohol Psychosis. Set to "1" if existed, otherwise "0".



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#	Field Name	Len	Pos	Description
63	Disease Coefficients HCC52	1	106	Drug/Alcohol Dependence. Set to "1" if existed, otherwise "0".
64	Disease Coefficients HCC54	1	107	Schizophrenia. Set to "1" if existed, otherwise "0".
65	Disease Coefficients HCC55	1	108	Major Depressive, Bipolar, and Paranoid Disorders. Set to "1" if existed, otherwise "0".
66	Disease Coefficients HCC67	1	109	Quadriplegia, Other Extensive Paralysis. Set to "1" if existed, otherwise "0".
67	Disease Coefficients HCC68	1	110	Paraplegia. Set to "1" if existed, otherwise "0".
68	Disease Coefficients HCC69	1	111	Spinal Cord Disorders/Injuries. Set to "1" if existed, otherwise "0".
69	Disease Coefficients HCC70	1	112	Muscular Dystrophy. Set to "1" if existed, otherwise "0".
70	Disease Coefficients HCC71	1	113	Polyneuropathy. Set to "1" if existed, otherwise "0".
71	Disease Coefficients HCC72	1	114	Multiple Sclerosis. Set to "1" if existed, otherwise "0".
72	Disease Coefficients HCC73	1	115	Parkinson's and Huntington's Diseases. Set to "1" if existed, otherwise "0".
73	Disease Coefficients HCC74	1	116	Seizure Disorders and Convulsions. Set to "1" if existed, otherwise "0".
74	Disease Coefficients HCC75	1	117	Coma, Brain Compression/Anoxic Damage. Set to "1" if existed, otherwise "0".
75	Disease Coefficients HCC77	1	118	Respirator Dependence/Tracheostomy Status. Set to "1" if existed, otherwise "0".



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#	Field Name	Len	Pos	Description
76	Disease Coefficients HCC78	1	119	Respiratory Arrest. Set to "1" if existed, otherwise "0".
77	Disease Coefficients HCC79	1	120	Cardio-Respiratory Failure and Shock. Set to "1" if existed, otherwise "0".
78	Disease Coefficients HCC80	1	121	Congestive Heart Failure. Set to "1" if existed, otherwise "0".
79	Disease Coefficients HCC81	1	122	Acute Myocardial Infarction. Set to "1" if existed, otherwise "0".
80	Disease Coefficients HCC82	1	123	Unstable Angina and Other Acute Ischemic Heart Disease. Set to "1" if existed, otherwise "0".
81	Disease Coefficients HCC83	1	124	Angina Pectoris/Old Myocardial Infarction. Set to "1" if existed, otherwise "0".
82	Disease Coefficients HCC92	1	125	Specified Heart Arrhythmias. Set to "1" if existed, otherwise "0".
83	Disease Coefficients HCC95	1	126	Cerebral Hemorrhage. Set to "1" if existed, otherwise "0".
84	Disease Coefficients HCC96	1	127	Ischemic or Unspecified Stroke. Set to "1" if existed, otherwise "0".
85	Disease Coefficients HCC100	1	128	Hemiplegia/Hemiparesis. Set to "1" if existed, otherwise "0".
86	Disease Coefficients HCC101	1	129	Cerebral Palsy and Other Paralytic Syndromes. Set to "1" if existed, otherwise "0".
87	Disease Coefficients HCC104	1	130	Vascular Disease with Complications. Set to "1" if existed, otherwise "0".
88	Disease Coefficients HCC105	1	131	Vascular Disease. Set to "1" if existed, otherwise "0".



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#	Field Name	Len	Pos	Description
89	Disease Coefficients HCC107	1	132	Cystic Fibrosis. Set to "1" if existed, otherwise "0".
90	Disease Coefficients HCC108	1	133	Chronic Obstructive Pulmonary Disease. Set to "1" if existed, otherwise "0".
91	Disease Coefficients HCC111	1	134	Aspiration and Specified Bacterial Pneumonias. Set to "1" if existed, otherwise "0".
92	Disease Coefficients HCC112	1	135	Pneumococcal Pneumonia, Empyema, Lung Abscess. Set to "1" if existed, otherwise "0".
93	Disease Coefficients HCC119	1	136	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage. Set to "1" if existed, otherwise "0".
94	Disease Coefficients HCC130	1	137	Dialysis Status. Set to "1" if existed, otherwise "0".
95	Disease Coefficients HCC131	1	138	Renal Failure. Set to "1" if existed, otherwise "0".
96	Disease Coefficients HCC132	1	139	Nephritis. Set to "1" if existed, otherwise "0".
97	Disease Coefficients HCC148	1	140	Decubitus Ulcer of Skin. Set to "1" if existed, otherwise "0".
98	Disease Coefficients HCC149	1	141	Chronic Ulcer of Skin, Except Decubitus. Set to "1" if existed, otherwise "0".
99	Disease Coefficients HCC150	1	142	Extensive Third-Degree Burns. Set to "1" if existed, otherwise "0".
100	Disease Coefficients HCC154	1	143	Severe Head Injury. Set to "1" if existed, otherwise "0".
101	Disease Coefficients HCC155	1	144	Major Head Injury Set to "1" if existed, otherwise "0".



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Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
102	Disease Coefficients HCC157	1	145	Vertebral Fractures without Spinal Cord Injury. Set to "1" if existed, otherwise "0".
103	Disease Coefficients HCC158	1	146	Hip Fracture/Dislocation. Set to "1" if existed, otherwise "0".
104	Disease Coefficients HCC161	1	147	Traumatic Amputation. Set to "1" if existed, otherwise "0".
105	Disease Coefficients HCC164	1	148	Major Complications of Medical Care and Trauma. Set to "1" if existed, otherwise "0".
106	Disease Coefficients HCC174	1	149	Major Organ Transplant Status. Set to "1" if existed, otherwise "0".
107	Disease Coefficients HCC176	1	150	Artificial Openings for Feeding or Elimination. Set to "1" if existed, otherwise "0".
108	Disease Coefficients HCC177	1	151	Amputation Status, Lower Limb/Amputation Complications. Set to "1" if existed, otherwise "0".
109	Disabled Disease HCC5	1	152	Disabled*Opportunistic Infections. Set to "1" if existed, otherwise "0".
110	Disabled Disease HCC44	1	153	Disabled*Severe Hematological Disorders. Set to "1" if existed, otherwise "0".
111	Disabled Disease HCC51	1	154	Disabled*Drug/Alcohol Psychosis. Set to "1" if existed, otherwise "0".
112	Disabled Disease HCC52	1	155	Disabled*Drug/Alcohol Dependence. Set to "1" if existed, otherwise "0".
113	Disabled Disease HCC107	1	156	Disabled*Cystic Fibrosis. Set to "1" if existed, otherwise "0".
114	Disease Interactions INT1	1	157	DM_CHF. Set to "1" if existed, otherwise "0".
115	Disease Interactions INT2	1	158	DM_CVD. Set to "1" if existed, otherwise "0".



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Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
116	Disease Interactions INT3	1	159	CHF_COPD. Set to "1" if existed, otherwise "0".
117	Disease Interactions INT4	1	160	COPD_CVD_CAD. Set to "1" if existed, otherwise "0".
118	Disease Interactions INT5	1	161	RF_CHF. Set to "1" if existed, otherwise "0".
119	Disease Interactions INT6	1	162	RF_CHF_DM. Set to "1" if existed, otherwise "0".

Trailer Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '3'
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Total Record Count	9	7 – 15	Record count in display format 9(9). Includes header and trailer records.
4	Filler	147	16 – 162	Spaces



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Header Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "1"	1 = Header, 2 = Details, 3 = Trailer
2	Contract Number	Char(5)	2	6	5		Unique identification for a Medicare Advantage or stand-alone Prescription Drug Plan contract.
3	Run Date	Char(8)	7	14	8	Format as yyyymmdd	The run date when this file was created.
4	Payment Year and Month	Char(6)	15	20	6	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(142)	21	164	144	Spaces	

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "2"	1 = Header, 2 = Details, 3 = Trailer
2	Health Insurance Claim Account Number	Char(12)	2	13	12	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.



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Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
3	Beneficiary Last Name	Char(12)	14	25	12	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	26	32	7	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	33	33	1	1 byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	34	41	8	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	42	42	1	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	43	51	9	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	Char(1)	52	52	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 through 34.
10	Age Group Female35_44	Char(1)	53	53	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 through 44.
11	Age Group Female45_54	Char(1)	54	54	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 through 54.



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
12	Age Group Female55_59	Char(1)	55	55	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 through 59.
13	Age Group Female60_64	Char(1)	56	56	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 through 64.
14	Age Group Female65_69	Char(1)	57	57	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 through 69.
15	Age Group Female70_74	Char(1)	58	58	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 through 74.
16	Age Group Female75_79	Char(1)	59	59	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 through 79.
17	Age Group Female80_84	Char(1)	60	60	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 through 84.
18	Age Group Female85_89	Char(1)	61	61	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 through 89.
19	Age Group Female90_94	Char(1)	62	62	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 through 94.



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Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
20	Age Group Female95_GT	Char(1)	63	63	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 95 and greater.
21	Age Group Male0_34	Char(1)	64	64	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 through 34.
22	Age Group Male35_44	Char(1)	65	65	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 through 44.
23	Age Group Male45_54	Char(1)	66	66	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 through 54.
24	Age Group Male55_59	Char(1)	67	67	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 through 59.
25	Age Group Male60_64	Char(1)	68	68	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 through 64.
26	Age Group Male65_69	Char(1)	69	69	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 through 69.
27	Age Group Male70_74	Char(1)	70	70	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 through 74.



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
28	Age Group Male75_79	Char(1)	71	71	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 through 79.
29	Age Group Male80_84	Char(1)	72	72	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 through 84.
30	Age Group Male85_89	Char(1)	73	73	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 through 89.
31	Age Group Male90_94	Char(1)	74	74	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 through 94.
32	Age Group Male95_GT	Char(1)	75	75	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 95 and greater.
33	Originally Disabled Female	Char(1)	76	76	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female aged (age>64) and original Medicare entitlement was due to disability.
34	Originally Disabled Male	Char(1)	77	77	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male aged (age>64) and original Medicare entitlement was due to disability.
35	Disease Coefficients RXHCC1	Char(1)	78	78	1	Set to "1" if applicable, otherwise "0"	HIV/AIDS



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
36	Disease Coefficients RXHCC2	Char(1)	79	79	1	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
37	Disease Coefficients RXHCC3	Char(1)	80	80	1	Set to "1" if applicable, otherwise "0"	Infectious Diseases
38	Disease Coefficients RXHCC8	Char(1)	81	81	1	Set to "1" if applicable, otherwise "0"	Acute Myeloid Leukemia
39	Disease Coefficients RXHCC9	Char(1)	82	82	1	Set to "1" if applicable, otherwise "0"	Metastatic Cancer, Acute Leukemia, and Severe Cancers
40	Disease Coefficients RXHCC10	Char(1)	83	83	1	Set to "1" if applicable, otherwise "0"	Lung, Upper Digestive Tract, and Other Severe Cancers
41	Disease Coefficients RXHCC17	Char(1)	84	84	1	Set to "1" if applicable, otherwise "0"	Diabetes with Specified Complications
42	Disease Coefficients RXHCC18	Char(1)	85	85	1	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
43	Disease Coefficients RXHCC19	Char(1)	86	86	1	Set to "1" if applicable, otherwise "0"	Disorders of Lipoid Metabolism
44	Disease Coefficients RXHCC20	Char(1)	87	87	1	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
45	Disease Coefficients RXHCC21	Char(1)	88	88	1	Set to "1" if applicable, otherwise "0"	Other Specified Endocrine/Metabolic/ Nutritional Disorders
46	Disease Coefficients RXHCC24	Char(1)	89	89	1	Set to "1" if applicable, otherwise "0"	Chronic Viral Hepatitis
47	Disease Coefficients RXHCC31	Char(1)	90	90	1	Set to "1" if applicable, otherwise "0"	Chronic Pancreatic Disease
48	Disease Coefficients RXHCC33	Char(1)	91	91	1	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
49	Disease Coefficients RXHCC34	Char(1)	92	92	1	Set to "1" if applicable, otherwise "0"	Peptic Ulcer and Gastrointestinal Hemorrhage
50	Disease Coefficients RXHCC37	Char(1)	93	93	1	Set to "1" if applicable, otherwise "0"	Esophageal Disease
51	Disease Coefficients RXHCC39	Char(1)	94	94	1	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis
52	Disease Coefficients RXHCC40	Char(1)	95	95	1	Set to "1" if applicable, otherwise "0"	Bechets Syndrome and Other Connective Tissue Disease
53	Disease Coefficients RXHCC41	Char(1)	96	96	1	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
54	Disease Coefficients RXHCC42	Char(1)	97	97	1	Set to "1" if applicable, otherwise "0"	Inflammatory Spondylopathies
55	Disease Coefficients RXHCC43	Char(1)	98	98	1	Set to "1" if applicable, otherwise "0"	Polymyalgia Rheumatica
56	Disease Coefficients RXHCC44	Char(1)	99	99	1	Set to "1" if applicable, otherwise "0"	Psoriatic Arthropathy
57	Disease Coefficients RXHCC45	Char(1)	100	100	1	Set to "1" if applicable, otherwise "0"	Disorders of the Vertebrae and Spinal Discs
58	Disease Coefficients RXHCC47	Char(1)	101	101	1	Set to "1" if applicable, otherwise "0"	Osteoporosis and Vertebral Fractures
59	Disease Coefficients RXHCC48	Char(1)	102	102	1	Set to "1" if applicable, otherwise "0"	Other Musculoskeletal and Connective Tissue Disorders
60	Disease Coefficients RXHCC51	Char(1)	103	103	1	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders
61	Disease Coefficients RXHCC52	Char(1)	104	104	1	Set to "1" if applicable, otherwise "0"	Disorders of Immunity
62	Disease Coefficients RXHCC54	Char(1)	105	105	1	Set to "1" if applicable, otherwise "0"	Polycythemia Vera



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#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
63	Disease Coefficients RXHCC55	Char(1)	106	106	1	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Blood Diseases
64	Disease Coefficients RXHCC57	Char(1)	107	107	1	Set to "1" if applicable, otherwise "0"	Delirium and Encephalopathy
65	Disease Coefficients RXHCC59	Char(1)	108	108	1	Set to "1" if applicable, otherwise "0"	Dementia with Depression/Behavioral Disturbance
66	Disease Coefficients RXHCC60	Char(1)	109	109	1	Set to "1" if applicable, otherwise "0"	Dementia/Cerebral Degeneration
67	Disease Coefficients RXHCC65	Char(1)	110	110	1	Set to "1" if applicable, otherwise "0"	Schizophrenia
68	Disease Coefficients RXHCC66	Char(1)	111	111	1	Set to "1" if applicable, otherwise "0"	Other Major Psychiatric Disorders
69	Disease Coefficients RXHCC67	Char(1)	112	112	1	Set to "1" if applicable, otherwise "0"	Other Psychiatric Symptoms/Syndromes
70	Disease Coefficients RXHCC75	Char(1)	113	113	1	Set to "1" if applicable, otherwise "0"	Attention Deficit Disorder
71	Disease Coefficients RXHCC76	Char(1)	114	114	1	Set to "1" if applicable, otherwise "0"	Motor Neuron Disease and Spinal Muscular Atrophy



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Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
72	Disease Coefficients RXHCC77	Char(1)	115	115	1	Set to "1" if applicable, otherwise "0"	Quadriplegia, Other Extensive Paralysis, and Spinal Cord Injuries
73	Disease Coefficients RXHCC78	Char(1)	116	116	1	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy
74	Disease Coefficients RXHCC79	Char(1)	117	117	1	Set to "1" if applicable, otherwise "0"	Polyneuropathy, Except Diabetic
75	Disease Coefficients RXHCC80	Char(1)	118	118	1	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
76	Disease Coefficients RXHCC81	Char(1)	119	119	1	Set to "1" if applicable, otherwise "0"	Parkinson's Disease
77	Disease Coefficients RXHCC82	Char(1)	120	120	1	Set to "1" if applicable, otherwise "0"	Huntington's Disease
78	Disease Coefficients RXHCC83	Char(1)	121	121	1	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions
79	Disease Coefficients RXHCC85	Char(1)	122	122	1	Set to "1" if applicable, otherwise "0"	Migraine Headaches
80	Disease Coefficients RXHCC86	Char(1)	123	123	1	Set to "1" if applicable, otherwise "0"	Mononeuropathy, Other Abnormal Movement Disorders



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Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
81	Disease Coefficients RXHCC87	Char(1)	124	124	1	Set to "1" if applicable, otherwise "0"	Other Neurological Conditions/Injuries
82	Disease Coefficients RXHCC91	Char(1)	125	125	1	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
83	Disease Coefficients RXHCC92	Char(1)	126	126	1	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction and Unstable Angina
84	Disease Coefficients RXHCC98	Char(1)	127	127	1	Set to "1" if applicable, otherwise "0"	Hypertensive Heart Disease or Hypertension
85	Disease Coefficients RXHCC99	Char(1)	128	128	1	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
86	Disease Coefficients RXHCC102	Char(1)	129	129	1	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage and Effects of Stroke
87	Disease Coefficients RXHCC105	Char(1)	130	130	1	Set to "1" if applicable, otherwise "0"	Pulmonary Embolism and Deep Vein Thrombosis
88	Disease Coefficients RXHCC106	Char(1)	131	131	1	Set to "1" if applicable, otherwise "0"	Vascular Disease
89	Disease Coefficients RXHCC108	Char(1)	132	132	1	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis



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TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
90	Disease Coefficients RXHCC109	Char(1)	133	133	1	Set to "1" if applicable, otherwise "0"	Asthma and COPD
91	Disease Coefficients RXHCC110	Char(1)	134	134	1	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders
92	Disease Coefficients RXHCC111	Char(1)	135	135	1	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
93	Disease Coefficients RXHCC112	Char(1)	136	136	1	Set to "1" if applicable, otherwise "0"	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections
94	Disease Coefficients RXHCC113	Char(1)	137	137	1	Set to "1" if applicable, otherwise "0"	Acute Bronchitis and Congenital Lung/Respiratory Anomaly
95	Disease Coefficients RXHCC120	Char(1)	138	138	1	Set to "1" if applicable, otherwise "0"	Vitreous Hemorrhage and Vascular Retinopathy, Except Diabetic
96	Disease Coefficients RXHCC121	Char(1)	139	139	1	Set to "1" if applicable, otherwise "0"	Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies
98	Disease Coefficients RXHCC122	Char(1)	140	140	1	Set to "1" if applicable, otherwise "0"	Open-angle Glaucoma
99	Disease Coefficients RXHCC123	Char(1)	141	141	1	Set to "1" if applicable, otherwise "0"	Glaucoma and Keratoconus



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Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
100	Disease Coefficients RXHCC126	Char(1)	142	142	1	Set to "1" if applicable, otherwise "0"	Larynx/Vocal Cord Diseases
101	Disease Coefficients RXHCC129	Char(1)	143	143	1	Set to "1" if applicable, otherwise "0"	Other Diseases of Upper Respiratory System
102	Disease Coefficients RXHCC130	Char(1)	144	144	1	Set to "1" if applicable, otherwise "0"	Salivary Gland Diseases
103	Disease Coefficients RXHCC132	Char(1)	145	145	1	Set to "1" if applicable, otherwise "0"	Kidney Transplant Status
104	Disease Coefficients RXHCC134	Char(1)	146	146	1	Set to "1" if applicable, otherwise "0"	Chronic Renal Failure
105	Disease Coefficients RXHCC135	Char(1)	147	147	1	Set to "1" if applicable, otherwise "0"	Nephritis
106	Disease Coefficients RXHCC137	Char(1)	148	148	1	Set to "1" if applicable, otherwise "0"	Urinary Obstruction and Retention
107	Disease Coefficients RXHCC138	Char(1)	149	149	1	Set to "1" if applicable, otherwise "0"	Fecal Incontinence
108	Disease Coefficients RXHCC139	Char(1)	150	150	1	Set to "1" if applicable, otherwise "0"	Incontinence



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TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
109	Disease Coefficients RXHCC140	Char(1)	151	151	1	Set to "1" if applicable, otherwise "0"	Impaired Renal Function and Other Urinary Disorders
110	Disease Coefficients RXHCC144	Char(1)	152	152	1	Set to "1" if applicable, otherwise "0"	Vaginal and Cervical Diseases
111	Disease Coefficients RXHCC145	Char(1)	153	153	1	Set to "1" if applicable, otherwise "0"	Female Stress Incontinence
112	Disease Coefficients RXHCC157	Char(1)	154	154	1	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Decubitus
113	Disease Coefficients RXHCC158	Char(1)	155	155	1	Set to "1" if applicable, otherwise "0"	Psoriasis
114	Disease Coefficients RXHCC159	Char(1)	156	156	1	Set to "1" if applicable, otherwise "0"	Cellulitis and Local Skin Infection
115	Disease Coefficients RXHCC160	Char(1)	157	157	1	Set to "1" if applicable, otherwise "0"	Bullous Dermatoses and Other Specified Erythematous Conditions
116	Disease Coefficients RXHCC165	Char(1)	158	158	1	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
117	Disease Coefficients RXHCC166	Char(1)	159	159	1	Set to "1" if applicable, otherwise "0"	Pelvic Fracture



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TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
118	Disease Coefficients RXHCC186	Char(1)	160	160	1	Set to "1" if applicable, otherwise "0"	Major Organ Transplant Status
119	Disease Coefficients RXHCC187	Char(1)	161	161	1	Set to "1" if applicable, otherwise "0"	Other Organ Transplant/Replacement
120	Disabled Disease RXHCC65	Char(1)	162	162	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and Schizophrenia
121	Disabled Disease RXHCC66	Char(1)	163	163	1	Set to "1" if applicable, otherwise "0"	Disable (Age<65) and Other Major Psychiatric Disorders
122	Disabled Disease RXHCC108	Char(1)	164	164	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and Cystic Fibrosis
			164	164	164		



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TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Trailer Record Format

#	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "3"	1 = Header, 2 = Details, 3 = Trailer
2	Contract Number	Char(5)	2	6	5		Unique identification for a Medicare Advantage or stand-alone Prescription Drug Plan contract.
3	Total Record Count	Char(9)	7	15	9	Includes all header and trailer records	Record count in display format 9(9).
4	Filler	Char(151)	16	164	149	Spaces	



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Figure 8G illustrates an example of a Part C MOR report. Figure 8H illustrates an example of a RAS RxHCC MOR report.

Figure 8G – Part C MOR Report Format

```

1***GROUP=H8888,CONTRACT=H8888,
1RUN DATE: 20031219                RISK ADJUSTMENT MODEL OUTPUT REPORT
PAGE:      1
PAYMENT MONTH: 200401              PLAN: H8888 CHAMPION INSURANCE
RAPMORP1

0          LAST          FIRST          DATE OF
HIC        NAME          NAME          I      BIRTH    SEX & AGE GROUP
-----
123456789A  WOOD          CHARLES          W      19250225  Male75-79
123456789B  TREE          LILLIAN          L      19270418  Female75-79
123456789A  GRASS          ALBERT          A      19421213  Male60-64
HCC DISEASE GROUPS:  HCC019 Diabetes without Complication
                     HCC080 Congestive Heart Failure
                     HCC092 Specified Heart Arrhythmias
INTERACTIONS:      INTI01 DM_CHF

```

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.



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Figure 8H - RAS RxHCC MOR Report Format

1RUN DATE: 20060124		RISK ADJUSTMENT MODEL OUTPUT REPORT		
PAGE: 1				
PAYMENT MONTH: 200602		PLAN: H9999 ACME INSURANCE COMPANY		
RAPMORP2				
0	LAST	FIRST	DATE OF	
HIC	NAME	NAME	I BIRTH	SEX & AGE GROUP

123456789A	TWO	RUTH	M 19181122	Female85-89
RXHCC DISEASE GROUPS:		RXHCC019 Disorders of Lipoid Metabolism		
		RXHCC048 Other Musculoskeletal and Connective Tissue Disorders		
		RXHCC092 Acute Myocardial Infarction and Unstable Angina		
		RXHCC098 Hypertensive Heart Disease or Hypertension		
		RXHCC159 Cellulitis, Local Skin Infection		
123456789A	BREEZE	WINDY	T 19620730	Female35-44
RXHCC DISEASE GROUPS:		RXHCC045 Disorders of the Vertebrae and Spinal Discs		
		RXHCC085 Migraine Headaches		
		RXHCC098 Hypertensive Heart Disease or Hypertension		
		RXHCC113 Acute Bronchitis and Congenital Lung/Respiratory Anomaly		
		RXHCC129 Other Diseases of Upper Respiratory System		
		RXHCC144 Vaginal and Cervical Diseases		

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.

EXHIBIT B

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev. 11032; Issued: 09-30-21)

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3.1 – Introduction

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

All references to Medicare Administrative Contractors (MACs) include Affiliated Contractors (ACs). Affiliated Contractors are FI's and Carriers.

A. Goals

This section applies to Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT), and Recovery Auditors, as indicated.

The Medicare Administrative Contractors (MACs) shall analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant. The goal of MAC administrative actions is to correct the behavior in need of change and prevent future inappropriate billing. The priority for MACs is to minimize potential future losses to the Medicare Trust Funds through targeted claims review while using resources efficiently and treating providers and beneficiaries fairly.

For repeated infractions, MACs have the discretion to initiate progressively more severe administrative action, commensurate with the seriousness of the identified problem. (Refer to PIM chapter 3, §3.7.1). MACs shall deal with serious problems using the most substantial administrative actions available, such as 100 percent prepayment review of claims. Minor or isolated inappropriate billing shall be remediated through provider notification or feedback with reevaluation after notification. When medical review (MR) notification and feedback letters are issued, the MAC MR staff shall ensure that Provider Outreach and Education (POE) staff has access to copies of the letters in case a provider requests further education or POE determines that future education is needed. While program savings are realized through denials of payment for inappropriate provider billing, the optimal result occurs when compliance is achieved and providers no longer incorrectly code or bill for non-covered services.

The Medicare Fee For Service Recovery Audit program is a legislatively mandated program (Tax Relief and Health Care Act of 2006) that utilizes Recovery Auditors to identify improper payments paid by Medicare to fee-for-service providers. The Recovery Auditors identify the improper payments, and the MACs adjust the claims, recoup identified overpayments and return underpayments.

MAC, CERT and Recovery Auditor staff shall not expend Medicare Integrity Program (MIP)/ MR resources analyzing provider compliance with Medicare rules that do not affect Medicare payment. Examples of such rules include violations of conditions of participation (COPs), or coverage or coding errors that do not change the Medicare payment amount.

The COPs define specific quality standards that providers shall meet to participate in the Medicare program. A provider's compliance with the COPs is determined by the CMS

Regional Office (RO) based on the State survey agency recommendation. If during a review, any contractor believes that a provider does not comply with conditions of participation, the reviewer shall not deny payment solely for this reason. Instead, the contractor shall notify the RO and the applicable State survey agency.

When a potential underpayment or overpayment is identified, certain steps are normally followed to determine if a payment error exists. These steps are referred to as the claims development process. The reviewer generally does the following:

- Investigates the claims and associated documentation;
- Performs appropriate research regarding liability, benefit categories, statutory requirements, etc.;
- Determines if a payment error exists and the nature of the error;
- Notifies the beneficiary and provider/supplier; and
- Starts the payment reconciliation process.

B. New Provider/New Benefit Monitoring

This section applies to the MACs.

The MACs shall analyze data to identify patterns of billing aberrancies of providers new to the Medicare program. The MACs have the option of performing prepayment or postpayment review of claims submitted by new providers as needed. The CMS encourages the MACs to perform these reviews on a prepayment basis to have the greatest chance of identifying and reducing the error rate of new providers. When MACs review the claims of a new provider, the MACs shall perform a limited review of generally 20-40 claims in order to evaluate accurate billing.

The MACs shall also monitor for provider use of new statutory benefits and to ensure correct coverage, coding, and billing from the beginning. New benefit edits shall continue until the MAC is satisfied that the new benefits are being used and billed appropriately or until the MAC determines that resources would best be spent on other types of review.

3.2 – Overview of Prepayment and Postpayment Reviews (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MACs, CERT, RACs, SMRCs, and Unified Program Integrity Contractors (UPICs), as indicated.

A. Prepayment and Postpayment Review

Prepayment review occurs when a reviewer makes a claim determination before claim payment has been made. Prepayment review always results in an “initial determination”. Postpayment review occurs when a reviewer makes a claim determination after the claim has been paid. Postpayment review results in either no change to the initial determination or a “revised determination” indicating that an overpayment or underpayment has occurred.

B. Prepayment Edit Capabilities

Prepayment edits shall be able to key on a beneficiary's Medicare beneficiary identifier (Mbi), National Provider Identifier (NPI) and specialty code, service dates, and diagnosis or procedure code(s) (i.e., Healthcare Common Procedure Coding System [HCPCS] and/or International Classification of Diseases diagnoses codes), Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

The MAC systems shall be able to select claims for prepayment review using different types of comparisons. At a minimum, those comparisons shall include:

- Procedure to Procedure -permits contractor systems to screen multiple services at the claim level and in history.
- Procedure to Provider - permits selective screening of services that need review for a given provider.
- Frequency to Time- permits contractors to screen for a certain number of services provided within a given time period.
- Diagnosis to Procedure- permits contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin B12 injection is related to pernicious anemia, absent of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.
- Procedure to Specialty Code or TOB- permits contractors to screen services provided by a certain specialty or TOB.
- Procedure to Place of Service- permits selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional MAC system comparisons shall include, but are not limited to the following:

- Diagnoses alone or in combination with related factors.

- Revenue linked to the health care common procedure coding system (HCPCS).
- Charges related to utilization, especially when the service or procedure has an established dollar or number limit.
- Length of stay or number of visits, especially when the service or procedure violates time or number limits.
- Specific providers alone or in combination with other parameters.

The MR edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician or claims analyst can review the claim and associated documentation (including documentation requested after the claim is submitted) in order to make determinations about coverage and payment under Section 1862(a) (1) (A) of the Act.

Namely, the claim is for a service or device that is medically reasonable and necessary to diagnose or treat an injury or improve the functioning of a malformed body member. All non-automated review work resulting from MR edits shall:

- Involve activities defined under the MIP at §1893(b)(1) of the Act;
- Be articulated in the MAC's medical review strategy;
- Be designed in such a way as to reduce the MAC's CERT error rate or prevent the MAC's CERT error rate from increasing, or;

Prevent improper payments identified by the RACs.

3.2.1 – Setting Priorities and Targeting Reviews (Rev. 399, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

This section applies to MACs and Recovery Auditors, as indicated. Recovery Auditors perform targeted reviews consistent with their statements of work (SOWs).

The MACs have the authority to review any claim at any time, however, the claims volume of the Medicare Program doesn't allow for review of every claim. The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for improper payment.

The MACs shall develop a problem-focused, outcome-based MR strategy and Strategy Analysis Report (SAR) that defines what risks to the Medicare trust fund the MAC's MR

programs will address and the interventions that will be implemented during the fiscal/option year as addressed in PIM chapter 7.

The MACs shall focus their edits where the services billed have significant potential to be non-covered or incorrectly coded. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate billing or improper payments. The MACs shall have in place a program of systematic and ongoing analysis of claims and data from Recovery Auditors and CERT, among other sources, in order to focus intervention efforts on the most significant errors.

The MACs shall initiate a targeted provider-specific prepayment review only when there is the likelihood of sustained or high level of payment error. MACs are encouraged to initiate targeted service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis.

The MACs have the discretion to select target areas because of:

- High volume of services;
- High cost;
- Dramatic change in frequency of use;
- High risk problem-prone areas; and/or,
- Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability. Probe reviews are not required when targeted areas are based on data from these entities.

In an effort to identify the claims most likely to contain improper billing, MACs are encouraged to use prepayment and postpayment screening tools or natural language coding software. MACs shall not deny a payment for a service simply because the claim fails a single screening tool criterion. Instead, the reviewer shall make an individual determination on each claim. MACs have the discretion to post the screening tools in use to their Web site or otherwise disclose to the provider community. Recovery Auditors shall use screening tools and disclose their use to the provider community consistent with the requirements in their statements of work (SOWs).

MACs and Recovery Auditors shall NOT target a provider for review solely based on the provider's preferred method of maintaining or submitting documentation. For example, a MAC or Recovery Auditor shall NOT choose a provider for review based only on the fact that the provider uses an electronic health record or responds to documentation requests using the Electronic Submission of Medical Documentation (esMD) mechanism. (More information about esMD can be found in Section (3.2.3.5))

3.2.2 - Provider Notice

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, UPICs, and SMRC as indicated.

Because the CERT contractors select claims on a random basis, they are not required to notify providers of their intention to begin a review.

Providers may submit unsolicited documentation to the MAC when submitting a claim. Providers are to list the PWK 02 Report Transmission Code (PWK (paperwork) modifier) on the claim when submitting this documentation. MACs should inform the providers that they are NOT required to submit unsolicited documentation (and the corresponding PWK modifier) and that the absence or presence of PWK modifier does not mean that their claim will be reviewed. MACs should, at their discretion, consider posting to their website or sending letters to providers informing them of what additional documentation is needed to make a determination on the claim.

A. Notice of Provider-Specific Review

When MAC data analysis indicates that a provider-specific potential error exists that cannot be confirmed without requesting and reviewing documentation associated with the claim, the MAC shall review a sample of representative claims. Before deploying significant medical review resources to examine claims identified as potential problems through data analysis, MACs shall take the interim step of selecting a small "probe" sample of generally 20-40 potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures that medical review activities are targeted at identified problem areas. The MACs shall ensure that such a sample is large enough to provide confidence in the result, but small enough to limit administrative burden. The CMS encourages the MACs to conduct error validation reviews on a prepayment basis in order to help prevent improper payments.

MACs shall select providers for error validation reviews in the following instances, at a minimum:

- The MAC has identified questionable billing practices (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis;
- The MAC receives alerts from other MACs, Quality Improvement Organizations (QIOs), CERT, RACs, OIG/GAO, or internal/external components that warrant review;
- The MAC receives complaints; or,
- The MAC validates the items bulleted in §3.2.1.

Provider-specific error validation reviews are undertaken when one or a relatively small number of providers seem to be experiencing similar/recurrent problems with billing. The MACs shall document their reasons for selecting the provider for the error validation

review. In all cases, they shall clearly document the issues noted and cite the applicable law, published national coverage determination, or local coverage determination.

For provider-specific problems, the MAC shall notify providers in writing that a probe sample review is being conducted. MACs shall consider sending letters to providers informing them of what additional documentation is needed to make a determination on the claim. MACs have the discretion to use a letter similar to the letters in Exhibit 7 of the PIM when notifying providers of the probe review and requesting documentation. MACs have the discretion to advise providers of the probe sample at the same time that medical documentation or other documentation is requested.

Generally, MACs shall subject a provider to no more than one probe review at any time; however, MACs have the discretion to conduct multiple probes for very large billers as long as they will not constitute undue administrative burden.

MACs

The MACs shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. MACs shall indicate whether the review will occur on a prepayment or postpayment basis. This notification may be issued via certified letter with return receipt requested. MACs shall notify providers of the specific reason for selection. If the basis for selection is comparative data, MACs shall provide the data on how the provider varies significantly from other providers in the same specialty, jurisdiction, or locality. Graphic presentations help to communicate the perceived problem more clearly.

RACs

The RACs are required to post a description of all approved new issues to the RAC's Web site before correspondence is sent to the provider. After posting, the RAC should issue an additional documentation request (ADR) to the provider, if warranted.

Unified Program Integrity Contractor (UPIC)

The UPICs shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. UPICs shall indicate whether the review will occur on a prepayment or postpayment basis. UPICs shall maintain a copy of the letter and the date it was mailed. This notification shall be mailed the same day that the edit request is forwarded to the MAC. Refer to Exhibit 45 for the letter to be sent.

B. Notice of Service-Specific Review

This section applies to MACs, RACs and SMRC as indicated.

Service-specific reviews are undertaken when the same or similar problematic process is noted to be widespread and affecting one type of service (e.g., providing tube feedings to

home health beneficiaries across three (3) states).

MACs

Web site postings

The MACs shall provide notification prior to beginning a service-specific review by posting a review description on their Web site. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination on their Web site. MACs shall keep the Web site current by posting active reviews.

MACs should, at their discretion, create an archive for old review topics that are no longer under active review. Active review is defined as the time period during which ADRs are sent, determinations are made and findings are communicated to the providers. MACs should categorize the active review topics by provider type.

Individual written notices

MACs have the discretion to also notify providers about a service-specific review by sending individual notices to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination in the written notices.

RACs

Before beginning widespread service-specific reviews, RACs shall notify the provider community that the RAC intends to initiate review of certain items/services through a posting on the RAC Web site describing the item/service that will be reviewed.

Additionally, for medical record reviews, the RACs shall send ADRs to providers that clearly articulate the items or services under review and indicate the appropriate documentation to be submitted.

Unified Program Integrity Contractors (UPICs)

The UPICs shall provide notification prior to beginning a service-specific review by sending individual written notices to the affected providers. This notification shall be mailed the same day that the edit request is forwarded to the MAC. The UPICs shall maintain a copy of the letter and the date it was mailed. Refer to Exhibit 45 for the letter to be sent.

SMRC

The SMRC shall operate/maintain a public Web site that displays what types of issues are under review. For each area, the SMRC shall include a link to the relevant OIG/GAO or

other reports available. In addition to the Web site, the SMRC shall notify providers about a service-specific review by sending an ADR. The SMRC shall state what additional documentation is needed from providers to make a claim determination in the ADR.

3.2.2.1 - Maintaining Provider Information

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MAC.

A. Provider Tracking System (PTS)

The MACs shall have a PTS in place to identify and track all individual providers currently under action plans to correct identified problems, such as not reasonable and necessary, incorrect coding, and inappropriate billing. MACs shall use the provider tracking system (PTS) to coordinate contacts with providers such as MR notifications, telephone calls directly related to probe reviews, and referrals to POE. The MACs shall ensure that if a provider is to be contacted as a result of more than one problem, redundant contacts are minimized. The MACs shall also coordinate corrective action information with the UPICs to ensure contacts are not in conflict with benefit integrity related activities. The MAC PTS shall contain the date a provider is put on a provider-specific edit. The MAC shall reassess all providers on provider-specific prepayment or postpayment review on a quarterly basis to determine whether the behavior has improved. The MAC shall note the results of these quarterly assessments in the PTS. If the behavior has improved sufficiently and the edit was turned off, note that date as well in the PTS. When a MAC becomes aware that the provider has appealed a medical review determination to an Administrative Law Judge (ALJ), the MAC should send a letter to the ALJ and describe the information in the PTS to demonstrate the corrective actions that have been taken by the MAC.

B. Recovery Auditor Case Files

The Recovery Auditor shall maintain case files following the guidelines in the Recovery Auditor SOW.

C. Provider Addresses

This section applies to MACs, CERT, and Recovery Auditors, as indicated.

The MACs, CERT and Recovery Auditors shall mail the ADR to the best known address for the provider. MACs are encouraged to indicate the procedure a provider can follow to update address information in their ADRs and on their Web sites. If a provider wishes to have ADRs sent to one address but demand letters sent to a different address, MACs are encouraged to accommodate this request.

Note: Providers and suppliers must complete and submit a Medicare enrollment application (either the paper CMS-855 or a submission via Internet-based Provider Enrollment, Chain & Ownership [PECOS] to change existing information in the Medicare enrollment record.)

D. When the Provider or Supplier No Longer Occupies a Physical Address

This section applies to MACs and UPICs, as indicated.

When the MACs and UPICs become aware that the provider or supplier no longer occupies a physical address, any future correspondence shall reference only the claim control numbers and not list the individual beneficiary data (e.g., names and Medicare beneficiary identifiers). This process is contingent on current automated system limits.

The following are situations where the MAC and UPIC can assume the provider or supplier no longer occupies the last known location. This list is not exhaustive and the MACs and UPICs should use other means to confirm addresses, at their discretion.

- The MAC and UPIC receive mail that has been returned by the post office indicating no known address;
- An onsite visit has confirmed the address is vacant or is occupied by another occupant; or,
- A beneficiary complaint(s) is on record stating the provider or supplier is no longer at the address and follow up confirms the complaint.

In the above situations, correspondence from the MACs and UPICs shall only contain the claim control number and advise the provider or supplier to contact them for a list of the specific claims associated with the overpayment. This process will prevent the potential compromise of Medicare beneficiary names and/or Medicare beneficiary identifiers being sent to an abandoned address (or a location with a new occupant). If the letter is returned from the post office, maintain the notification on file for evidence.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, and UPICs, as indicated.

A. General

In certain circumstances, the MACs, CERT, RACs, and UPICs may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an additional documentation request (ADR). The term ADR refers to all documentation requests associated with prepayment review and postpayment review. MACs, CERT, RACs, and UPICs have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. The MAC, RAC, and UPIC shall not deny other claims submitted before or after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation. The CERT contractor shall solicit documentation in those circumstances in accordance with its Statement of Work (SOW).

The term "additional documentation" refers to medical documentation and other documents such as supplier/lab/ambulance notes and includes:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.
- Supplier/lab/ambulance notes include all documents that are submitted by suppliers, labs, and ambulance companies in support of the claim (e.g., Certificates of Medical Necessity, supplier records of a home assessment for a power wheelchair).
- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

NOTE: Reviewers shall consider documentation in accordance with other sections of this manual.

The MAC and UPIC have the discretion to deny other "related" claims submitted before or after the claim in question, subject to CMS approval as described below. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Approved examples of "related" claims that may be denied as "related" are in the following situations:

- When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services.

For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.

- Reserved for future approved "related" claim review situations. The MAC shall report to their BFL and COR prior to initiating denial of "related" claims situations.

The MAC and UPIC shall await CMS approval prior to initiating requested "related" claim(s) review. Upon CMS approval, the MAC shall post the intent to conduct "related" claim review(s) to their Web site within 1 month prior to initiation of the approved "related" claim review(s). The MAC shall inform CMS of the implementation date of the "related" claim(s) review 1 month prior to the implementation date.

If "related" claims are denied automatically, MACs shall count these denials as automated review. If the "related" claims are denied after manual intervention, MACs shall count these denials as non-medical record review.

The RAC shall utilize the review approval process as outlined in their SOW when performing reviews of "related" claims.

The MAC, RAC, and UPIC are not required to request additional documentation for the "related" claims before issuing a denial for the "related" claims.

Contractors shall process appeals of the "related" claim(s) separately.

B. Authority to Collect Medical Documentation

Contractors are authorized to collect medical documentation by the Social Security Act. Section 1833(e) states "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states "...no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

The OMB Paperwork Reduction Act collection number for prepayment medical review is 0938-0969. MACs shall use this number on every additional documentation request or any other type of written request for additional documentation for prepayment medical review. It can be in the header, footer or body of the document. CMS suggests the information read "OMB #: 0938-0969" or OMB Control #: 0938-0969." Postpayment medical review does not require an OMB control number.

C. PWK (Paperwork) Modifier

MAC medical review departments are only required to review unsolicited documentation when the claim suspends for a medical review edit/audit. MACs shall not send an ADR request for a claim with a PWK modifier until after review of the PWK unsolicited documentation or the waiting days have elapsed without receipt of documentation.

MACs shall allow 7 calendar “waiting days” (from the date of receipt of the claim) for additional unsolicited documentation to be submitted or 10 calendar “waiting” days for the unsolicited documentation to be mailed. Contractors serving island territories shall have the flexibility to adjust “waiting days” as is necessary. CMS expects that any adjustment from the core 7/10 days will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has 30 calendar days to make a determination on the claim. If the contractor cannot make a determination on the claim after reviewing the unsolicited documentation submitted, they shall request additional documentation using their normal business procedures for ADR that are outlined in Chapter 3 of the Program Integrity Manual.

3.2.3.1 - Additional Documentation Requests (ADR)

(Rev.933; Issued: 01-10-20; Effective: 02- 03- 20; Implementation: 01-06- 20)

This section applies to MACs, Recovery Auditors, CERT and UPICs, as indicated.

The MACs, CERT, Recovery Auditors, and UPICs shall specify in the ADR only those individual pieces of documentation needed to make a determination. When reviewing documentation, the reviewer shall give appropriate consideration to all documentation that is provided in accordance with other sections of this manual.

The MACs and the RACs shall also support soliciting documentation from the provider or supplier via Electronic Submission of Medical Documentation (esMD). The contractors shall send an Electronic Medical Documentation Request (eMDR) via esMD to those providers/suppliers that have registered to receive the request electronically. The contractors are encouraged to explore other ways to send eMDRs electronically (For example, using direct exchange, clearinghouses, state Health Information Exchange (HIEs)).

Providers interested in submitting documentation via esMD can find information on the CMS esMD website at <http://www.cms.gov/esMD>.

A. Outcome Assessment Information Set (OASIS)

Medicare’s Home Health PPS Rate Update for CY 2010 final rule, published in the November 10, 2009 Federal Register, includes a provision to require the submission of the OASIS as a condition of payment, that is codified in regulations 42 CFR§484.210(e).

Beginning January 1, 2010, home health agencies (HHAs) are required to submit an OASIS as a condition for payment. The MACs shall deny the claim if providers do not meet this regulatory requirement. The assessment must be patient specific, accurate and reflect the current health status of the patient. This status includes certain OASIS elements used for calculation of payment. These include documentation of clinical needs, functional status, and service utilization.

B. Plan of Care (POC)

Comprehensive care planning is essential to good patient care under the Medicare program. In fact, it is specifically written into the coverage and/or certification requirements for a number of healthcare settings. For purposes of the Part A benefit for home health, inpatient rehabilitation facility and hospice, the Social Security Act describes criteria and standards used for covering these services. This includes establishing an individualized POC.

The POC identifies treatment goals and coordination of services to meet patient needs as set forth in CFR §418.200 requirement for coverage. The POC must be established by a physician(s). However, in the case of a hospice, in addition to the physician, an interdisciplinary group shall establish a POC.

Section 1814(a)(2)(C), Part B 1835(a)(2)(A) of the Act, and CFR §409.43 state that a POC established by a treating physician must contain all pertinent information, such as, the patient history, initial status, treatment goals, procedures/services duration, and progress notes.

CFR§412.622 requires an individualized POC by a rehabilitation physician that meets the requirements listed in the regulation. MACs shall deny the claim as not meeting statutory requirements under the Social Security Act when the provider of services fails to comply with the POC requirements.

Pursuant to 42 CFR §489.21, a provider of services shall not charge a beneficiary for services that have been denied for the reasons stated above.

3.2.3.2 - Time - Frames for Submission

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT, SMRC, and UPICs, as indicated.

In certain circumstances, the MACs, CERT, SMRC, RACs, UPICs and other contractors may not be able to make a determination on prepayment or post-payment claims they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an ADR.

Contractors are authorized to collect medical documentation by the Social Security Act (the Act).

Section 1815(a) of the Act states that "...no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

Section 1833(e) of the Act states that "[n]o payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

In addition, Contractors are required to ensure that payment is limited to those items and services that are reasonable and necessary.

Section 1862(a)(1)(A) of the Act states that "[n]otwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services— which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Contractors are required, when authoring correspondence related to ADRs, to cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act exclusively when referring to the authority for requiring submission of documentation.

A. Prepayment Review Time Frames

When requesting documentation for prepayment review, the MACs and UPICs shall notify providers when they expect documentation to be received. The reviewer should not grant extensions to providers who need more time to comply with the request. Reviewers shall deny claims when the requested documentation to support payment is not received by the expected timeframe.

B. Post-payment Review Time Frames

When requesting documentation for post-payment review, the MACs, CERT, SMRC, UPICs and RACs shall notify providers when they expect documentation to be received. MACs, CERT, SMRC, UPICs and RACs have the discretion to grant extensions to providers who need more time to comply with the request.

The MACs, CERT, SMRC, UPICs and RACs shall deny claims when the requested documentation to support payment is not received by the expected timeframe (including any applicable extensions).

C. For esMD submissions

The esMD review contractor shall use the Enterprise File Transfer (EFT) system receipt date as the date the documentation was received. If the EFT receipt date is outside of the contractors normal business hours, the following business day shall be used as the receipt date. Contractors shall pull for esMD files at least every 4 hours (business hours) daily; including a mandatory pulling between the hours of 6-7pm EST daily. If unforeseeable circumstances occur, in which contractors are not technically capable of retrieving documentation in a timely manner due to issues outside of their control, contractors are to notify the esMD Team and can use the date documentation was available to be retrieved once issues have been resolved in the EFT system.

3.2.3.3 - Third-party Additional Documentation Request (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT and UPICs, as indicated.

Unless otherwise specified, the MAC, RAC and UPIC shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, RAC and UPIC.

The CERT reviewer shall request medical record documentation from the referring provider as submitted/identified by National Provider Identifier/Unique Physician Identification Number on the claim when such information is not sent in by the billing supplier/provider initially and after a request for additional documentation fails to produce medical documentation necessary to support the service billed and supported by the Local and National Coverage Determinations.

The MAC, UPIC and RAC have the discretion to send a separate ADR to third- party entities involved in the beneficiary's care. They shall not solicit documentation from a third party unless they first or simultaneously solicit the same information from the billing provider or supplier. The following requirements also apply:

- The MACs, UPICs and RACs shall notify the third party and the billing provider or supplier that they have 30 calendar days to respond for a prepayment review or 45 calendar days for a postpayment review for MACs and RACs and 30 calendar days for UPICs.
- For prepayment review, the MACs and UPICs shall pend the claim for 45 calendar days. This 45 day time period may run concurrently

as the 45 days that the billing provider or supplier has to respond to the ADR letter;

- The MACs and UPICs have the discretion to issue as many reminder notices as they deem appropriate to the third party via email, letter or phone call prior to the 30th or 45th calendar day, as discussed above;
- When information is requested from both the billing provider or supplier and a third party and a response is received from one or both that fails to support the medical necessity of the service, the MACs and UPICs shall deny the claim, in full or in part, using the appropriate denial code. Contractors shall count these denials as medical record reviews.
- Contractors shall include language in the denial notice reminding providers that beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub.100- 04, Medicare Claims Processing Manual, chapter 30.
- Refer to §3.2.3.7 for ADR to ordering providers for lab services.

3.2.3.4 - Additional Documentation Request Required and Optional Elements

(Rev. 557, Issued: 11-26-14, Effective: 12-29-14, Implementation: 12-29-14)

This section applies to Medicare Administrative Contractors (MAC), Recovery Auditors, Comprehensive Error Rate Testing (CERT), and Supplemental Medical Review Contractors (SMRC), as indicated.

- The MAC shall use discretion to ensure that the amount of medical documentation requested does not negatively impact the provider's ability to provide care.
- The Recovery Auditors shall issue Additional Documentation Requests (ADR) in accordance with limits established by their Contracting Officer's Representative (COR) for each calendar year.
- The MACs, CERT, SMRCs, and Recovery Auditors, shall request records related to the claim(s) being reviewed and have the discretion to collect documentation related to the beneficiary's condition before and after a service.

- The MACs, Recovery Auditors, and SMRCs have the discretion to issue as many reminder notices as they deem appropriate. Reminder notices can be issued via email, letter, or phone call.
- The CERT shall issue reminder notices in accordance with its SOW.
- The MACs, Recovery Auditors, and SMRCs shall not target their ADRs to providers based solely on the provider's electronic health record status or chosen method of submitting records.

When requesting documentation for postpayment medical review, the MACs, CERT, SMRCs and Recovery Auditors shall use the unified postpayment ADR letter format. Contractors shall maintain the format of the letter, but have the discretion to insert case-specific information. In other words, contractors shall not change the order of the sections on the letter, but should modify the text underneath each section to provide detailed information and accurately reflect the information specific to the subject of the letter. The detailed text in the Exhibit 46 templates serves only to provide an example of what types of information belong under each section heading. The templates show the format and order contractors shall use when constructing postpayment ADR letters.

If any of the elements are lengthy, contractors have the discretion to utilize an attachment to provide the details. If a contractor does not have attachments, but has supplementary information to provide in the text of the letter, the contractor should insert the text beneath the section title "Attachments / Supplementary Information").

The MACs, CERT, SMRCs and Recovery Auditors shall include the following elements in their ADRs and shall use the appropriate templates provided in Exhibit 46:

A. Introductory Paragraph

- CMS as the government agency making the request;
- The program making the request (e.g. the MAC program, the SMRC program, the Recovery Audit Program, the CERT program); and
- The regulations and/or laws that apply to the request.

The first paragraph in the ADR may identify the following:

- The program purpose;
- Where additional information about the program and regulations can be found, for example, a website reference; and
- Additional program information that may be helpful to the provider or supplier.

B. Reason for Selection

The reason the provider or supplier was sent the ADR letter and notes about the claims under review.

C. Action

The action(s) the provider or supplier shall take as a result of receiving the ADR letter.

D. When

The date a provider/supplier shall reply to the ADR letter and submit the documentation to the contractor.

E. Consequences

The consequences if the provider or supplier fails to submit the requested documentation.

F. Instructions

Instructions and notes that will help the provider or supplier respond to the ADR letter.

G. Submission Methods

The methods the provider or supplier can submit the requested documentation.

H. Questions

Contractor contact information for provider inquiries related to the ADR.

I. Attachments / Supplementary Information

- If there are attachments or other supplementary information associated with the ADR, provide a listing of the attachment titles or provide the supplementary information.

**3.2.3.5 - Acceptable Submission Methods for Responses to ADRs
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)**

This section applies to MACs, Recovery Auditors, CERT, and UPICs, as indicated.

Reviewers shall be clear in their ADR letters about what documentation submission methods they will accept from a provider or Health Information Handler (HIH). The MACs, CERT, and Recovery Auditors shall accept documents via paper, fax, CD/DVD, and electronic submission of medical documentation (esMD).

A. Paper

The MACs, CERT, and Recovery Auditors are encouraged to state in the ADRs that paper medical documentation can be mailed by any means including US Postal Service, FedEx, UPS, or certified mail. To facilitate delivery of documentation, MACs, CERT and Recovery Auditors should provide a physical mailing address instead of a P.O. Box.

B. Fax

If the MACs, CERT, or Recovery Auditors have the capability to offer fax confirmation, they are encouraged to send such confirmations with every successfully received fax.

C. **Imaged Medical Documentation File(s) Sent on CD/DVD**

The MACs and CERT shall state in the ADR that imaged medical documentation files on CD/DVD may be mailed by any means. Recovery Auditor ADRs shall provide a Web site link or phone number that provides information regarding the requirements for submitting imaged documentation on CD or DVD.

D. **Medical Documentation Sent via Electronic Submission of Medical Documentation (esMD) Transmission**

Electronic Submission of Medical Documentation (esMD) is a system that allows providers/HHs to submit medical documentation over secure electronic means. Information about the esMD system can be found at www.cms.gov/esMD.

MACs and CERT are encouraged to state in their ADRs how providers can get more information about submitting medical documentation via the esMD mechanism.

Any time a new esMD service or document type is being offered, and any contractor wants to publish a public announcement (Web posting, list serve, tweet, etc.) the contractor must clear the announcement with CMS.

3.2.3.6 - Reimbursing Providers and HHs for Additional Documentation

(Rev. 786, Issued: 04-13-18, Effective: 05-14-18, Implementation: 05-14-18)

A. General

1. Rules for MACs, SMRC, CERT, and UPICs

- The MACs, SMRC, CERT, and UPICs are not required to pay for medical documentation for either prepayment or post payment review.

2. Rules for RACs

- RACs performing post payment review of hospital inpatient prospective payment system (PPS) and long term care facilities are required to pay the providers for submitting requested medical records. RACs shall pay according to the payment rate schedule listed in section B below.

- RACs performing post payment review of provider types other than hospital inpatient PPS and long term care facilities are required to pay the providers for submitting requested medical records, according to the payment rate schedule listed in section B below.
- Providers under a Medicare reimbursement system (such as Critical Access Hospitals) receive no reimbursement for submitting medical records.
- RACs shall pay a maximum of \$15.00 per record, including first class postage if applicable, for requested documents submitted via mail/fax/CD/DVD.
- RACs shall pay a maximum of \$27.00 per record, including a transaction fee of \$2.00/case, for requested documents submitted via esMD.
- Payments will not be made for blank pages or documents/records that are not related to the claim being reviewed.
- RACs shall issue documentation submission payments on at least a monthly basis and shall issue all photocopying payments within 45 calendar days of receiving the documentation.

RACs shall honor all requests from providers to issue photocopying payments to HIHs. RACs should gather, from the provider, all necessary information, such as, the HIH's name, phone number and bank routing number, etc.

- Providers interested in submitting documentation via esMD can find information on the CMS esMD website at <http://www.cms.gov/esMD>.

B. Payment Schedule for Requested Medical Records

	Hospital Inpatient Prospective Payment System (PPS) Facilities and Long Term Care Facilities	Non-PPS Institutions and Practitioners
Documentation sent via mail, fax, CD/DVD	- 12 cents per page - Plus first class postage, if applicable - \$15.00 maximum per record	- 15 cents per page - Plus first class postage, if applicable - \$15.00 maximum per record
Documentation sent via esMD	- 12 cents per page - Plus \$2.00 transaction fee, per record - \$27.00 maximum per record	- 15 cents per page - Plus \$2.00 transaction fee, per case

		- \$27.00 maximum per record

*Note: Providers under a Medicare reimbursement system (such as Critical Access Hospitals) receive no reimbursement for submitting medical records. Also, payments will not be made for blank pages or documents/records that are not related to the claim being reviewed.

3.2.3.7 - Special Provisions for Lab Additional Documentation Requests (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, UPICs, and SMRC as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided upon implementation of ICD-10. ICD-9-CM is used for discharges and other services before that implementation.

When the MACs, CERT, RACs, and UPICs send an ADR for a lab service, the following documentation shall be requested from the billing lab:

- The order for the service billed (including sufficient information to allow the reviewer to identify and contact the ordering provider);
- Verification of accurate processing of the order and submission of the claim; and
- Diagnostic or other medical information supplied to the lab by the ordering provider, including any diagnosis codes or narratives.

The contractor shall deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or send an ADR to the ordering provider in order to determine medical necessity. The contractor shall review information from the lab and find it insufficient before the ordering provider is contacted. The contractor shall send an ADR to the ordering provider that shall include sufficient information to identify the claim in question.

If the documentation received does not demonstrate that the service was reasonable and necessary, the contractor shall deny the claim. These denials count as medical record reviews. Contractor denial notices shall remind providers that beneficiaries cannot be held liable for these denials unless they have received proper liability notification before services were rendered, as detailed in CMS Pub. IOM 100-04, chapter 30.

3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT, SMRC, and UPICs, as indicated.

A. Additional Documentation Requests

The reviewer authority to request that documentation be submitted, to support claims payment, is outlined in Section 3.2.3.2 of this chapter.

If information is requested from both the billing provider or supplier and/or a third party and no response is received within the expected timeframes (or within a reasonable time following an extension), the MACs, RACs, SMRC, and UPICs shall deny the claim, in full or in part, as not reasonable and necessary. Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

MACs shall count these denials as automated review or non-medical record review depending whether the denial is automated or requires manual intervention. For claims that had a PWK modifier, and the unsolicited documentation was reviewed, the review shall be counted as medical record review.

B. No Response

During prepayment review, if no response is received within the expected timeframes, the MACs and UPICs shall deny the claim.

During post-payment review, if no response is received within the expected timeframes (or extension), the MACs, RACs, UPICs and SMRC shall deny the claim as not reasonable and necessary. These contractors shall cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act exclusively when referring to the authority for requiring submission of documentation, when denying claims for no response within the expected timeframes. The MACs shall count these denials as non-medical record reviews.

C. Insufficient Response

If the MAC, CERT, RAC, SMRC, or UPIC requests additional documentation to verify compliance with a benefit category requirement, and the submitted documentation lacks evidence that the benefit category requirements were met, the reviewer shall issue a benefit category denial. If the submitted documentation includes defective information (the documentation does not support the physician’s certification), the reviewer shall deny the claim as not meeting the reasonable and necessary criteria.

3.2.3.9 - Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Contractors shall make available general reopening process information via their website, in their ADR letters, or through remittance advice notices.

If the MACs receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim. MACs who choose to reopen a specific claim shall notify the provider or supplier of their intent to reopen that claim. Notification to the provider/supplier of the intent to reopen a specific claim shall be completed through any of the following mechanisms: Interactive Voice Response (IVR), contractor website portal, telephone contact, by letter, fax, email or secure messaging within 3 business days of identification of the request to reopen or receipt of medical record documentation. MR will make an MR determination on the lines previously denied due to failure to submit requested documentation, and do one of the following, within 60 calendar days of receiving documentation in the mailroom:

- For claims originally selected for postpayment review, the reviewer shall issue a new letter containing the revised denial reason and the information required by PIM chapter 3 §3.6.4;
- For claims originally selected for prepayment review, the MAC shall enter the revised MR determination into the shared system, generating a new Medicare Summary Notice (MSN) and remittance advice with the new denial reason and appeals information;
- The workload, costs, and savings associated with this activity shall be allocated to the appropriate MR activity (e.g., MR reopenings);

In cases where the MAC or UPIC denied a claim and the denial is appealed, the appeals entity will send the claim to the contractor's MR department for reopening in accordance with CMS Pub. IOM 100-04, chapter 34, § 10.3. The claim sent back to the contractor's MR department must have been denied using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

The MR department of the contractor (AC, MAC, or UPIC) who initiated the prepayment edit shall be responsible for conducting the reopening.

- The MACs who choose not to reopen claims when documentation is received past the deadline shall retain the information (hardcopy or electronic) in a location where it can be easily accessed.

If the RAC receives requested documentation from a supplier after a denial has been issued they shall not reopen the claim.

- If a RAC receives documentation after the submission deadline, but before they have issued a demand letter, the RAC shall review and consider the late documentation when making a claim determination;
- If the RAC receives a late response to a documentation request after they have issued a demand letter, the RAC shall retain the documentation so that it is available for review during the appeal process.

For information on how CERT handles late documentation, please refer to Chapter 12, Section 12.3.9.

3.2.3.10 - Record Retention and Storage

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, and UPICs shall abide by all documentation retention requirements listed in all litigation holds issued via Joint Signature Memoranda or Technical Direction Letters (JSM/TDL). Recovery Auditors shall comply with the record retention requirements in its SOWs.

3.2.4 - Use of Claims History Information in Claim Payment Determinations

(Rev. 802; Issued: 06-22-18; Effective: 07-24-18; Implementation: 07-24-18)

A. Contractors to Which This Section Applies

This section applies to MACs, CERT, SMRC, and RACs.

B. General

In certain circumstances it may be appropriate for medical reviewers to use relevant and accessible claims history to assist in making medical record review determinations. Examples of when this may be used for payment purposes, include, but are not limited to:

1. Reviewers have the discretion to use beneficiary payment history to identify other providers, other than the billing entity, who may have documentation to support payment of a claim. MAC, CERT and RAC reviewers have the discretion to contact identified providers for supporting documentation. Example: A diabetic beneficiary may have an order from a family practitioner but is also seeing an endocrinologist. The documentation from the family practitioner does not support the level of diabetic testing, but medical records from the endocrinologist do support the level of testing.

2. Reviewers have the discretion to use claims history information to document an event, such as a surgical procedure, that supports the need for a service or item billed in limited circumstances. In some cases, this event occurs a number of years prior to the date of service on the claim being reviewed, making it difficult to collect medical record documentation. If repeated attempts to collect medical record of the event are unsuccessful, contractors have the discretion to consider claims history information as documentation of the event. Contractors shall document their repeated attempts to collect the medical record if they chose to consider claims history information as documentation of the event. Example: A beneficiary is eligible for immunosuppressant drugs only if they received an organ transplant. Patients generally remain on these life-saving drugs for the rest of their life so it is possible for the transplant to have occurred many years prior to the date of service being reviewed. If there was no record of the transplant in the medical documentation provided by the ordering physician, the contractor may use claims history to validate the transplant occurred.

3. Reviewers shall use claims history information to verify that the frequency or quantity of supplies provided to a beneficiary do not exceed policy guidelines.

4. Reviewers shall use claims history information to identify duplication and overutilization of services.

3.2.5 - Targeted Probe and Educate (TPE)

(Rev. 10132; Issued: 05-15-2020; Effective: 06-16-2020; Implementation: 06-16-2020)

This section applies to MACs.

A. Overview

The purpose of Targeted Probe and Educate (TPE) is to decrease provider burden, reduce appeals, and improve the medical review/education process.

This section describes requirements that MACs shall follow when performing medical review as part of TPE.

TPE reviews can be either prepayment or postpayment and involve MACs focusing on specific providers/suppliers that bill a particular item or service.

A round of TPE typically involves the review of 20-40 claims, per provider/supplier, per service/item, and corresponding education. In rare circumstances, CMS may approve a probe sample of other than 20-40 claims. This process is typically repeated for up to three rounds, but may involve additional rounds at CMS direction. MACs discontinue the process if/when providers/suppliers become compliant. Providers/suppliers who remain non-compliant after three rounds of TPE are referred to CMS for further action.

B. Provider Selection

The MACs shall initiate a provider-specific, prepayment or postpayment review based upon data analysis, as discussed in §3.2.1. MACs shall also initiate targeted, provider-specific, prepayment or postpayment review upon referral from the Recovery Auditor Contractor (RAC), Comprehensive Error Rate Testing (CERT), Unified Program Integrity Contractor (UPIC), Office of Inspector General (OIG), or Government Accountability Office (GAO) when directed by CMS. MACs shall target providers/suppliers who have historically high claim denial rates, who have billing practices that vary from their peers, or when evidence suggests that there is a potential risk to the Medicare Trust Fund.

Probe Selection

The MACs shall select probe samples of typically 20-40 claims. Probe samples of different sizes may be deemed appropriate on a case-by-case basis, with approval by CMS.

Provider Notification Letter

The MACs shall send a notification letter to providers/suppliers being targeted for review that:

- Outlines the targeted probe & educate process,
- Explains the process by which providers/suppliers will be able to receive one-on-one education and the types of education that will be available,
- Notifies providers/suppliers that MACs shall have the option to refer providers/suppliers to the RAC or UPIC as a result of non-response to Additional Development Requests (ADRs), and
- Includes the following language to remind providers of 42 CFR §424.535

“In addition, we remind you that the regulation at 42 CFR §424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier’s Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.”

C. TPE One-On-One Education

For the TPE process, one-on-one education is defined as teleconference calls, face-to-face visits, electronic visits using webinar technology, or other similar technologies that enable direct communication between the MAC educator and the provider/supplier. MACs shall record these activities in monthly reporting to CMS as well as document and maintain the results of the education, and/or attempts for education, for data analysis and possible future reporting.

Intra-Probe Education

The MAC may identify errors in the claim(s) that can be easily resolved during the course of provider's/supplier's probe reviews. Easily curable errors include, but are not limited to, missing documentation that can be resolved through the submission of additional documentation and missing signatures that can be resolved with a signature attestation. When the MAC identifies an easily curable error, the MAC shall contact the provider to address the error and allow the provider to submit missing documentation, etc.

Post-Probe Education

The MAC shall contact the provider/supplier via telephone (or face-to-face, electronic visits using webinar technology, or other similar technologies as they become available) to offer a one-on-one educational session after each round of probe review. If the provider/supplier declines the offer for one-on-one education, MACs shall maintain a record of the effort and the reason for denial. The purpose of this one-on-one education is to:

- 1) Alert the provider of errors identified and how they may be resolved for future claim submissions; and
- 2) Provide education regarding the review topic to help prevent new issues from arising during future rounds of review. This post-probe one-on-one education should be individualized, claims-specific, and conducted in a format that is interactive, allowing the provider/supplier to ask questions as needed.

The MAC shall provide a minimum of 45 days after each post-probe educational session, before selecting new claims for review, to allow time for the provider/supplier to cure identified errors.

D. Post-Probe Activity

Final Results Letter

The MAC shall send the provider/supplier a letter detailing the results of the claims reviewed at the conclusion of each round of review. The MAC shall include details regarding the provider's/supplier's specific claim errors. For providers/suppliers who will be released from review due to meeting the established error rate goal, results letters shall indicate that the provider is being released from review for one year, with the caveat that additional review may occur at any time should the MAC identified changes in billing pattern. For providers/suppliers who continue to have high error rates after three rounds of TPE review, results letters shall indicate that they have not met the established goal error rate and will be referred to CMS for additional action, which may include additional rounds of TPE review, 100 percent prepayment review, extrapolation, referral to a Recovery Auditor, and/or referral for revocation. Additionally, the letter shall include the following language to remind providers of 42 CFR §424.535.

“In addition, we remind you that the regulation at 42 CFR §424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier’s Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.”

Determining the Need for Additional TPE

The MAC shall calculate the provider/supplier claim error rate and payment error rate at the conclusion of each round of TPE. The MAC shall use the provider/supplier error rate to determine whether an additional round of TPE is appropriate.

Closure and Monitoring

A provider/supplier may be removed from TPE after any round if they demonstrate low error rates or sufficient improvement in error rates, as determined by the MAC. MACs shall use data analysis to monitor the providers/suppliers who have been discontinued from the TPE process. MACs shall conduct follow-up review in one year or sooner if data analysis indicates changes in billing patterns or when potential risk to the Medicare Trust Fund is identified.

E. Referrals

If a provider/supplier continues to have a high error rate at the conclusion of three rounds of TPE, the MAC shall refer to CMS for further action. Referrals shall include details regarding the reason the provider/supplier was selected for TPE review, TPE review results, results of appealed denials (to the extent available at the time of referral), any education provided (or offered and refused), and any other relevant information that may be helpful in determining appropriate next steps.

The MAC shall refer suspected fraudulent providers to the UPIC at any time during the TPE process.

F. Next Steps

Once the MAC refers a provider/supplier to CMS, details are reviewed to determine if additional action must be taken by the MAC. Additional actions that may be required include, but are not limited to, additional rounds of TPE review, 100 percent prepayment review, extrapolation, referral to a Recovery Auditor, and/or referral for revocation. If CMS directs the MAC to conduct an additional round of TPE review, the MAC shall send the provider/supplier a notification letter indicating that an additional round of review is required. These reviews shall be of claims with dates of service at least 45 days after the prior round’s post probe education and after the provider/supplier has received the aforementioned notification letter.

3.3 – Policies and Guidelines Applied During Review

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, Supplemental Medical Review Contractors (SMRCs) and UPICs, as indicated.

A. Statutes, Regulations, the CMS' Rulings, National Coverage Determinations, Coverage Provisions in Interpretive Medicare Manuals, and Local Coverage Determinations

The primary authority for all coverage provisions and subsequent policies is the Social Security Act. In general, MACs, CERT, Recovery Auditors, SMRCs, and UPICs shall apply the provisions of the Act according to the following hierarchy of documents in effect at the time the item(s) or service(s) was provided to make medical review decisions:

- Social Security Act
- Code of
- Federal Regulations CMS'
- Rulings
- National Coverage Determination (NCDs)
- Coverage provisions in Interpretive Manuals or Internet Only Manuals (IOM) which includes Medical Review Guidance in the Medicare Program Integrity Manual
- CMS coding policies
- Technical Direction Letters (TDLs)* The relevant MAC's Local Coverage Determination (LCDs) The relevant MAC's local articles
- AHA Coding Clinics.

*TDLs that contain MR guidance may provide an exception to this hierarchy.

B. Coding Guidelines

The MACs, CERT, Recovery Auditors, and UPICs shall apply coding guidelines to services selected for review. All contractors shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, International Classification of Diseases Guidelines (ICD), CMS HCPCS or ICD policy or guideline requirements, LCDs, or MAC articles.

C. Internal Medical Review Guidelines

The MAC, CERT, Recovery Auditor, and UPIC staffs have the discretion to develop detailed written review guidelines to guide staff during claim reviews. Internal MR guidelines shall specify the information to be reviewed by reviewers and the appropriate resulting determination. Recovery Auditors are required to develop written review

guidelines in accordance with their SOW. The MACs, CERT, Recovery Auditors, and UPICs shall make their internal MR guidelines available to their staff, as needed. Internal MR Guidelines shall not create or change the CMS policy.

3.3.1 - Types of Review: Medical Record Review, Non-Medical Record Review, and Automated Review (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, and UPICs, as indicated.

A. General

Most of the claim review activities completed for the purpose of identifying inappropriate billing and avoiding improper payments are divided into three distinct types: Medical Record Review, Non-Medical Record Review, and Automated Review.

The chart below indicates which contractors perform which types of review:

Contractor Type	Prepayment			Postpayment	
	Medical Record Review	Non-Medical Record Review	Automated Reviews	Medical Record Review	Non-Medical Record review
MACs	Yes	Yes	Yes	Yes	Yes
CERT	No	No	No	Yes	No
RACs	No	No	No	Yes	No
SMRC	No	No	No	Yes	Yes
UPIC	Yes	No	No	Yes	Yes

3.3.1.1 - Medical Record Review (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, Supplemental Medical Review Contractor(s) and UPICs, as indicated.

A. Definition

Medical record review involves requesting, receiving, and reviewing medical documentation associated with a claim.

Medical record review, for the purpose of determining medical necessity, requires a licensed medical professional to use clinical review judgment to evaluate medical record documentation.

B. Clinical Review Judgment

Clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria is to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. MAC, CERT, RAC, and UPIC clinical review staff shall use clinical review judgment when making medical record review determinations about a claim.

Clinical review judgment does not replace poor or inadequate medical records. Clinical review judgment by definition is not a process that MACs, CERT, RACs and UPICs can use to override, supersede or disregard a policy requirement. Policies include laws, regulations, the CMS' rulings, manual instructions, MAC policy articles attached to an LCD or listed in the Medicare Coverage Database, national coverage decisions, and local coverage determinations.

C. Credentials of Reviewers

The MACs, MRAC, and CERT shall ensure that medical record reviews for the purpose of making coverage determinations are performed by licensed nurses (RNs), therapists or physicians. Current LPNs may be grandfathered in and can continue to perform medical record review. The MACs, MRAC, and CERT shall not hire any new LPNs to perform medical record review. UPICs, RACs and the SMRC shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs.

During a medical record review, nurse and physician reviewers may call upon other health care professionals (e.g., dietitians or physician specialists) for advice. The MACs, MRAC, and CERT, shall ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e., speech therapy claim, physical therapy). RACs and the SMRC shall follow guidance related to calling upon other healthcare professionals as outlined in their respective SOWs.

RACs shall ensure that a licensed medical professional will perform medical record reviews for the purpose of determining medical necessity, using their clinical review judgment to evaluate medical record documentation. Certified coders will perform coding determinations. CERT and MACs are encouraged to make coding determinations by using certified coders. UPICs have the discretion to make coding determinations using certified coders.

D. Credential Files

The MACs, MRAC, CERT, RACs, and UPICs shall maintain a credentials file for each reviewer (including consultants, contract staff, subcontractors, and temporary staff) who performs medical record reviews. The credentials file shall contain at least a copy of the reviewer's active professional license.

E. Quality Improvement (QI) Process

The MACs, CERT, RACs, and SMRCs shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. The MACs, CERT, RACs, and SMRCs shall attend the annual medical review training conference as directed by the CMS and/or their SOW. The MACs, CERT, RACs, and SMRCs shall include inter-rater reliability assessments in their QI process and shall report these results as directed by CMS.

F. Advanced Beneficiary Notice (ABN)

The MACs, CERT, RACs, UPICs, and SMRCs shall request as part of the ADR, during a medical record review, a copy of any mandatory ABNs, as defined in Pub. 100-04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. If the claim is determined not to be reasonable and necessary, the contractor will perform a face validity assessment of the ABN in accordance with the instructions stated in Pub. 100-04 Medicare Claims Processing Manual chapter 30 section 50.6.3.

The Face Validity assessments do not include contacting beneficiaries or providers to ensure the accuracy or authenticity of the information. Face Validity assessments will assist in ensuring that liability is assigned in accordance with the Limitations of Liability Provisions of section 1879 of the Social Security Act.

G. MAC Funding Issues

The MAC-medical record review work performed by medical review staff for purposes other than MR (e.g., appeals) shall be charged, for expenditure reporting purposes, to the area requiring medical review services.

All medical record review work performed by MACs shall:

- Involve activities defined under the Medicare Integrity Program (MIP) at Section 1893(b)(1) of the Act;
- Be articulated in its medical review strategy; and
- Be designed in such a way as to reduce its Comprehensive Error Rate Testing (CERT) error rate or prevent the contractor's error rate from increasing.

The MACs shall be mindful that edits suspending a claim for medical review to check for issues other than inappropriate billing (i.e. completeness of claims, conditions of participation, quality of care) are not medical review edits as defined under Section 1893(b)(1) of the Act and cannot be funded by MIP. Therefore, edits resulting in work other than that defined in Section 1893 (b) (1) shall be charged to the appropriate Program Management activity cost center. Activities associated with claims processing edits shall not be charged to MIP.

H. Review Timeliness Requirements

Prepayment Review Requirements for MACs

When a MAC receives requested documentation for prepayment review within 45 calendar days of the date of the ADR, the MAC shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination and 2) enter the decision into the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), or the VIPS Medicare System (VMS). The 30 calendar day timeframe applies to prepayment non-medical record reviews and prepayment medical record reviews. The 30 calendar day timeframe does not apply to prepayment reviews of Third Party Liability claims. The MACs shall make and enter a review determination for Third Party Liability claims within 60 calendar days.

Counting the 30 Calendar Day Timeframe

The MACs and RACs shall count day one as the date each new medical record is received in the mailroom. The MACs and RACs shall give each new medical record received an independent 30 day review time period.

Prepayment Review Requirements for UPICs

When a UPIC receives all documentation requested for prepayment review within 45 calendar days of the date of the ADR, the UPIC shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation. Medical review for the purpose of fraud, waste, or abuse requires 60 days to allow for the integration of information from the investigative process. This information may be a result of recent/concurrent investigative actions such as beneficiary/provider/supplier interviews, site visits and/or receipt of additional internal/external information.

Postpayment Review Requirements for MACs

The MAC shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation.

For claims associated with any referrals to the UPIC for program integrity investigation, MACs shall stop counting the 60-day time period on the date the referral is made. The

60-day time period will be restarted on the date the MAC received requested input from the UPIC or is notified by the UPIC that the referral has been declined.

For claims sent to MR for reopening by the contractor appeals department, in accordance with Pub. 100-04, chapter 34, §10.3, begin counting the 60 days from the time the medical records are received in the MR department.

Postpayment Review Requirements for RACs

When a RAC receives requested documentation for review within 45 calendar days of the date of the ADR, the RAC shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination, and 2) communicate the results to the provider.

State Laws that Affect Prepayment Review Timeliness Requirements

The MACs shall adhere to state laws that require an evidentiary hearing for the beneficiary before any denials are processed. The MAC shall review the claim within 30 days, allow the time required for the evidentiary hearing, and then continue with the processing of the claim on the next business day.

Postpayment Review Requirements for UPICs

To promote the timeliness of the investigative process, the UPICs shall complete postpayment medical review and provide the lead investigator with a final summary of the medical review findings that includes reference to the allegations being substantiated/not substantiated by medical review, reasons for denials, and any observations or trends noted within 60 calendar days, unless otherwise directed by CMS. The counting for the 60-day time period begins when all of the documentation is received by the UPIC. The UPIC shall have a HIPAA compliant process to receive this documentation that includes the application of the date the documents are received at the UPIC's designated mailing address for all methods described in section 3.2.3.5 of this chapter. The medical review unit shall communicate the medical review findings in a summary document to the investigative lead within 60 calendar days of receiving all of the requested documentation. Medical review for the purpose of fraud, waste, or abuse requires 60 days to allow for the integration of information from the investigative process. This information may be a result of recent/concurrent investigative actions such as beneficiary/provider/supplier interviews, site visits and/or receipt of additional internal/external information.

If the UPIC is unable to complete the postpayment medical review in 60 days, they shall communicate this to their COR and request an extension. This approval must be documented in the case management system by the contactor.

3.3.1.2 - Non-Medical Record Review

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, SMRC, and UPICs, as indicated.

A. Definition

Non-medical record reviews uses manual intervention, but only to the extent a reviewer can make a determination based on information on a claim. It does not require clinical judgment in review of medical record documentation. Contractors shall only perform a non-medical record review for denials of related claims and/or no receipt of ADR documentation where such denials cannot be automated.

3.3.1.3 - Automated Review

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Definition

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no manual intervention.

CERT refers to all reviews where no documentation was requested as “T-claim review.” T-claims are a particular category of claim reviewed by CERT. T-claims are claims that were automatically denied by the MAC.

B. Basis for Automated Reviews

The MAC, RAC, CERT, SMRC, and UPIC shall ensure that automated prepayment and postpayment denials are based on clear policy that serves as the basis for denial; or a Medically Unlikely Edit (MUE); or occurs when no timely response is received to an ADR.

When a clear policy exists (or in the case of a MUE), MACs, RACs, SMRC, and UPICs have the discretion to automatically deny the services without stopping the claim for manual review, even if documentation is attached or simultaneously submitted. Reviewers shall still make a determination based on the liability limitations of §1879 of the Act. The term “clear policy” means a statute, regulation, NCD, coverage provision in an interpretive manual, coding guideline, LCD or MAC article that specifies the circumstances under which a service will always be considered non-covered, incorrectly coded, or improperly billed.

A MUE is a unit of service (UOS) edit for a Healthcare Common Procedure Coding system (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. The MUE program provides a method to report medically reasonable and necessary UOS in excess of a MUE.

Automated edits can be used for apparent typographical errors (e.g., 10,000 blood cultures for the same beneficiary on the same day).

MACs shall implement automated prepayment review whenever appropriate.

The RACs refer to all reviews where no documentation was requested as “automated review.”

3.3.2 - Medical Review Guidance

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

This section describes the requirements that MACs, CERT, Recovery Auditors, and UPICs shall follow when reviewing submitted documentation. Additional requirements for UPICs are located in PIM chapter 4. When UPIC staff is performing benefit integrity reviews, their focus is different than that of MACs, CERT, and Recovery Auditors. For example, UPIC staff looks for some of the following situations when reviewing documentation:

- Possible falsification or other evidence of alterations including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries;
- Evidence that the service billed for was actually provided; or,
- Patterns and trends that may indicate potential fraud.

3.3.2.1 - Documents on Which to Base a Determination

(Rev. 802; Issued: 06-22-18; Effective: 07-24-18; Implementation: 07-24-18)

This section applies to MACs, CERT, RACs, SMRC and UPICs, as indicated.

The MACs, CERT, RACs, SMRC, and UPICs shall review any information necessary to make a prepayment and/or postpayment claim determination, unless otherwise directed in this manual. This includes reviewing any documentation submitted with the claim and any other documentation subsequently requested from the provider or other entity when necessary. In certain circumstances it may be appropriate for medical reviewers to consider relevant and accessible billing history or other information obtained from the Common Working File (in limited circumstances), outcome assessment and information set (OASIS), or the minimum data set (MDS), among others. For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier

or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met.

3.3.2.1.1 - Progress Notes and Templates

(Rev. 833; Issued: 10-12-18; Effective: 11-13-18; Implementation: 11-13-18)

A. Definitions

For the purposes of Section 3.3.2.1.1, the following definitions apply:

1. "Progress Notes" -- visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record. Progress notes may be in any form or format, hardcopy or electronic.

2. "Template" -- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.

Electronic records may involve any type of interface including but not limited to:

simple electronic documents,

sophisticated graphical user interfaces (GUIs) with clinical decision and documentation support prompts, or

electronic pen capture devices.

“Licensed/Certified Medical Professional (LCMP)” – Medical professional licensed or certified to practice in the state in which services are rendered. For the purposes of documenting DMEPOS items, the physician or LCMP must not have a financial relationship with the DMEPOS supplier.

B. Guidelines Regarding Which Documents Review Contractors Will Consider

The review contractor shall consider all medical record entries made by physicians and LCMPs. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation.

The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the applicable National and Local Coverage Determination for further details.

CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates except for the clinical templates it publishes on its website. A physician/LCMP may choose any template to assist in

documenting medical information. Contractors shall consider information captured in templates when conducting medical review.

Some templates provide limited options and/or space for the collection of information such as by using “check boxes,” predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to **select one that allows for a full and complete collection of information** to demonstrate that the applicable coverage and coding criteria are met.

Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the signed by the ordering physician.. See PIM §5.7 for additional information on documentation.

C. Financial Liability

The physician/LCMP should be aware that inadequate medical record documentation can lead to a financial liability for the Beneficiary and/or Supplier, should the reviewer determine that a claim is not supported.

In addition, the physician/LCMP should be aware that when ordering an item or service that will be furnished by another entity, Section 1842(p)(4) of the Social Security Act requires that adequate documentation supporting medical necessity be provided to the entity at the time that the item or service is ordered. Physicians/LCMPs who fail submit documentation upon a supplier's request may trigger increased MAC or RAC review of the physician/LCMP's evaluation and management services.

3.3.2.1.2 –DMEPOS Orders

(Rev. 10190; Issued: 06-19-2020, Effective: 01-01-2020; Implementation: 07-01-2020)

Totality of the Record

All DMEPOS items require a Standard Written Order (SWO) from the treating practitioner as a condition of payment. Medicare contractors shall consider the totality of the medical record when reviewing for compliance of the SWO elements. This will allow

contractors to account for the dynamic nature of electronic medical record documentation systems, and give them additional discretion when they believe the entirety of the record demonstrates compliance with our order requirements. For example, a contractor may nonetheless support payment when an order has a missing or flawed element that is clearly documented elsewhere in the record.

Contractors acting as a secondary reviewer shall grant deference to the initial reviewer's discretion, if such an initial decision resulted in a reasonably prudent decision that aligns with Medicare coverage and coding instructions.

3.3.2.2 - Absolute Words and Prerequisite Therapies

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

The MACs, CERT, Recovery Auditors, and UPICs shall not deviate from coverage provisions if absolute words such as “never” or “only if” are used when making claim determinations where a regulation, CMS ruling, NCD, LCD, or MAC policy article exists. In these cases, reviewers shall not make any exceptions or give individual consideration.

Requirements for prerequisite therapies shall be followed when deciding whether to cover a service if listed in coverage provisions in interpretive manuals (e.g., “conservative treatment has been tried, but failed”).

3.3.2.3 - Mandatory Policy Provisions

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, Recovery Auditors, CERT and UPICs, as indicated.

CERT contractors select claims for review on a random basis and do not select claims that are suspect. The CERT reviewers shall review every line on the randomly selected claim that affects payment to determine if the following types of requirements are met:

- Coding requirements;
- Benefit category requirements;
- The reasonable and necessary requirements of the NCDs and LCDs, among others.

The MACs and UPICs select claims to prevent or identify an improper payment. They are only required to review the suspect line and not every line on the selected claims. The selected line does not need to be completely reviewed. Along with reviewing the line for coding accuracy, the MACs should review for medical necessity if the provider has been notified that both types of review will occur. The UPICs shall use discretion in notifying the provider.

3.3.2.4 - Signature Requirements

(Rev. 11032; Issued: 09-30-21; Effective: 10-12-21; Implementation: 11-10-21)

This section is applicable for Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), Supplemental Medical Review Contractors (SMRCs), Comprehensive Error Rate Testing (CERT), and Recovery Audit Contractor (RACs), as indicated.

For medical review purposes, Medicare requires that services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies. For example, if the physician's authenticated documentation corroborates the nurse's unsigned note, and the physician was the responsible party per Medicare's payment policy, medical reviewers would consider signature requirements to have been met. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

NOTE: Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note.

Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, *Section* 80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN, etc.) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

EXCEPTION 4: CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

NOTE: Conditions of participation (COP) are not conditions of payment.

If MAC and CERT reviewers find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation that contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, UPICs, SMRC, and CERT shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, MACs, *UPICs*, SMRC, and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).
- If the signature is missing from any other medical documentation (other than an order), MACs, *UPICs*, SMRC, and CERT shall accept a signature attestation from the author of the medical record entry.

B. Signature Log

Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted

signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

C. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

“I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

Although this format is acceptable, the CMS currently neither requires nor instructs providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers. However, since no form for signature attestation has been approved by the Office of Management and Budget (OMB), the contractors should not give the providers any standard format on which to submit the attestation. Once the OMB has assigned an OMB Paperwork Reduction Act number to this attestation form, its use will be mandatory.

Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to “backdate” the plan of care.

D. Signature Guidelines

The guidelines below will assist in determining whether to consider the signature requirements met:

- In the situations where the guidelines indicate “**signature requirements met,**” the reviewer shall consider the entry.
- In situations where the guidelines indicate “**contact billing provider and ask a non-standardized follow up question,**” the reviewer shall contact the person or organization that billed the claim and ask if the billing entity would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins on the date of the telephone contact with the provider or on the date the request letter is received by the provider. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry.
- In cases where a reviewer has requested a signature attestation or log, the time for completing the review is extended by 15 days. This extension starts upon receipt of the signature attestation or log.
- The MACs, CERT and UPICs shall document all contacts with the provider and/or other efforts to authenticate the signature.

Note: The MACs, CERT and UPICs shall **NOT** contact the **biller when the claim should be denied for reasons unrelated** to the signature requirement.

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
	Example:  John Whigg, MD		

4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a signature log, or an attestation statement	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is UNaccompanied by: a signature log, or an attestation statement Example:		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but accompanied by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name UNaccompanied by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name		X
	Example: John Whigg, MD		
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

E. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and

software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

F. Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber and dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve beneficiary safety and quality of care.

A “qualified” e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing).

1. E-Prescribing for Part B Medications (Other than Controlled Substances)

The MAC, CERT and UPIC reviewers shall accept as a valid order any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system. For Medicare Part B medical review purposes, a qualified e-prescribing system is one that meets all 42 CFR §423.160 requirements. When Part B medications have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

2. E-Prescribing for Part B Controlled Substance Medications

Historically, the Drug Enforcement Agency (DEA) has not permitted the prescribing of controlled substance medications through e-prescribing systems. Therefore, when reviewing claims for controlled substance medications, MAC, CERT and UPICs reviewers shall only accept hardcopy pen and ink signatures as evidence of a medication order. However, the DEA is in the process of establishing requirements for electronic prescriptions for controlled substances. Refer to 21 CFR §§1300, 1304, 1306 and 1311 for further information.

3. E-Prescribing for Medications Incident to DME

The MAC, CERT and UPICs reviewers shall accept as valid any e-prescribed order for medications incident to Durable Medical Equipment (DME), other than controlled substances. For the purpose of conducting Medicare medical review of medications incident to DME, a qualified e-prescribing system is one that meets all §42 CFR 423.160

requirements. When medications incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Refer to PIM chapter 5 for further details regarding additional signature requirements for DMEPOS.

H. Signature Dating Requirements

For medical review purposes, if the relevant regulation, NCD, LCD and other CMS manuals are silent on whether the signature must be dated, the MACs, CERT and UPICs shall ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Example: The claim selected for review is for a hospital visit on October 4. The ADR response is one page from the hospital medical record containing three (3) entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer should conclude that the physician visit was conducted on October 4.

I. Additional Documentation Request Language Regarding Signatures

The CERT contractor shall use language in its ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document. For example, a hospital discharge summary in the physician's office files may be unsigned, whereas the version of the discharge summary in the hospital files should be signed and dated. MACs are encouraged to use such language in their letters. In addition, MACs, CERT and UPICs have the discretion to add language to their ADRs stating that the provider is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer finds a note with a missing or illegible signature, the ADR may inform the provider that it should submit a signature log or signature attestation as part of the ADR response.

The following is sample language that reviewers may choose to use in certain ADRs:

“Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you

provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.

If you question the legibility of your signature, you may submit an attestation statement in your ADR response.

If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated.”

J. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the UPIC for development. If MAC, RAC, SMRC or CERT reviewers identify a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate UPIC for further development.

3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, SMRC and UPICs, as indicated.

A. Amendments, Corrections and Delayed Entries in Medical Documentation

All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, SMRC and UPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in section B below. The MACs, CERT, Recovery Auditors, SMRC and UPICs shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, SMRC and UPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or

delayed entry as such, and

2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Clearly identify all original content, without deletion.

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by:

1. Using a single line strike through so the original content is still readable, and
2. The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name. For example, if the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information, the reviewer shall accept the entry.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, SMRC and UPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

- a. Distinctly identify any amendment, correction or delayed entry; and
- b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

If the MACs, CERT, SMRC or Recovery Auditors identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the UPIC and may consider referring to the RO and State Agency.

3.3.2.6 - Psychotherapy Notes

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors or UPICs, as indicated.

Psychotherapy notes are defined in 45 CFR§164.501 as “notes recorded by a mental health professional which document or analyze the contents of a counseling session and

that are separated from the rest of a medical record.” The definition of psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of administered treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis, ongoing progress and progress to date. This class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall the MACs, CERT, Recovery Auditors or UPICs request that a provider submit psychotherapy notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the automatic denial of a claim.

If the medical documentation includes any of the information included in the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting information required to support that the claim is for reasonable and necessary services. MACs, Recovery Auditors, CERT or UPICs shall review the claim using the supporting documentation submitted by the provider. If the provider does not submit information sufficient to demonstrate that services were medically necessary, the claim shall be denied. Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub. IOM, 100-04 chapter 30, §30.1.

3.3.2.7 - Review Guidelines for Therapy Services

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

Financial limitations on therapy services (therapy caps) were originally initiated by the Balanced Budget Act of 1997 and have been implemented at times without an exceptions process. During a time when no exceptions process exists, contractors shall deny claims for Part B occupational, physical, and speech-language pathology therapy services, except for hospital outpatient therapy services, which exceed the therapy cap. There is no therapy cap for hospital outpatient therapy services.

Automatic Process for Exception from the Therapy Cap

Section 1833(g)(5) of the Social Security Act provides that contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances.

For therapy services provided during a time when a therapy cap exceptions process is in effect, the contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if:

- The beneficiary meets specific conditions listed in CMS Pub.100-04, chapter 5, §10.2 for exception from the therapy cap, or
- The beneficiary does not meet the specific criteria in CMS Pub.100-04, chapter 5, §10.2, but has a need for medically necessary therapy services above the therapy cap.

In both of these situations, the contractor shall require that the therapist maintain on file, necessary documentation to support the medical necessity of therapy services. Documentation requirements are found in CMS Pub.100-02, chapter 15, section 230.3.

Request for Exception from Therapy Caps

Contractors shall not require providers to submit written requests for exception from the therapy cap. Instead, the placement of the KX modifier on the claim shall be interpreted as a request for exception from the cap. For beneficiaries who the clinician believes will require therapy treatment days in excess of those payable under the therapy cap, and who meet the above bulleted criteria for automatic exception, the Medicare contractor shall require the provider to maintain sufficient documentation on file to support the medical necessity for this service. Use of the KX modifier shall be interpreted as the therapist's attestation that services provided above the cap are medically necessary.

The contractor shall require the provider to maintain on file documentation in accordance with CMS Pub.100-02, chapter 15, section 220.3 and CMS Pub.100-04, chapter 5, sections 10.2 and 20 with the request for treatment days in excess of those payable under the therapy cap.

If the clinician attests that the requested services are medically necessary by using a KX modifier on the claim line, the contractor may make the determination that the claim is medically necessary. That determination is binding on the contractor in the absence of:

- potential fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- A pattern of aberrant billing by a provider.

Should such evidence of potential fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the KX modifier was used on the claim.

Progressive corrective action (PCA) and medical review have a role in the therapy exception process. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. The exception is granted on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of

patterns of aberrant billing of the services by the provider/supplier. Services deemed medically necessary are still subject to review related to fraud or abuse. An example of inappropriate use of the process is the routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap.

3.3.2.8 - MAC Articles

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

A. General

The MACs have the discretion to publish articles communicating certain information to providers, such as any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy. The MACs are required to enter articles that address LCDs, coding or medical review-related billing and claims considerations into the Medicare Coverage Database (MCD).

For the purposes of this manual, the term "publish" will be used to describe any form of dissemination including posting on a Web site, distributing at a seminar, e-mailing, or printing in a hardcopy bulletin. The MAC Medical Review Departments are responsible for the development of articles associated with new or revised LCDs and for entering those articles into the Medicare Coverage Database. Other widespread educational articles shall not be charged to MR.

The MAC medical review departments shall send articles to the appropriate department within the MAC for publishing. All newly created articles shall be posted on the MAC's Web site where duplicate copies can be obtained by providers/suppliers.

When NCDs or other coverage instructions issued by the CMS include specific conditions or parameters for covered services, the MACs have the discretion to develop and publish a list of covered codes associated with the coverage provision. MACs have the discretion to automate denials for codes not included on the list without the development of a LCD if the NCD indicates or states that no other condition or parameters will be covered.

MACs also have the discretion to:

- Publish definitions of procedure codes, lists of items that may be billed under a particular code, or minimum requirements that providers must meet in order to bill using a certain code.
- Publish a product classification list that instructs providers about which specific products meet the definitional requirements of a particular HCPCS code. Developing or revising an LCD for this

article is unnecessary.

- Explain which off-labeled uses of the Food and Drug Administration (FDA) approved drugs are considered reasonable and necessary within the diagnosis codes that reflect such uses.
- Explain the benefit category decisions and publish a list of drugs/biologicals that are considered usually self-administered. MACs should enter their self-administered medication exclusion list into the Medicare Coverage Database. This database can be accessed at www.cms.gov/mcd.
- MACs have the discretion to explain which HCPCS code or group of codes properly describes a particular service.
- MACs have the discretion to publish State non-physician licensure information that governs services billed by the physician under the "incident to" provision.

The MACs shall ensure that articles do not conflict with NCDs, LCDs, policy, or coverage provisions in interpretive manuals. Although a comment and notice process is not required, MACs are encouraged to consult with stakeholders in the provider community when developing articles. MACs shall monitor comments about articles from clinician providers and respond to their concerns, as needed, by issuing revised or clarifying articles.

NOTE: Nothing in this section precludes the MACs or UPICs from making individual claim determinations, even in the absence of an article or LCD.

3.3.3 - Reviewing Claims in the Absence of Policies and Guidelines (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, Recovery Auditors, and UPICs have the discretion to review claims, in the absence of policies, whether a NCD, coverage provision in an interpretive Medicare manual, or LCD exists for that service. When making individual claim determinations, they shall determine that the service in question is covered based on whether the service meets all of the conditions listed in section 3.6.2.1.

3.4 - Prepayment Review of Claims (Rev.902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)

This section applies to MACs and UPICs.

A. General

Non-random (targeted) review is defined as review conducted with a specific reason or logic to substantiate the cause for review. MACs are encouraged to initiate non-random service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors or other sources.

The MACs shall initiate targeted provider-specific prepayment review only when there is the likelihood of a sustained or high level of improper payments.

B. 100% Prepayment Review and Random Review Instructions

Section 1302 of the Health Care and Education Reconciliation Act (HCERA) repealed section 1874A (h) of the Social Security Act which had placed restrictions on prepayment medical review. CMS review contractors shall comply with Section 1 random review and Section 2 100% prepayment review.

1. Random Review

Random review is defined as review conducted without a specific reason or logic to substantiate the cause for review. MACs have the discretion to conduct random reviews of services; however, CMS does not recommend random reviews. MACs shall notify the CMS Contracting Officer's Representative (COR), Regional Office Technical Monitor (TM), and Business Function Lead (BFL) of its intent to conduct random review. The MAC shall describe what the intended result of the random review will be, an estimate of the number of claims to be reviewed randomly and the rationale as to why random review would be more effective than targeted review.

2. 100% Prepayment Review

100% prepayment review is defined as review of every claim submitted by a targeted provider for a specific code (i.e., DRG, CPT, HCPCs). 100% prepayment review also includes review of every claim submitted by the targeted provider.

MACs have the discretion to conduct 100 % prepayment review of providers. CMS considers 100 % prepayment review to be appropriate when a provider has a prolonged time period of non-compliance with CMS policies. Any MAC that plans to conduct 100 % prepayment review shall inform the CMS COR, Regional Office TM, and BFL in advance about any provider being placed on 100 % prepayment review. In addition, the MAC shall provide

- The background information on attempts to educate the provider.
- The historical improper payment rate of the provider before beginning 100% prepayment review.
- The length of time the provider is expected to be on 100 % prepayment reviews.

- The estimated number of claims and the dollar value of claims expected to be reviewed per month.
- The criteria for removing the provider from 100 % prepayment review.

3. UPIC Initiated Prepayment Reviews

No UPIC shall initiate a 100% prepayment review without CMS approval, except 100% prepayment reviews associated with a Payment Suspension. Therefore, the UPIC shall provide its COR and IAG BFL a summary of the investigation, any prior history (if applicable) with the provider/supplier in question, and any other relevant information in a format agreed upon by the COR and IAG BFL.

If the COR and IAG BFL agree that 100% prepayment review is appropriate, the UPIC shall include the case on the next case coordination meeting agenda for discussion and final approval. During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to these investigations. If the UPIC has subsequent questions following the case coordination meeting, the UPIC shall coordinate with its COR and IAG BFL.

3.4.1 - Electronic and Paper Claims

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The Administrative Simplification Compliance Act (ASCA, Section 3 of Pub. L, 107-105, 42 CFR 424.32) requires that all Medicare claims be submitted electronically using the ASC X12 837 institutional or professional claim formats with few exceptions. MACs shall not require providers to submit paper claims when they are targeted for prepayment medical record review. The MACs shall allow providers that qualify for an ASCA mandatory electronic billing exception to submit paper claims when they are targeted for prepayment review (See IOM Pub.100-04, chapter 24, §90 for exceptions).

3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

The MACs shall ensure that any edit that could result in a denial based on a LCD or NCD includes the LCD or NCD ID number(s) associated with the denial. The MACs shall ensure that any edit that could result in a denial based on a lab negotiated NCD includes the NCD ID number(s) associated with the denial.

3.4.1.2 - Not Otherwise Classified (NOC) Codes

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

The MAC MR staff should assist claims processing staff in making coverage and pricing determinations on NOC HCPCS/CPT codes. The claims processing staff will need information from the MR staff so that they can price the service in accordance with CMS pricing methodologies described in the Claims Processing Manual (IOM Pub. 100-04). MACs shall keep track of pricing determinations for frequently billed services so that the claims processing staff can price future claims using established MR pricing guidelines for that service.

3.4.1.3 - Diagnosis Code Requirements

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs and UPICs, as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided on and after the implementation of ICD-10-CM. ICD-9-CM is used for discharges and other services before the implementation of ICD-10-CM.

Section 1833(e) of the Act states that no payment should be made “under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person....” MACs and UPICs should require submission of information, in accordance with the requirements below, that they deem necessary to make a claim determination and determine appropriate payment. Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by a LCD.

A. Claims Submitted by Physicians or Certain Non-Physician Practitioners Must Contain Diagnosis Codes.

Section 1842 (p) (1) of the Act states that for each claim submitted by physicians or certain non-physician practitioners (defined in 1842(b) (18) (C) of the Act) “shall include the appropriate diagnosis code (or codes)....” For claims submitted with invalid, truncated, or missing diagnosis codes, MACs and UPICs shall classify the claim as rejected as unprocessable within the MCS. See the Claims Processing Manuals IOM Pub.100-04.

B. Claims Submitted by All Other Provider Types Must Contain Diagnosis Codes if required by a LCD

During a service-specific review to address potential abuse or overutilization, MACs and UPICs should require that diagnosis codes be submitted with each claim for the targeted service. The diagnosis information is used to determine if the services are covered and correctly coded. MACs and UPICs should require that ICD diagnosis codes be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in a LCD for that service. This outreach shall occur via Web site, bulletin articles, etc.

For provider-specific reviews, MACs and UPICs have the discretion to require submission of diagnosis codes to support that the reasonable and necessary criteria has been met on all claims submitted by individual non-physician providers who have been targeted because of unusual billing practices, fraud referrals, etc., even if no LCD exists requiring such codes. For claims submitted with invalid, truncated, or missing diagnosis codes, reviewers shall classify the claim as unable to be processed, and return the claim to the provider (RTP). See the Claims Processing Manual IOM Pub.100-04.

C. Requirements for Lab Claims

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ and Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the panel codes, contractors may review these claims. Should contractors determine the need to develop a LCD for laboratory panel codes the MAC shall develop these policies at the panel code level. In some instances of perceived abuse of the panel codes, the contractors may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

3.4.1.4 - Prepayment Review of Claims Involving Utilization Parameters (Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

A. For Non-lab Claims

The MACs shall implement prepayment edits that will prevent payment to providers who have a pattern of billing for items or services that are not covered, incorrectly coded or inappropriately billed. The MACs shall respond quickly when they identify providers who seem to have egregious overutilization of a non-lab item or service and who bill for egregious amounts. The identification of, and response to these providers shall be within the context of the MAC's MR Strategy and prioritization of review targets.

B. Utilization Denials

The MACs have the discretion to establish edits to automatically deny services when overutilization of a non-lab service is identified and clear policy serves as the basis for denial.

The MACs shall establish medical record review edits and make individual claim determinations when overutilization of a non-lab service is identified and there is not clear policy to serve as the basis for denial.

The MACs shall establish medical record review edits that do not involve utilization parameters and make individual claim determinations when overutilization of a lab service is identified and there is no clear policy to serve as the basis for denial. For example, if the problem is limited to a few laboratory providers, the MAC could develop a provider-specific prepayment edit to suspend payment for all of the lab services in question from the problem providers. If the problem is widespread, the MAC could develop a service-specific edit to suspend payment for all of the lab services in question or all of the services in question for a particular diagnosis or revenue code. Based on data analysis within each MAC jurisdiction, the MACs shall focus the edit by provider, diagnosis, procedure code, or in any other way except by use of a utilization parameter.

3.4.1.5 - Prepayment Review Edits

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

A. Automated Edits

Automated prepayment edits, designed by MAC staff, are put in place to prevent payment for non-covered, incorrectly coded, or inappropriately billed services. Most automated payment edits will be service-specific. The MAC will rarely install a provider-specific automated prepayment edit.

B. Limits on Automated Prepayment Review

The MACs shall not install edits that result in the automatic denial of payment for items or services based solely on the diagnosis of a progressively debilitating disease when treatment may be reasonable and necessary. The appearance of a progressively debilitating disease on a claim or history does not permit automated denials that presume a stage of that disease that negates the effectiveness of treatment. Likewise, when a beneficiary with a progressively debilitating disease experiences an illness or injury unrelated to his or her progressively debilitating disease, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided item or service. For instance, a claim for treatment for an acute urinary tract infection cannot be denied by automatic edit just because the beneficiary has a diagnosis of multiple sclerosis.

3.4.2 – Prepayment Medical Record Review Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall focus prepayment medical record review edits to suspend only claims with a high probability of aberrant billing practices. Focused edits reduce provider burdens and increase the efficiency of MR activities. The MACs shall ensure that edits are specific enough to identify only the services that they determine to be questionable

based on data analysis. MACs are encouraged to ensure that most MR edits are located in the table driven portion of the system and are not hard coded. It is important to have the flexibility to modify MR edits based on workload demands and changes in provider behavior.

The MACs have the discretion to establish prepayment medical record review edits that are either service-specific or provider-specific. Provider-specific edits can suspend all claims from a particular provider or focus on selected service(s), place of service, or other parameters.

3.5 - Postpayment Medical Record Review of Claims

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs shall initiate targeted provider-specific or service-specific postpayment medical record review only when there is the likelihood of a sustained or high level of payment error. RACs, UPICs, and SMRC shall perform postpay review of claims as outlined in their SOW.

3.5.1 - Re-opening Claims

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, SMRC and UPICs, as indicated.

The MACs, CERT, RACs, SMRC, and UPICs shall adhere to the rules found in CFR 405.980 through 986 when conducting automated or postpayment medical record reviews. High error rate and/or potential overutilization, identified by data analysis, are reasons to perform postpayment review and represent sufficient cause to reopen claims in accordance with 42 CFR 405.986. See Pub. 100-04, chapter 34 for more information on good cause for reopening.

3.5.2 - Case Selection

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, and UPICs, as indicated.

Case review and development provisions:

The MACs and the SMRC shall not perform postpayment review of unassigned claims. A claim submitted for a service or supply by a provider who has not accepted the Medicare fee schedule is an unassigned claim.

- The MACs, SMRC, and UPICs have the discretion to select cases for postpayment review on a claim-by-claim basis or use statistical sampling for overpayment estimation.

- When MACs, SMRC, and UPICs conduct claim-by-claim postpayment review, they shall only collect or refund the actual overpayment or underpayment amount.
- When MACs, SMRC, and UPICs conduct statistical sampling for overpayment estimation as specified in PIM chapter 8, they shall extrapolate the sampling results to the known universe of similar claims when calculating the projected overpayment or underpayment amount.
- The MACs, RACs, SMRC, and UPICs have the discretion to conduct the postpayment review onsite at the provider or supplier's location.
- MAC staff shall review their provider tracking system, using RAC Data Warehouse (RACDW) data, and consult with the UPICs to ensure non- duplication during the process of selecting providers for postpayment review.
- To prevent duplicate claim reviews, the MACs, SMRC, and RACs shall use the RACDW to identify, and exclude from review, claims that were previously reviewed, or that are under current review, by another contractor.
- CERT shall duplicate another contractor's review, when appropriate, if those claims are chosen as part of a statistically valid random sample to measure the improper payment rate.
- This instruction does not prevent the UPICs from reviewing a claim that has been reviewed by another contractor in order to support their case development or other administrative action.
- When the MACs, CERT, RACs, SMRC and UPICs choose to send the provider an ADR for a postpayment review, they shall do so in accordance with PIM chapter 3, §3.2.3.2. The contractors may grant an extension of the submission timeframes at their discretion or in accordance with their SOWs.
- The MACs, CERT, RACs, SMRC and UPICs make coverage, coding, and/or other determinations when re-adjudicating claims.
- The MACs, CERT, RACs, SMRC and UPICs shall document all incorrectly paid, denied, or under-coded (e.g., billed using a procedure/supply or other code that is lower than what is supported by medical documentation) items or services.

- Services newly denied as a result of re-adjudication shall be reported as positive values.
- Services that were denied, but are reinstated as a result of re-adjudication shall be reported as negative values.
- The MACs, CERT, RACs, SMRC and UPICs shall document the rationale for denial and include the basis for revisions in each case (important for provider appeals). MACs, CERT, and UPICs should include copies of the NCD, coverage provisions from interpretive manuals, or LCD and any applicable references needed to support individual case determinations. RACs and the SMRC shall include detailed rationale as outlined in their SOWs.
- The MACs have the discretion to deny payment without the review of the claim with a medically unlikely service edit.

3.5.3 - CMS Mandated Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

In past years, CMS created mandated edits that suspend certain claims for medical review coverage and coding review. However, more recently, CMS has given the contractors the discretion to prioritize workload to effectively lower the error rate. CMS is now in the process of removing such mandated coverage and coding review edits from CWF, pricer, grouper, fee schedules, etc.

Contractors may override CMS mandated edits that suspend for medical review coverage and coding review without performing review if one or more of the following conditions apply:

1. The contractor does not have MR responsibility for the claim, or
2. The contractor's data analysis/priority setting/ MR strategy does not indicate this service is a problem in their jurisdiction, or
3. It is not a skilled nursing facility (excluding swing beds) or a home health demand bill (these demand bills must be reviewed).

3.5.4 - Tracking Medicare Contractors' Prepayment and Postpayment Reviews

(Rev.755; Issued: 11-09-17; Effective: 12-11-17; Implementation: 12-11-17)

Medicare Administrative Contractors (MACs) shall input all prepayment and postpayment complex reviews into the Recovery Audit Data Warehouse. All claims chosen for review by the MAC where an additional documentation request letter was

issued to the provider before or after payment was made shall be included. MACs shall include all reviews, even those that did not result in an improper payment.

Claims may be manually uploaded into the data warehouse or submitted by flat file. The MACs shall use the file layout provided by CMS for claims uploaded to the Recovery Audit Data Warehouse. Postpayment claims shall be submitted to the Recovery Audit Data Warehouse by the 20th day of every month for the previous month. Prepayment claims shall be submitted to the Recovery Audit Data Warehouse by the 15th day of every month for the previous month.

MAC staff who need access to the Data Warehouse shall contact RAC@cms.hhs.gov.

3.6 - Determinations Made During Review

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

A. General

The MACs, CERT, Recovery Auditors, and UPICs shall be able to differentiate the type of determination made, ensuring that limitation of liability determinations are appropriate.

When the MAC determines, through prepayment data analysis or postpayment review, that an inappropriate claim has been submitted; or the Recovery Auditor determines, in post-payment review, that an improper payment has been made, the MAC and Recovery Auditor shall verify that the error represents an unacceptable practice and not just an explainable aberrancy. Some legitimate reasons for anomalous data include:

- The provider may be associated with a medical school, research center, or may be a highly specialized facility, for instance, the facility may be a Medicare- dependant hospital or CAH, which might skew the type of claims submitted; or
- The community in which the provider practices may have special characteristics such as socio-economic level or a concentration of a specific age group that leads to an apparent aberrancy in the use of certain services.

The MACs, CERT, Recovery Auditors, and UPICs have the discretion to make other determinations during the review of a claim to avoid or identify improper payments for such things as duplicate claims, etc. Other examples are listed below:

Example 1: A Medicare policy states that when three (3) procedures are performed during the same operative session, Medicare pays 100 percent for the first, 50 percent for

the second and 25 percent for the third. A claim is identified where all three (3) procedures were paid at 100 percent.

Example 2: A claim was paid using the fee schedule from the prior year.

Example 3: A Medicare payment policy states that in order to pay for a capped rental item, consideration shall be given to whether the item was in “continuous use” by the beneficiary for a specified time period. A claim is found to have been paid out of compliance with this policy provision.

If, at any time, the medical review detects potential fraud, MACs, CERT, and Recovery Auditors, shall refer the issue to the appropriate UPIC.

3.6.1 - Determining Overpayments and Underpayments (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, and UPICs. It does not apply to CERT or Recovery Auditors.

A. General

The results of the re-adjudication are used to determine the overpayment or underpayment amount for each claim. Re-adjudicating claims may not result in a payment correction. Where statistical sampling for overpayment estimation is used, refer to instructions in the PIM chapter 8, §8.4 and to Exhibits 9, 10, 11 and 12 for projection methodologies based on FFS claims. For claims paid under PPS rules, MACs and UPICs shall develop projection methodologies in conjunction with their statisticians that are consistent with the requirements found in PIM chapter 8, §8.4. MACs and UPICs shall net out the dollar amount of services underpaid during the cost accounting period, meaning that amounts owed to providers are balanced against amounts owed from providers.

Amounts of the following overpayments are to be included in each provider's or supplier's estimate for the reviewed sample:

- According to the provisions of §1879 of the Act, the provider or supplier is liable for the overpayment of initially paid claims that were later denied on re- adjudication if :

- (1) The basis for denial is by reason of §1862(a) (l) or (9) of the Act
- (2) The provider or supplier knew or could reasonably have been expected to know that the items or services were excluded from coverage, and

- For denials of non-assigned claims make a §1842(l) determination on denials for §1862(a)(1)
- The provider or supplier was not without fault for the overpayment as defined in §1870 of the Act.

For appeal purposes, overpayment estimations applicable under §1879 of the Act will be identified separately from denials in which §1879 of the Act does not apply. Where both types of denials occur in the sample, MACs and UPICs calculate and document separate under/overpayments for each type of denial. For recovery purposes, however, both denial results are combined.

3.6.2 - Verifying Errors

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, and UPICs, as indicated.

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be deemed high priority and contractors must be able to document the rationale for selection.

3.6.2.1 - Coverage Determinations

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, Recovery Auditors, and UPICs shall deny an item or service if it does not meet any of the conditions listed below:

- The item or service does not fall into a Medicare benefit category.
- The item or service is statutorily excluded on grounds other than §1862(a) (1) (A) of the Act.
- The item or service is not reasonable and necessary under §1862(a) (1) (A) of the Act.
- The item or service does not meet other Medicare program requirements for payment.

3.6.2.2 - Reasonable and Necessary Criteria

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

CMS issues national coverage determinations (NCDs) that specify whether certain items, services, procedures or technologies are reasonable and necessary under §1862(a) (1) (A) of the Act. In the absence of an NCD, Medicare contractors are responsible for determining whether services are reasonable and necessary. If no local coverage determination (LCD) exists for a particular item or service, the MACs, CERT, Recovery Auditors, and UPICs shall consider an item or service to be reasonable and necessary if the item or service meets the following criteria:

- It is safe and effective;
- It is not experimental or investigational; and
- It is appropriate, including the duration and frequency in terms of whether the service or item is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
 - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
 - Ordered and furnished by qualified personnel; and,
 - One that meets, but does not exceed, the beneficiary's medical need.

There are several exceptions to the requirement that a service be reasonable and necessary for diagnosis or treatment of illness or injury in order to be considered for payment. The exceptions appear in the full text of §1862(a) (1) (A) of the Act. See also PIM chapters 13, §5.1 and 7.1.

3.6.2.3 - Limitation of Liability Determinations

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

Section 1879(a)-(g) of the Act limits the financial liability of beneficiaries, providers, and suppliers by permitting Medicare payments, or requiring refunds, for certain services and items for which Medicare payment would otherwise be denied. The purpose of this provision is to protect beneficiaries from liability in certain cases of denied services. The limitation of liability provisions apply only to claims for services not statutorily excluded, that are denied for the following reasons:

- The service or item did not meet the reasonable and necessary criteria;
- The beneficiary or provider did not know, or could not have been reasonably expected to know that the service or item would not be covered; and
- The beneficiary receives certain screening tests and preventive services in excess of the guidelines.

(See IOM Pub. 100-04, chapter30, §20 for more information).

The MACs, CERT, and UPICs shall first examine benefit categories and statutory exclusions to determine if a service or item is covered. Recovery Auditors shall examine categories and exclusions as outlined in their SOW. If the item or service meets the requirements of the appropriate benefit category and is not excluded by statute, the next consideration is whether the service was reasonable and necessary. When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, MACs, CERT, Recovery Auditors, and UPICs shall make and document determinations as appropriate to §§1879, 1870, and 1842(l) of the Act. Because the determinations can be appealed, it is important that the rationale for the determination be documented initially and at each level of appeal.

Limitations of liability provisions do not apply if there is a statutory exclusion, even if the service meets the reasonable and necessary criteria.

3.6.2.4 - Coding Determinations

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, Recovery Auditors, and UPICs, as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided on and after the implementation of ICD-10-CM.. ICD-9-CM is used for discharges and other services before that date.

The MACs, CERT, SMRC, Recovery Auditors, and UPICs shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT-4), Coding Clinic for ICD, Coding Clinic for HCPCS, and any coding requirements listed in CMS manuals or MAC articles.

In certain situations, it is appropriate for contractors to up code or down code a claim (or items or services on a claim) and adjust the payment. When the medical record supports a higher or lower level code, the MACs, SMRC, CERT, UPICs and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment.

The MACs, SMRC, CERT, UPICs and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable CMS medical review instructions. The MACs, SMRC, CERT, UPICs and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.

Example situations where it is appropriate to up code or down code a claim are:

1. CBC with diff was ordered and billed but CBC without diff was provided;
2. X-ray with contrast was ordered and billed but X-ray without contrast was provided;
3. E&M level 3 was billed but the medical record supports level 2 (or other level);
4. PPS (DRG/RUG/HHRG) code was billed but the medical records supports a different code; and
5. Quantity of diabetic test strips exceeds limits; for example, quantity was provided for insulin treated but the patient was not insulin treated.

3.6.2.5 - Denial Types

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MACs, CERT, RACs, and UPICs, as indicated.

A. Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

The MACs, CERT, RACs, and UPICs shall be cognizant that the denial type may affect the financial liability of beneficiaries. They shall ensure that benefit category denials take precedence over statutory exclusion and reasonable and necessary

denials. They shall ensure that statutory exclusion denials take precedence over reasonable and necessary denials. MACs, CERT, and UPICs shall use the guidelines listed below in selecting the appropriate denial reason. RACs shall follow denial reason guidance outlined in their SOW.

- If additional documentation was requested from the provider or other entity for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not received within 45 calendar days or a reasonable time thereafter, the MACs, CERT, and UPICs shall issue a reasonable and necessary denial, in full or in part.
- If additional documentation was requested because compliance with a benefit category requirement is questioned and the documentation received fails to support compliance with the benefit category, the MACs, CERT, and UPICs shall issue a benefit category denial.
- If additional documentation was requested because compliance with a benefit category requirement is questioned and the received documentation shows evidence that the benefit category requirement is present but is defective, the MACs, and UPICs shall issue a reasonable and necessary denial.

EXAMPLE 1: A MAC is conducting a review of partial hospitalization (PH) claims from a provider who has a pattern of failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the MAC finds that there is no signed certification present in the medical record. The MAC shall deny all PH services for this beneficiary under §1835(a) (2) (F) of the Act (a benefit category denial). However, in the second medical record, the MAC determines that a signed certification is present in the medical record, but the documentation does not support the physician's certification, the services shall be denied under §1862(a) (1) (A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

Example 2: The MAC performs a medical record review on a surgical procedure claim and determines that the procedure was cosmetic in nature and was not reasonable and necessary; the denial reason would be that the service is statutorily excluded since statutory exclusion denials take precedence over reasonable and necessary denials.

The MACs, CERT, RACs, and UPICs shall deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full, and provide the

specific reason for the denial whenever there is evidence that a service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act, NCD, or coverage provision in an interpretive manual;
- Is statutorily excluded by other than §1862(a)(1) of the Act;
- Is not reasonable and necessary as defined under §1862(a) (1) of the Act. MACs, CERT, RACs, and UPICs shall use this denial reason for all non-responses to documentation requests;
- Was not billed in compliance with the national and local coding, payment or billing requirements; and/or
- Was not delivered or provided to the beneficiary, or not provided as billed.

The denial explanation needs to be more specific than merely repeating one of the above bullets. The general exception to the need for a full denial explanation is in the event of a clerical error, for example, the billing entity transposes two digits in the Medicare beneficiary identifier on a claim. The claim is quickly returned, usually electronically, to the provider for correction. In the case of dual-eligible beneficiaries where there is a State-specific policy, see CMS IOM Pub. 100-04, chapter 30, §60.5 A for a detailed explanation of handling administrative denials.

3.6.3 - Beneficiary Notification

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, and UPICs, as indicated.

A. General

If a claim is denied through prepayment or postpayment review, the MAC shall notify the beneficiary consistent with the requirements in PIM chapter 3, §3.6.2.3. The MAC shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN). The CERT, RACs, and UPICs are not required to issue beneficiary notices for claims they deny. Instead, CERT, RACs, and UPICs shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate beneficiary notice.

The MACs are required to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of a LCD. All denials that result from LCDs shall provide the MSN message 15.19 in addition to the current applicable message. Message 15.19 states (IOM Pub. 100-04, chapter 21):

“A local coverage determination (LCD) was used when we made this decision. A LCD provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary, carrier or (Medicare Administrative Contractor) by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LCD to see whether additional information from your physician would change our decision.”

The MACs shall make these messages available in Spanish where appropriate. The 15.19 portion of the MSN message states:

Una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La LCD es una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta póliza está disponible en su intermediario, local o en su empresa de seguros Medicare, o en su Contratista Administrative de Medicare, al llamar al número que aparece en la información de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la LCD para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

The MACs shall use the above message in every instance of a prepayment denial where a LCD was used in reviewing the claim. Use this message, and message 15.20 (now for FISS MACs, and when 15.20 is fully implemented for contractors on the MCS/VMS systems) on both full and partial denials, whether the denial was made following automated, non-medical review, or medical record review. MACs shall not use this message on denials not involving LCDs. For claims reviewed on a postpayment basis, include the language exactly as contained in the MSN message above if sending the beneficiary a new MSN. If sending a letter, include the language exactly as contained in the MSN message above. Message 15.20 currently states:

“The following policies [insert LCD ID# and NCD#] were used when we made this decision.”(Pub.100-04, chapter 21).

The MACs shall continue to use 15.19 in conjunction with the MSN message 15.20, where 15.19 is applicable. MACs should, at their discretion, combine these messages if necessary, but 15.19 shall not be deleted.

In the case where the results of claims sampling are extrapolated to the universe, only those beneficiaries in the sample need to be notified. In RAC cases, the RAC and MAC Joint Operating Agreement (JOA) shall specify what information the RAC will supply to allow the MAC to notify the beneficiary when re-adjudication results in a change to the initial determination.

3.6.4 - Notifying the Provider

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to, MACs, RACs, and UPICs, as indicated.

A. General

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider even if no overpayment determination is made. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the RACs shall issue a Review Results Letter for all audits as outlined in their SOW requirements.

UPICs shall comply with the requirements listed below when issuing Review Results Letters. Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;
- Reason for conducting the review or good cause for reopening;
- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;
- The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded and if others were payable;
- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;
- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;
- Total underpayment amounts;
- Total overpayment amounts that the provider or supplier is responsible for;
- Total overpayment amounts the provider or supplier is not

responsible for because the provider or supplier was found to be without fault;

- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days (not applicable to RACs or UPICs);
- The provider's or supplier's right to request an extended repayment schedule (not applicable to RACs or UPICs);
- The MACs and UPICs shall include limitation of liability and appeals information in the provider notices;
- The MACs shall include appeals information in the provider notices;
- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and
- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re- review in 6 months).

If a claim is denied through prepayment review, the MACs and UPICs are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and RAC shall notify the provider by issuing a notification letter to meet this requirement. The UPIC shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for medical record review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

C. RACs

For overpayments detected through medical record review, the RAC shall send a review results letter as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For underpayments, the RAC shall notify the provider as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and pay back the underpayment.

D. UPICs

For overpayments detected through medical record review, and after coordination between the UPIC and OIG, the UPIC shall send a review results letter (the MAC sends the demand letter). In addition, the UPIC shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The UPIC shall use discretion on whether to send the review results letter.

E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC or UPIC had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, that the denial was made without reviewing the documentation because the requested documentation was not received or was not received within the allowable time frame (§1862(a) (1) of the Act). This information will be useful to the provider in deciding whether to appeal the decision. When denying the claims, contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

For claims where the reviewer makes a denial following medical record review, the reviewer has the discretion to indicate in the denial notice, using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer that the denial was made after review of submitted documentation. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.

3.6.5 - Provider Financial Rebuttal of Findings

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to the MACs. It does not apply to Recovery Auditors, CERT, and UPICs.

A. General

Providers or suppliers have the right to submit a financial rebuttal statement in accordance with 42 CFR 405.370-375 following receipt of the review results letter and prior to recoupment of the overpayment. The rebuttal statement and any accompanying evidence must be submitted within 15 calendar days from the date of the results letter unless the MAC staff find cause to extend or shorten the time frame.

B. Review of Financial Rebuttal Statement(s)

Within 15 calendar days of receipt of a financial rebuttal, MAC staff shall consider the statement and any evidence submitted to reach a determination regarding whether the facts justify the recoupment. However, the MAC shall not delay recovery of any overpayment beyond the date indicated in the review results letter in order to review and respond to the rebuttal statement even if the principal of the debt is modified after reviewing the rebuttal statement (See 42 CFR 405.375(a)). The MAC shall provide a copy of the rebuttal request and a copy of the MAC's response on the rebuttal outcome to the UPICs.

C. Cost Report Issues

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider as a result of a postpayment review using statistical sampling for overpayment estimation is based on the interim payment rate in effect at the time of the review.

3.6.6 - Review Determination Documentation Requirements
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, and UPICs, as indicated.

For each claim denied, in full or in part, the MACs, CERT, and UPICs shall carefully document the basis for the denial in the internal claim record. If there are several reasons for denial they shall document each reason in the internal claim record. In addition, the internal claim record should document the date and content of the provider notice of review (§ 3.2.2), additional documentation requests (§3.2.3), and third party documentation requests and response (§3.2.3.3).

In verifying an overpayment, MACs, CERT, Recovery Auditors, and UPICs shall carefully document claims for services not furnished or not furnished as billed so that the denials are more likely to be sustained upon appeal and judicial review.

3.7 - Corrective Actions
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall take corrective actions they deem necessary based upon their findings during or after a review. These actions may include payment suspension, imposition of civil money penalties, institution of prepayment or postpayment review, additional edits, etc.

Providers/suppliers who show a pattern of failing to comply with requests for additional supporting documentation for any claims submitted to CMS may be subject to medical record review for all claims. This paragraph applies to both providers and suppliers and to instances in which CMS or its contractors request documentation directly from these entities to support services billed on the claim. This paragraph does not change or diminish the provider's or supplier's responsibility to provide required documentation. For purposes of this paragraph, a pattern is two or more ADRs that have gone unanswered.

3.7.1 - Progressive Corrective Action (PCA)

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall ensure that actions imposed upon Medicare providers or suppliers for failure to meet Medicare rules, regulations and other requirements are appropriate given the level of non-compliance.

When an error has been validated through MR, the corrective action imposed by the MACs should match the severity of the error. PCA is a means of evaluating the relative risk of the error and assigning appropriate corrective actions. The principles of PCA are:

- It is data-driven. Errors are validated by prepayment and postpayment claims review. (See below).
- Hypotheses and edits are tested prior to implementation to determine facility, utility, and return on investment.
- Workloads are targeted, specific, and prioritized.
- Money is collected when errors are validated.
- Referrals for potential fraud are made when necessary.
- Provider feedback and education are mandatory.
- Medical review resources should be used efficiently.

For each provider data identifies as being at risk, the potential error is validated with prepayment or postpayment review of generally 20-40 potentially erroneous claims. Payments are either denied or recouped. Any underpayments by Medicare will be netted out during the financial reconciliation process. Corrective actions are then implemented based on whether the error represents a minor, moderate, or major concern.

For potentially risky services, errors are validated by prepayment and postpayment review of generally up to 100 potential problem claims for that service from a representative sample of providers. Service-specific errors may require more widespread education for providers and may require the implementation of service-specific prepayment edits.

An example of a minor concern would be a provider with a low error rate and no pattern of errors who has made a relatively minor error with low financial impact. Education and collection of the overpayment may be sufficient corrective actions.

For moderate concerns, where a provider with a low error rate has made an error with substantial financial impact, some level of prepayment review should be considered. The prepayment review should be tracked and adjusted or eliminated according to the provider's response.

A major concern would be a provider with a high error rate who has made a high-dollar error with no mitigating circumstances, indicating the need for stringent administrative action. A high level prepayment review should be considered along with possible payment suspension and referral to the UPICs.

3.7.1.1 - Provider Error Rate

(Rev. 738; Issued: 08-18-17; Effective Date: 09-19-17; Implementation Date: 09-19-17)

This section applies to MACs.

If the MAC identifies a provider-specific problem, the provider error rate is an important consideration in deciding how to address the problem. For instance, a provider with a low error rate with no history of patterns of errors may require a fairly minor corrective action plan such as education with recoupment of overpayment. Other factors such as the total dollar value of the problem and the past history of the provider also deserve consideration. The MAC assesses the nature of the problem as minor, moderate or major and uses available tools such as data analysis and evaluation of other information to validate the problem.

A. Provider Error Rate Formula

The MACs shall include claims denied due to no response to ADRs when calculating the provider error rate.

The MACs shall use the following formula for prepayment review to calculate the provider's service specific error rate:

Total Dollar amount of allowable** charges for services billed in error as determined by MR***

Total Dollar amount of allowable** charges for services subject to a medical review documentation request

For postpayment review, the MACs shall use the following formula to calculate the provider's service specific error rate:

Total Dollar amount of services paid in error as determined by MR***

Total Dollar amount of services subject to a medical review documentation request

**If allowable charges are not available, submitted charges may be used until system changes are made.

***Net out (subtract) the dollar amount of charges under billed

3.7.1.2 - Vignettes

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

The following vignettes provide guidance on how the MACs shall characterize and respond to varying levels of confirmed errors. These are examples of results from medical review accompanied by suggested corrective actions. This information should only be used as a guide and is not meant to be a comprehensive list of vignettes nor an inclusive list of administrative actions. The MAC MR department shall include communication and follow-up with provider outreach and education (POE) throughout the PCA process to coordinate efforts toward problem resolution. The MACs shall monitor trends indicating widespread educational need and shall ensure that POE staff has access to copies of all MR provider notification and feedback letters so they are prepared for provider requests for education (See IOM Pub. 100-04, chapter 20, §3.4.2, for further information).

1. Twenty claims from one provider are reviewed. Once claim is denied because a physician signature is lacking on the plan of care. The denial reflects 7 percent of the dollar amount of claims reviewed. Judicious assessment of medical review resources indicates no further review is necessary at this time. The MAC uses data analysis to determine where to target medical review activities in the future.
2. Forty claims from one provider are reviewed. Twenty claims are for services determined to be not reasonable and necessary. These denials reflect 50 percent of the dollar amount of claims reviewed. One hundred percent prepayment review is initiated due to the high number of claims denied and the high dollar

amount denied. The MAC provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem.

3. Forty claims from one provider are reviewed. Thirty-five claims are denied. These denials reflect 70 percent of the dollar amount of claims reviewed. Payment suspension is initiated due to the high denial percentage and the Medicare dollars at risk. The MAC provides notification to the provider about the specific errors made and makes a priority referral to POE to inform them of the severity of the problem.
4. Forty claims from one provider are reviewed. Thirty-three claims are denied. These denials reflect 25 percent of the dollar amount of the claims reviewed. The MAC provides notification to the provider about the specific errors made. The MAC initiates a moderate amount (e.g., 30 percent) of prepayment medical review to ensure proper billing.
5. Thirty-five claims from one provider are reviewed. Thirty claims are denied representing 75 percent of the dollar amount of the claims reviewed. Many of the denials represent services provided to beneficiaries who did not meet the Medicare eligibility requirements. The MAC provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem. A consent settlement offer is made but declined by the provider. A postpayment review of statistical sampling for overpayment estimation is performed and an overpayment is projected to the universe of similar claims from the provider. Overpayment collection is initiated.
6. Twenty-five claims from one supplier are reviewed. Five claims representing 5 percent of the dollar amount of the claims are denied. This supplier is known to the DME MAC as one who has a significant decrease in billing volume when targeted medical review is initiated. The DME MAC is concerned that this supplier may be selectively submitting bills when placed on medical review and chooses to continue some level of prepayment medical review despite the low error rate.
7. Twenty claims from one provider are reviewed. Ten claims are denied for incomplete physician orders representing 65 percent of the dollar amount of the claims. The MAC issues a letter to inform the home health agency (HHA) about the denials and the reason for the denials. In response to the notification letter, the agency owner initiated a mandatory training program for select staff. The HHA was put on 30 percent prepayment medical review. Results of the review indicated an improvement in the error rate to 30 percent (based on dollars denied divided by dollars reviewed). On appeal, most of the denials were overturned. The MAC consults with the ALJ to understand why the cases are being overturned and consults with the RO on appropriate next steps.

3.7.1.3 - Provider Notification and Feedback

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

Direct communication between the MAC and the provider is an essential part of solving problems. This process is carried out through written communication or by telephone as a result of specific claims or a group of reviewed claims. The overall goal of providing notification and feedback is to ensure proper billing practices and appropriate consideration of coverage criteria so claims will be submitted and paid correctly.

The MACs shall include an offer to provide individualized education in the notification letter along with contact information for POE. When inquiries are received in response to a provider notification or feedback letter, only responses to those inquiries directly related to a specific claim or group of claims reviewed on probe or targeted medical review shall be charged to medical review. This charge must be in the appropriate activity code or applicable SOW section for the type of review performed.

3.7.2 - Comparative Billing Reports (CBRs)

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

The MACs have the discretion to develop and issue comparative billing reports in the following three (3) situations:

1. Provider-specific CBRs for providers with aberrant billing patterns.

The MACs have the discretion to give provider-specific comparative billing reports to providers with the highest utilization for the services they bill in order to address potential over-utilization. The MACs have the discretion to send the CBRs based solely on data analysis, without further review or CBRs may be included in the feedback and notification information issued as a result of probe and targeted medical review. These reports shall provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. MACs should not charge a fee for providing these reports.

2. Provider-specific or specialty-specific CBRs requestors.

To provide good customer service, MACs have the discretion to provide specific reports to providers or provider associations who request such a report. They may charge a fee for providing these discretionary reports. However, any money collected shall be reported as a credit in the appropriate activity code or the applicable SOW section and be accompanied with a rationale for charging the fee. Revenues collected from these discretionary activities shall be used only to cover the cost of these activities, and shall not be used to supplement other MAC activities. If the MACs

choose to make such reports available, the MACs shall describe on their Web site the mechanism by which a provider or provider association can request the report and state the associated fee.

3. CBRs for service-specific problems

When widespread problems are verified, MACs shall refer that information to their POE department for possible Web site posting. For example, data analysis may reveal that home health providers in a particular state bill three (3) times more of a particular code than do home health providers in other surrounding states. The MACs shall not charge a fee for posting these reports.

The MACs shall ensure that POE staff has ready access to copies of all MR provider notification and feedback letters so that they will have this information available in the event that a provider contacts POE requesting education. If the problem identified by MR is of medium or high priority, the MAC shall make a priority referral to POE, alerting POE staff to the degree of severity and educational need.

3.7.3 - Evaluating the Effectiveness of Corrective Actions

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall evaluate the effectiveness of their corrective actions on targeted providers or problem areas at least every three (3) months until there is evidence that the poor practice has been corrected. MACs shall establish a method to determine the disposition of educational referrals made to POE to ensure coordination of efforts and resolution of identified problems. MACs have the discretion to use the PTS to perform this function, but are not mandated to do so. MACs shall use the PTS to coordinate contacts with providers regarding MR activities. MACs shall also coordinate this information with the UPICs to ensure contacts are not in conflict with fraud related activities.

3.7.3.1 - Evaluation of Prepayment Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall develop prepayment edits based on the findings of data analysis, followed by identification and prioritization of identified problems. The MACs shall evaluate all service-specific and provider-specific prepayment edits as follows:

- Automated edits shall be evaluated annually, and
- Non-medical record review or medical record review edits shall be evaluated quarterly.

The edit evaluations are to determine their effectiveness on the provider or service area while assessing the effect of the edit tasks on workload. The MACs shall consider an edit to be effective when it has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. The MACs shall revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, for instance, a measurable impact is expected, or a quarter is too brief a time period to observe a change. The MACs shall analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. The MACs should replace existing effective edits to address problems that are potentially more costly, if appropriate.

3.7.3.2 - Evaluating Effectiveness of Established Automated Edits (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

MACs shall consider the following factors when looking at edit effectiveness for established automated edits:

- Time and staffing needs for review and appeal reviews. MACs shall implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as when denial categories are causing the greatest impact on appeals, the outcome of the appeal, and
- MACs shall maintain and make available to the appropriate CMS staff documentation demonstrating that they consider appeals in their edit evaluation process; and specificity of edits in relation to identified problem(s).

The MACs should note that even an automated edit that results in no denials may be effective as long as the presence of the edit is not preventing the installation of other automated edits. The MAC shall provide the claims data necessary to the UPIC to evaluate the effectiveness of edits implemented at UPIC request. The MACs shall provide this report on a monthly basis by the 15th business day of each month. This requirement could also be met by the UPICs retrieving claim data necessary directly from the EDC if available.

A. Edit Effectiveness for all Other Edits

The MACs shall consider the following factors when looking at edit effectiveness for all other edits:

- Time and staffing needs for review and appeal reviews. MACs

shall implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MAC MR unit and the UPIC just specific to UPIC edits information such as which denial categories are causing the greatest impact on appeals, and the outcome of the appeal. MACs shall maintain and make available to CMS documentation demonstrating that appeal outcomes are considered in their edit evaluation process;

- Specificity of edits in relation to identified problem(s);
- Demonstrated change in provider behavior, i.e., the MAC can show a decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;
- Impact of educational or deterrent effect in relation to review costs; and
- The relative priorities or competing edits in terms of the number of claims/days/charges.

The MACs shall test each edit before implementation to verify that the edit accomplishes the objective of efficiently selecting claims for review and to determine the edit's impact on workload.

3.7.3.3 - Evaluation of Postpayment Review Effectiveness (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall determine if any other corrective actions are necessary such as:

- Uncovering potential fraud in the course of MR postpayment review activities. The MR unit shall refer these cases to the UPIC. If it is believed that the overpayment resulted from potential fraud, a refund may not be requested from the provider until the potential fraud issue is resolved.
- Initiating provider or supplier specific edits to focus prepayment view on the problem provider or supplier or group of providers or suppliers, if appropriate ;
- Working with the CMS Central Office Division of Benefit Integrity

Management Operations (DBIMO) Fraud and Abuse Suspensions and Sanctions (FASS) Team to suspend payment to the provider or group of providers;

- Referring provider certification issues to the State survey agency through CMS staff;
- Referring quality issues involving inpatient hospital services to the RO and QIO; and
- Coordinating with the QIO and MAC on interrelated billing problems

The MACs periodically perform a follow-up analysis of the provider(s) or supplier(s) for as long as necessary to determine if further corrective actions are required. In some cases, it may be feasible and timely to perform the follow-up analysis of the provider or supplier after the three (3) month time period. The MACs shall continue to monitor the provider(s) or supplier(s) until there is a referral to the UPICs for potential fraud, evidence that the utilization or billing problem is corrected, or data analysis indicating resources would be better utilized elsewhere.

3.7.4 - Tracking Appeals

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

The MACs shall track and evaluate the results of appeals. It is not an efficient use of medical review resources to deny claims that are routinely reversed upon appeal. When such outcomes are identified, MACs shall take steps to understand why hearing or appeals officers viewed the case differently from them, and discuss appropriate changes in policy, procedure, outreach or review strategies with the regional office.

3.7.5 - Corrective Action Reporting Requirements

(Rev.: 10100; Issued: 05-08-2020; Effective: 06-09-2020; Implementation: 06-09-2020)

A. General

This section applies to MACs.

The CMS will provide information to the MACs regarding CMS Recovery Audit Contractor (RAC), and OIG-identified issues via Technical Direction Letters (TDLs). The TDLs will be sent to the MACs on a quarterly basis. Each MAC shall report corrective actions by the dates stated in the TDLs.

B. Corrective Action Reporting on CMS and OIG-Identified Issues

The CMS will provide MACs with a list of issues on an Excel spreadsheet template (Corrective Actions Taken on CMS and OIG-Identified Issues). These issues may be uncovered by the RAC, OIG audits, internal CMS analysis, or other means. The MACs shall review the spreadsheet, type precise responses on the template (see interim and final reportable action statement samples below), and upload the excel file or flat file to the RAC Data Warehouse (RAC DW).

For each of the issues, MACs shall report interim actions, final actions, and action dates (see interim and final reportable action statement examples below). The common factor between all reportable actions is quantifiability. The distinguishing factor between the two types of reportable actions is intervention implementation. Interim reportable actions generally indicate in-progress reviews of issues prior to the initiation of final actions. Final reportable actions indicate specific interventions completed to prevent future improper payments.

Examples of interim reportable action statements:

- MAC is planning a 50% post-payment review (to be performed between 08/01/2014 – 08/31/2014) of 200 claims (with dates of service between 01/01/2012 – 12/31/2012).
- MAC performed a 100% pre-payment review for DRG numbers #### – #### on 02/14/2014 (with dates of service between 01/01/2012 – 12/31/2012).
- MAC performed a pre-payment widespread review using a 100 claim probe on 03/26/2014 (with dates of service between 01/01/2012 – 12/31/2012).
- MAC performed a provider-specific pre-payment review on 04/17/2014 (with dates of service between 01/01/2012 – 12/31/2012).
- Due to resource limitations, not yet able to fully research issue (with dates of service between 01/01/2012 – 12/31/2012).

Examples of final reportable action statements:

- MAC held a provider seminar for 500 chiropractors regarding documentation requirements on 11/12/2013.
- MAC published an article regarding billing for nebulizer drugs on 02/27/2014 that explained the coverage policy for nebulizer drugs.
- MAC installed an automated edit and validated functionality on 03/19/2014 for codes #### – ####.
 - If readily available, please provide edit effectiveness as defined in PIM section 3.7.3.1 – Evaluation of Prepayment Edits. <Please insert cost savings and number or percentage of claims denied.>
- MAC performed a provider -specific review resulting in a provider education activity. <Comparative Billing Report, letter, one-on-one telephone explanation,...>...on 05/19/2014.
- Based on analysis, this is not an issue within jurisdiction X.

Interim and final reportable action statement rationales:

- In the additional comments section of the TDL template, MACs shall provide brief supplementary rationales for the reported actions. o For example, rationales may state that analysis produced no significant findings due to low volume, claims paid, lower risk and lower priority ranking when compared with other issues.
- The MACs have the discretion to also utilize the additional comments section to briefly explain pertinent background information regarding the MACs processes for specific issues. The MACs may also utilize the space to communicate suggestions for CMS to consider regarding possible future actions.

The MACs shall use the format (Corrective Actions Taken on CMS and OIG-Identified Issues) located in Exhibit 18, section A for reporting purposes. The MACs shall use the prescribed format, acceptable to the RAC DW. The MACs shall upload the file by the date specified in the TDL. If the due dates fall on a weekend or a federal holiday, the MAC shall upload the file on the closest business day after the weekend or holiday. A TDL may occasionally provide an exception to the submission criteria described in the PIM and the exception will be stated within the text of the memorandum.

Updates to previous reportable actions

The MACs shall keep CMS informed of any updates or changes to interim or final reportable actions on top issues from past TDL responses. The format located in Exhibit 18, Section A will included a column titled 'Updated Responses.' The MACs shall enter the following information, in a single cell, for each update:

- The New Issue number being updated
- The Issue Label
- The fiscal year and quarter that the responses were first provided
- The type of response originally provided [Interim or Final]
- The type of response being provided in the update [Interim or Final]
- The response statement in the format described above

The MACs should leave this section blank if they have no updates for the quarter.

C. Overpayment Recovery Reporting

The CMS will provide the MACs with specific claims information from Office of the Inspector General (OIG) audits on a quarterly basis via TDLs. These specific claims have not been reviewed by the OIG and overpayments have not yet been identified. The MACs have the discretion to review these specific OIG-identified claims. The MACs shall report overpayment recoveries pertaining to the specific OIG-identified claims to the CMS on a quarterly basis. If the MAC does not plan on conducting review or cannot

conduct review on the specific OIG-identified claims, the MAC shall indicate that no medical review will be conducted and shall also indicate the reason why no medical review and/or overpayment recovery will be conducted on the particular claims set. The reporting shall include the Medicare contractor number, the OIG audit number (e.g. A-01-08-00528, OEI-01-04-0060) and the cumulative amount collected on the overpayments resulting from the specific set of OIG-identified claims. The cumulative amount shall include appeals. The CMS will indicate the “final reporting date” in the reporting document when the recovery process has been completed for a specific set of OIG-identified claims. CMS will indicate when the report shall be closed. The MACs have the discretion to report on overpayments that have been referred or are uncollectable at this time resulting from the specific set of OIG-identified claims.

The MACs shall submit their response to CMS on or before March 1, June 1, September 1, and December 1. If the due dates fall on a weekend or a federal holiday, the MACs shall submit the report on the closest business day after the weekend or holiday. The MACs shall submit their response in Excel via email to the CMS contact indicated in the most recent TDL from CMS which includes the claim information and report number. The MACs shall use the format titled “Overpayment Recovery on OIG Claims Format” located in Exhibit 18 for reporting purposes. The MAC has the discretion to readjust the format for use in Excel. The MAC shall complete all fields in the format except for the one optional column. The MACs have the discretion to complete the column titled “Overpayments referred or uncollectable (in dollars).”

3.8 - Administrative Relief from MR During a Disaster (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs and Recovery Auditors. UPICs refer to the PIM chapter 4.

A. General

When a disaster occurs, whether natural or man-made, MACs and Recovery Auditors shall anticipate both an increased demand for emergency and other health care services, and a corresponding disruption to normal health care delivery systems and networks. In disaster situations, MACs should do whatever they can to ensure that all Medicare beneficiaries have access to the emergency or urgent care they need. MACs are encouraged to let providers know (via Web site, responses to provider calls, etc.) that the provider's first responsibility, as in any emergency, is to provide the needed emergency or urgent service or treatment. The MACs should assure providers they will work with providers to ensure that they receive payment for all covered services. The administrative flexibility available to MACs and Recovery Auditors is discussed below. These actions will prevent most inappropriate denials and subsequent appeals.

B. Definition of Disaster

A disaster is defined as any natural or man-made catastrophe (such as hurricane, tornado,

earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be requested by the MACs and Recovery Auditors in the course of a Medicare audit, interrupt normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), and/or otherwise significantly limit the provider's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure). The fact that a provider is located in a presidentially declared disaster area under the power of the Stafford Act is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical documentation.

C. Basis for Providing Administrative Relief

In the event of a disaster, MACs and Recovery Auditors shall grant temporary administrative relief to any affected providers for up to 6 months (or longer with good cause). Administrative relief is to be granted to providers on a case-by-case basis in accordance with the following guidelines:

- The MACs and Recovery Auditors shall make every effort to be responsive to providers who are victims of the disaster and whose medical documentation may be partially or completely destroyed.
- Providers must maintain and submit verification upon contractor request by the MAC or Recovery Auditor that (1) a disaster has occurred and (2) medical record loss resulted from this disaster to the point where administrative relief from medical review requirements is necessary to allow the provider sufficient time to retrieve copies of, or restore damaged, medical documentation.

Verification of the disaster and the resultant damage should include but is not limited to:

- (1) Copies of claims filed by the provider with his/her insurance and liability company; and
- (2) Copies of police reports filed to report the damage, (3) copies of claims submitted to FEMA for financial assistance, (4) copies of tax reports filed to report the losses, or (5) photographs of damage. MACs and Recovery Auditors shall not routinely request providers to submit verification of damage or loss of medical record documentation.

D. Types of Relief

Providers Directly Affected By Disaster

The MACs and Recovery Auditors shall stop sending ADR letters to providers who have been directly affected for at least 60 calendar days. The MACs and Recovery Auditors shall allow up to an additional six months beyond the original due date for the submission of requested records. Requests for extensions beyond this date can be granted with good cause at the discretion of the MAC or Recovery Auditor.

In the case of complete destruction of medical records where no backup records exist, MACs and Recovery Auditors shall accept an attestation that no medical records exist and consider the services covered and correctly coded. In the case of partial destruction, MACs and Recovery Auditors should instruct providers to reconstruct the records as much as possible with whatever original records can be salvaged. Providers should note on the face sheet of the completely or partially reconstructed medical record: "This record was reconstructed because of disaster."

Providers Indirectly Affected By Disaster

For providers that are indirectly affected by a disaster (e.g., an interruption of mail service caused by a grounding of US commercial air flights), MACs and Recovery Auditors shall take the following actions:

For ADRs, extend the parameter that triggers denial for non-receipt of medical records from 45 calendar days to 90 calendar days. ADRs shall reflect that the response is due in 90 calendar days rather than 45 calendar days. This action will prevent most inappropriate denials and unnecessary increases in appeals workload.

If the MAC or Recovery Auditor receives the requested documentation after a denial has been issued but within a reasonable number of days beyond the denial date, the MAC or Recovery Auditor has the discretion to reopen the claim and make a medical review determination. Many reviewers follow a standard 15 calendar days although MACs and Recovery Auditors shall make these decisions on a case-by-case basis. The MACs and Recovery Auditors shall allocate the workload, costs and savings to the appropriate MR activity.

The MACs and Recovery Auditors shall review reopened claims retroactively to the date of the disaster. The MAC's data analyses shall take into consideration the expected increase in certain services in disaster areas.

E. Impact on MAC Performance Evaluations

During performance evaluations, CMS will consider a waiver to all MAC MR requirements, as necessary, to allow MACs the flexibility to handle issues that arise in the aftermath of a disaster. Examples of such waived requirements include workload targets and any other MR administrative rules. MACs shall retain documentation of how their MR operations were affected during the disaster and make it available to Performance Evaluation Teams and other CMS Staff, upon request.

3.9 - Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings **(Rev. 853, Issued: 01-04-19; Effective: 02-05-19; Implementation: 02-05-19)**

This section in its entirety applies to MACs. This section applies to Recovery Auditors, CERT, UPICs, and the SMRC, as indicated in their SOWs.

Overview:

Effective March 20, 2017 several changes were made to the regulations that outline the activities related to contractor participation in ALJ hearings. Under the new regulations, CMS contractors are limited to 3 roles in an ALJ hearing: a Participant, a Party, or a Witness (defined in detail below). These changes are outlined in 42 CFR §405.1010 and 42 CFR §405.1012.

A physician overseeing participation shall be a current Contractor Medical Director (CMD), a contractor employed physician or any combination thereof. Nurses and other staff may assist the physician with the tasks described in this section. While the physician is generally the primary individual overseeing and/or taking party or participant status, a contractor may elect to have an attorney or clinician take party or participant status, or another experienced qualified individual if approved by their COR. In either situation, the contractor must be prepared to discuss details related to the facts of each claim under appeal, the relevant coverage policies and payment requirements, including any clarification required on decisions made earlier in the appeals process. For post-pay audit/overpayment cases, the contractor must be prepared to discuss the background on how the provider/supplier was selected for review, results of the sample case adjudications, as well as matters related to the extrapolation methodology and/or processes.

This section establishes expectations related to the contractor's participation and associated coordination activities, although CMS may provide additional guidance and direction as needed. Further rules and procedures related to the ALJ hearing process are contained in 42 CFR §405.1000.

The MAC shall capture and report the ALJ participation and party data in their monthly status report to CMS. Contractors shall record the frequency of their support as a witness in the narrative field of the monthly status reports. Contractors shall ensure that JOAs are sufficient to support the ALJ hearing process and related coordination activities.

Role of the Participant:

In accordance with the revised regulation under 42 CFR Part §405.1010(c) and (d), all contractors' participation as a participant (i.e., non-party) shall be limited to submitting written testimony and/or position papers (except in those instances when non-party

participants are able to provide testimony to clarify factual or policy issues in the case—as noted in the scenario below).

The regulations do not prohibit multiple CMS contractors and/or related entities from participating in the ALJ hearing as a participant. However, if no contractor or CMS invokes party status, then the first entity to submit their election to participate as a non-party participant to the ALJ may participate in the oral hearing (limited to clarification of factual or policy issues, as requested by the ALJ). All other entities may participate, but are precluded from the hearing and may only submit written testimony and/or position papers as indicated in 42 CFR §405.1010(d)(1) and (2). If the contractor is able to participate in the hearing, they shall be adequately prepared to respond to questioning by the ALJ regarding all issues related to the claims under appeal. Because participation status does not include the same rights as full party status, the contractor may not call witnesses or cross-examine witnesses of another party, as indicated in 42 CFR §405.1010(c)(1).

(Note: At this time, CMS would not expect contractors to be responsible for clarifying factual or policy issues for cases/claims outside of their jurisdiction.)

Role of the Party:

Contractors shall invoke party status in ALJ hearings in accordance with the regulatory provisions in 42 CFR § 405.1012 and the CMS-prescribed prioritization process, described below, for cases or items/services of interest to CMS. Under 42 CFR §405.1012(d)(1), the first contractor to invoke party status with the ALJ is made the party to the hearing. All other contractors who invoke party status for that particular hearing are made participants and are precluded from the hearing (See Role of the Participant section above).

Note: At this time, CMS would not expect contractors to be responsible for representing cases/claims outside of their jurisdiction.

If the contractor is interested in a particular case, but is precluded from invoking party status based on the CMS-prescribed prioritization of cases or otherwise, the contractor may request ‘leave’ from the ALJ in accordance with 42 CFR §405.1012(d)(2). The request for ‘leave’ process occurs outside of the Administrative Qualified Independent Contractor (AdQIC) portal, described below. In submitting a request for ‘leave’ to the ALJ, the contractor is formally requesting that the ALJ grant the contractor the right to be a secondary party to the hearing. Requests for ‘leave’ to the ALJ shall also include the reason(s) why the contractor believes that their presence as a secondary party in the ALJ Hearing is necessary. The ALJ shall make the determination as to whether the contractor is granted ‘leave.’ If this is approved, the contractor shall become a secondary party to the hearing. Alternatively, if denied, the contractor may participate as a participant or as a witness, based on the circumstance. (See Role of Witness section for additional information).

As a party, the contractor is able to orally participate in the hearing and may file position papers, call witnesses, and/or cross-examine witnesses of other parties. The contractor shall submit any position paper or additional evidence requested by the ALJ in accordance with 42 CFR §405.1012(c)(2)(i) and (ii). The contractor shall be adequately prepared to respond to questioning by the ALJ or other parties regarding all issues related to the claims under appeal. As a party to the hearing, contractors are subject to discovery by the other party to the hearing in accordance with 42 CFR §405.1037.

For Notice of Hearings (NOHs) received that include issues deemed significant by CMS or the contractor, the contractor shall, at a minimum:

- Invoke party status in ALJ cases per volume of ALJ cases funded for this activity;
- Participate in any pre-ALJ hearing conference calls, as needed, with other contractors (as facilitated by the appropriate Qualified Independent Contractor (QIC));
- Coordinate with Medical Director(s) or related personnel from other contractors intending to participate as consultants/expert witnesses, as necessary, in accordance with 42 CFR §405.1010(d)(3). In addition, the MAC shall coordinate with other contractors for those hearings in which they do not invoke party status, but decide to participate as a consultant/expert witness; and/or,
- Participate in the hearings as a party via telephone, video teleconferencing, or in-person.

Role of the Witness:

If the ALJ declines the request for contractor ‘leave’ on a particular hearing, the contractor may be called as a ‘witness’ by CMS or another CMS contractor that is a party to the hearing. A determination regarding the need for a ‘witness’ by the participating party shall be determined by the party and communicated to the contractor prior to the hearing. Contractors should, at their discretion, participate as a ‘witness’ in any case in which another CMS contractor and/or CMS has requested their support in a hearing. Contractors shall notify the requesting party no later than 10 days prior to the scheduled hearing in those instances in which contractors are unable to support the hearing as a ‘witness.’ As a ‘witness,’ contractors shall be tasked with supporting the party to the hearing in responding to policy or factual issues related to a particular case through direct examination and is subject to cross examination by the opposing party.

Note: Contractors who are interested in acting as a witness may indicate their interest via the AdQIC Portal. CMS contractors may indicate interest in participating as a witness without first making a request for ‘leave’ with an ALJ. Additionally, in accordance with 42 CFR §405.1020, witness designations/elections shall be made during the coordination of interest/role selection process, as described below, and shall be included in the response to a given NOH.

3.9.1 - Election of Status

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The contractor shall establish a process for assessing the NOHs received to determine which cases should be selected for participation, as well as the type of participation (participant, party, or witness) to be employed. Factors to be examined should include, but not be limited to: originator of initial denial, policy implications, dollars at issue, program integrity matters, and the extent to which a particular issue is, or has been, a recurring issue at the ALJ level of appeal.

Contractors shall, for those cases in which they were the medical reviewer issuing the denial subject to appeal, have a prioritized ability to invoke party status (in lieu of other appeals support contractors). This process is further described below.

A. Election of Participation Status Prior to Receipt of a Formal NOH

The election to participate as a participant shall be made consistent with 42 CFR §405.1010 and can be done either prior to receipt of a formal NOH or after the receipt of a formal NOH.

The regulations allow CMS contractors to elect to participate as a participant before issuance and/or receipt of the formal NOH. See section of 42 CFR §405.1010(b)(1) for additional information. If the contractor elects to participate before the receipt of the NOH, it shall send written notice of its intent to the assigned ALJ or attorney adjudicator, or the designee of the Chief ALJ, if no contact assigned yet, and to all parties on the reconsideration (per the prescribed OMHA process) within 30 calendar days after notification that a request for hearing had been filed. In accordance with the regulations, a position paper or written testimony must either be submitted within 14 calendar days of an election to participate, if no hearing has been scheduled, or no later than 5 calendar days prior to the hearing, if a hearing is scheduled, unless the ALJ grants additional time to submit the position paper or written testimony. Contractors should note that there is a risk that the case may be later resolved by the ALJ, or an Attorney Adjudicator within the OMHA, without a hearing.

B. Election of Participation or Party Status Following Receipt of the Formal NOH

The election to be a participant or a party to a hearing after receipt of the formal NOH shall be made consistent with 42 CFR §405.1010(b) or 42 CFR §405.1012, respectively, and the CMS-prescribed prioritization process, described below. If through the CMS-prescribed prioritization process it is determined that the contractor may act as either the party or a participant to a hearing, elections of participation must be sent by the Contractor within 10 calendar days of receipt of the NOH at the AdQIC to all parties listed on the NOH. Submission of a position paper, written testimony, and/or evidence must be submitted no later than five calendar days before the date of the scheduled

hearing. Copies of these items must also be sent to those parties listed on the NOH in accordance with 42 CFR §405.1010(c)(3)(ii) and 42 CFR §405.1012(c)(2)(ii).

C. CMS-prescribed Prioritization Process and AdQIC Portal for Providing a Response to the Formal NOH

As the AdQIC is tasked with coordinating contractor interest in participation among the related CMS contractors and/or CMS, all NOHs will be sent directly to the AdQIC from the OMHA. The AdQIC, within two (2) calendar days of receipt of the formal NOH from OMHA, will create a record in the AdQIC portal that will generate an email notification to all applicable CMS contractors (e.g., DME MAC, A/B MAC, UPIC, SMRC, and/or RAC) notifying them that a hearing has been scheduled.

Upon receipt of the formal NOH e-mail alert, all applicable CMS contractors shall log onto the AdQIC website, <https://participation.q2a.com>, to access the NOH information. All applicable CMS contractors shall make their elections, via the AdQIC website, within five (5) calendar days of the formal NOH e-mail sent date. To make an election, contractors must sign-in on the website (see above), and a dashboard will be available listing all appeals for the respective contractor that they may choose to participate in.

Users can also search for appeals based on the information provided in the notification email. Next, the contractors shall select the applicable NOH identifier and complete/submit the CMS Contractor Participation Form indicating for each appeal whether they would like to participate as a party, participant, or witness, and/or if they would like to call a witness if made a party to the hearing. CMS contractors that fail to sign-in to the AdQIC system and make their respective participation role selections, in the required timeframe, may be precluded from the prioritization process.

Note: Users will not be able to view the actual NOH document on the site. The website/dashboard will allow contractors to view all scheduled hearings for which they received an NOH.

For all NOH communications (e.g., NOHs received from OMHA, NOH email alerts) received after standard business hours (e.g., 4:00 p.m., ET) and/or during weekends or business Holidays, as defined by the respective entity, the AdQIC portal is programmed to calculate the response time beginning with the next applicable business day [e.g., if the AdQIC receives the formal NOH on a Friday at 4:00 pm, the five (5) calendar day timeframe begins on Monday (with Monday being day zero (0))].

The AdQIC portal will evaluate all submissions received and determine which entity shall have the primary opportunity to participate as a ‘party,’ and which entities can participate as ‘participants’ or ‘witnesses’ based on CMS’ prioritization logic.

The anticipated prioritization for the role of party status is as follows:

- 1) Primary opportunity for the ‘party’ role in an ALJ hearing will be

- granted to the entity that conducted the initial claim denial (e.g., UPIC, RAC, SMRC or medical review unit within the MAC).
- 2) If the entity that issued the initial claim denial does not have interest in participating as a party (due to workload considerations or otherwise) the QIC will have the primary opportunity to participate as a party.
 - 3) If no CMS contractors and/or CMS wish to invoke 'party' status in a hearing and multiple entities wish to be a participant, the primary participant shall be the entity that conducted the initial claim denial (e.g., UPIC, RAC, SMRC, or medical review unit within the MAC).
 - 4) If the entity that identified/conducted the initial claim denial does not wish to be the 'primary' participant on the case, the QIC will have the next opportunity to assume this role.

The AdQIC portal will review and prioritize contractor roles in a respective ALJ hearing (i.e., which contractor shall be the 'party', 'participants,' etc.), within 2 calendar days of receipt of the completed Contractor Participation forms. The website will automatically calculate the contractor's Participation Form response due date and each contractor's role determination, and prioritize participation elections on the next calendar day after the contractor response timeframe expires. Participation/role designations will be sent via a system-generated email notification to any contractors who expressed interest in participation. The status of elections for a given NOH will be available on the AdQIC's website once determinations have been made and notifications have been sent to the applicable CMS contractors.

On rare occasion, the QIC may need to facilitate a call with the CMS and the related contractors to determine the roles and/or responsibilities on a particular hearing.

Within 10 calendar days from the initial NOH receipt date, the AdQIC will reply on behalf of all applicable CMS contractors to the NOH and OMHA with a consolidated response. The consolidated response shall include a Notice of Election form for each applicable CMS contractor for a given NOH.

In the event that OMHA issues an amended NOH, the amended NOH email will be sent from OMHA directly to the AdQIC. The AdQIC will alert all applicable CMS contractors of the amended NOH within 2 calendar days of receipt of the amended NOH email from OMHA. CMS contractor participation roles, as determined via the prioritization process in the response to the original NOH and submitted to OMHA via a Notice of Intent (NOI), shall remain intact following issuance of an amended NOH by OMHA. However, if a CMS contractor wishes to change their method of participation following the receipt of an amended NOH, then the CMS contractor shall notify/work with the AdQIC and OMHA, as applicable (e.g., if another CMS contractor was designated as the Party and the QIC was made a non-party Participant, but now the QIC wishes to serve as a Party following the receipt of an amended NOH, then the QIC must request 'leave' with the

ALJ and notify the AdQIC if the request for 'leave' is approved).

D. Communications Outside of the Portal/AdQIC Process

While the AdQIC and its prioritization portal provide useful vehicles for assessing information transcribed from the notices of hearing received from OMHA and providing formal response, contractors are reminded of regulatory communications that occur outside of this process.

Contractors are reminded that the AdQIC portal and prioritization process is initiated by receipt of an NOH from OMHA. Therefore, Contractors electing status prior to receipt of an NOH shall follow the regulatory process (outlined in 42 CFR §405.1010) to alert OMHA and other parties that were sent a copy of the notice of reconsideration of their intent to participate, which occurs outside of the portal.

In accordance with section of 42 CFR §405.1010(b)(2) and (3), if a contractor elects to participate in an ALJ hearing, the contractor (not the AdQIC) shall provide written notice of its intent to participate to the parties who were sent a copy of an NOH. Failure to notify the other parties to the appeal, of the intent to participate, may result in the ALJ determining the contractor's election for a given NOH invalid. This requirement remains applicable in the event of an amended NOH, and contractors shall ensure compliance. All pertinent information (e.g. party names, mailing address) will be available in the portal for a given NOH.

Additionally, CMS contractors participating or taking party status shall provide copies of all submitted position papers, written testimony, and/or evidence to the ALJ and other appropriate parties within the time frames as set forth in 42 C.F.R. sections 405.1010, 405.1012, or 423.2010, as applicable. Failure to provide copies of submitted position papers, written testimony, and/or evidence within the required timeframe will result in the submissions not being considered by the respective ALJ. Providing copies of all submitted position papers, written testimony, and/or evidence to the appropriate parties remains applicable in the event an amended NOH is issued and contractors shall ensure compliance.

If a contractor requests 'leave' to the ALJ, or formally requests the ALJ to grant the contractor the right to be a secondary party to the hearing, this process occurs outside of the portal.

The ALJ sets the hearing date, time, and method by video teleconferencing (VTC), telephone, or in-person if VTC is not available or special circumstances exist. A party may object in writing to the time and place of the hearing, as soon as possible before the originally scheduled time but no later than 5 calendar days prior to the hearing, and include the reason for the objection along with a proposed alternative date and time. In addition, a party may request an in-person hearing by notifying the ALJ in writing and following the same procedures noted above for an objection to the time/place of the

hearing. The ALJ may reschedule if good cause is established per 42 CFR §405.1020(f) or (g).

3.9.2 - Coordination of the ALJ Hearing

(Rev. 748, Issued: 10-13-17; Effective: 11-14-17; Implementation: 11-14-17)

As needed, if multiple entities are participating in a hearing as a party, participant, or witness, the QIC will set up a brief pre-hearing conference call to discuss the respective entity's participation in the case, roles and responsibilities, etc. Examples in which this may be necessary include high dollar cases, extrapolated overpayments, policy implications, and/or fraud related cases, etc.

Pre-hearing briefing topics may include: coordination with OMHA on scheduling matters, the manner of participation, coordination on position papers or other written testimony submitted, and lessons learned from participation in the ALJ process.

There may be cases in which testimony from another contractor is necessary. The contractor may call those entities as a witness only if the contractor has declared party status. However, if the contractor submits a position paper as a participant, the contractor may collaborate with other contractors and document their views on the case in the paper—although only one contractor may typically participate via the hearing.

The contractor shall establish a single point of contact for ALJ offices on administrative matters involving notifications, scheduling, information sharing, and other coordination necessary between the ALJ, the appellant, and other contractors.

3.10 – Prior Authorization

(Rev. 876; Issued: 04-12-19; Effective: 05-13-19; Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. Overview

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter (e.g., provider, supplier, beneficiary, etc.) to send in medical documentation in advance of providing and billing for an item or service, to verify its eligibility for Medicare claim payment. Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the submitter of any potential issues with the information, as submitted.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare coverage, coding and payment requirements.

Contractors shall communicate to the submitter (and beneficiary upon request) their prior authorization decision and the assigned unique tracking number (UTN), which indicates that the submitter requested a prior authorization, for corresponding claim submissions.

For certain prior authorization programs, the requirement to prior authorize is a condition of payment, as further described in the sections below.

Absent any explicit CMS instruction to the contrary, submitters may correct identified issues with their prior authorization request(s) and resubmit their request(s) for prior authorization without restriction. Contractors shall conduct prior authorization reviews within the timeframes defined by CMS in the corresponding prior authorization program operational instruction(s).

The prior authorization process is further described in following sections.

B. Condition of Payment

Contractors shall determine if the requirement to prior authorize a particular item or service is a condition of payment, as specified in the individual operational instruction(s). If prior authorization is a condition of payment, claims submitted without an indication that the submitter made a prior authorization request (i.e., UTN) shall be denied upon receipt.

C. Outreach and Education

Contractors shall educate stakeholders each time a new prior authorization program is launched for a particular item or service, the requisite information and timeframes for prior authorization submissions, and the vehicle(s) for submitting such information to the contractor for assessment. Contractors shall make sure submitters are aware of the timeframes for contractors to render prior authorization decisions, for each individual prior authorization program.

Each prior authorization program will have an associated Operational Guide and will be available on the CMS website. Contractors shall, at a minimum, provide public access to agency-developed prior authorization operational guides, by posting the link(s) on their website.

Contractors shall hold group or individualized training sessions, as appropriate, to notify the stakeholders of upcoming prior authorization programs and to make sure there is ongoing understanding of the specific requirements for those applicable prior authorization programs.

D. Prior Authorization Submission

Contractors shall assess the information/documentation included in the prior authorization submission for completeness. Requisite information for individualized prior authorization programs will be included in the operational guides, and shall be available on the CMS website.

Requisite information may include, but is not limited to:

- Beneficiary Information (i.e., name, Medicare beneficiary identifier, date of birth)
- Physician/Practitioner Information (i.e., name, provider identification number, address)
- Supplier Information (i.e., name, national supplier clearinghouse (NSC) number, identification number, address)
- Documentation from the medical record to support the medical necessity of the item or service, and
- Any other relevant documents as deemed necessary by the contractor to process the prior authorization.

E. Prior Authorization Decisions

Contractors shall notify the submitter if their prior authorization submission results in a provisional affirmative, or non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/documentation does not meet Medicare's coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. Contractors shall provide notification of the reason(s) for the non-affirmation, if a request is non-affirmative, to the submitter. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times, unless otherwise specified.

Contractors shall send detailed decision letters to submitters. As appropriate for the given prior authorization program, contractors shall send detailed decision letters to other stakeholders (e.g., beneficiaries) using their official address on file. In addition, there may be certain prior authorization programs that require the contractors to notify the appropriate entity by other means, such as telephone.

If a claim is submitted for payment without an affirmative prior authorization decision on file, contractors shall use their existing processes to either suspend claims for additional review or to process claims as denials, based on each individualized prior authorization program, as detailed in the operational instruction.

F. Expedited Request

For certain items or services, delays in receipt of a prior authorization decision could jeopardize the life or health of the beneficiary. Contractors shall, for such items or services, expedite their decisions based on the operational instruction.

If the claim processing systems would unavoidably delay the delivery of the UTN in an expedited fashion, contractors shall nonetheless render an affirmative or non-affirmative decision to the submitter within the mandated, expedited timeframe. Contractors shall alert the submitter that the decision is being provided as expeditiously as possible, so that the item or service may be provided, but that the submitter should hold their claim and not submit it until such time as the UTN is received (in order to avoid a claims payment denial).

3.10.1 - Prior Authorization Program for Certain DMEPOS (Rev. 937; Issued: 01-31-20; Effective: 03-02-20; Implementation: 03-02-20)

A prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization is described in 42 CFR §405 and §414.234. Among other things, these sections establish a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the Prior Authorization Master List that shall require prior authorization, at its discretion. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, emerging trends, vulnerabilities identified in official agency reports, or other analysis, and may implement prior authorization nationally or locally.

The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234. The Master List can be found on the CMS website.

The Required Prior Authorization List is the items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The Required Prior

Authorization List can be found on the CMS website, and will be updated as additional codes are selected for prior authorization.

CMS may elect to exempt suppliers from prior authorization program upon demonstration of compliance with Medicare coverage, coding, and payment rules.

The CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via—(i) Federal Register notice; and (ii) Posting on the CMS prior authorization Web site.

3.10.2 - Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services

(Rev. 937; Issued: 01-31-20; Effective: 03-02-20; Implementation: 03-02-20)

A prior authorization process for certain hospital OPD services is described in 42 CFR §§419.80 through 419.89 as a method for controlling unnecessary increases in the volume of covered services. These sections establish requirements for the submission of a prior authorization request (PAR), the timeframes for the review of a PAR, and the process for CMS to exempt providers from prior authorization requirements.

The list of hospital OPD services requiring prior authorization will be updated through formal notice-and-comment rulemaking. Technical updates to the list of services, such as changes to the name of the service or the HCPCS code, will be published on the CMS website.

The CMS may elect to exempt a provider from this prior authorization process upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules after semiannual assessments. Providers must reach a prior authorization provisional affirmation threshold of 90 percent or greater to be eligible for exemption.

The CMS may suspend the outpatient department services prior authorization process requirements generally or for a particular service(s) at any time by issuing notification on the CMS website.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R11032PI</u>	09/30/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08	11/10/2021	12375
<u>R10984PI</u>	09/09/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08 - Rescinded and Replaced by Transmittal 11032	11/10/2021	12375
<u>R10365PI</u>	10/02/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08	08/27/2020	11884
<u>R10228PI</u>	07/27/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08 Rescinded and Replaced by Transmittal #10365	08/27/2020	11884
<u>R10197PI</u>	06/26/2020	Publication (Pub.) 100-08 Chapter 3 Updates to Section 3.2.3.2 (Timeframes for Submission) and Section 3.2.3.8 (No Response or Insufficient Response to Additional Documentation Requests (ADRs))	07/27/2020	11730
<u>R10190PI</u>	06/19/2020	Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F	07/01/2020	11599
<u>R10171PI</u>	06/12/2020	Updates to Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) and Ambulance Certification Signature Requirements	07/13/2020	11763
<u>R10132PI</u>	05/15/2020	Revising Subsection 3.2.5, Targeted Probe and Educate (TPE), in Chapter 3 of Publication (Pub.) 100-08	06/16/2020	11695
<u>R10100PI</u>	05/08/2020	Revision to Language in Chapter 3, Section 3.7.5 (Corrective Action Reporting Requirements) of Publication (Pub.) 100-08	06/09/2020	11756

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<u>R937PI</u>	01/31/2020	Updates to the Prior Authorization (PA) Guidance Within Publication (Pub.) 100-08	03/02/2020	11633
<u>R933PI</u>	01/10/2020	Update to Chapter 3, Section 3.2.3.1 Additional Documentation Requests (ADR) of Publication (Pub) 100-08	01/06/2020	10828
<u>R912PI</u>	10/18/2019	Medicare Administrative Contractor (MAC) Verification of Potential Errors and Corrective Actions Taken	11/19/2019	11463
<u>R907PI</u>	10/04/2019	Update to Chapter 3, Section 3.2.3.1 Additional Documentation Requests (ADR) of Publication (Pub) 100-08- Rescinded and Replaced by Transmittal #933	01/06/2020	10828
<u>R902PI</u>	09/27/2019	Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08	10/28/2019	11425
<u>R876PI</u>	04/12/2019	Update to Publication (Pub.) 100-08 to Provide Language-Only Changes for the New Medicare Card Project	05/13/2019	11109
<u>R853PI</u>	01/04/2019	Updates to the Appeals Prioritization Process	02/05/2019	10641
<u>R833PI</u>	10/12/2018	Templates in Medical Review	11/13/2018	10930
<u>R825PI</u>	09/21/2018	Credentials of Reviewers (This Change Request (CR) Rescinds and Fully Replaces CR 10157.)	10/22/2018	10909
<u>R819PI</u>	08/17/2018	Adding a Targeted Probe and Educate (TPE) Sub-Section Into Section 3.2 of Chapter 3 in Publication (Pub.) 100-08	09/17/2018	10876
<u>R796PI</u>	05/11/2018	Intent to Reopen	08/13/2018	9855
<u>R802PI</u>	06/21/2018	Use of Accessible and Applicable Claims History During Medical Review	07/24/2018	10640
<u>R791PI</u>	04/27/2018	Restoring Section 3.2.3 B. and Section 3.2.3 C. to Chapter 3 of Publication (Pub.) 100-08 in the Internet Only Manual (IOM)	05/29/2018	10505
<u>R786PI</u>	04/13/2018	Reimbursing Providers and Health Information Handlers (HIHs) for Additional Documentation	05/14/2018	10529
<u>R768PI</u>	02/08/2018	Post-Payment Review Timeliness Requirements	04/01/2018	9990
<u>R755PI</u>	11/09/2017	Tracking Medicare Contractors' Prepayment and Postpayment Reviews	12/11/2017	10177
<u>R751PI</u>	10/20/2017	Clarifying Signature Requirements	11/20/2017	10322

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<u>R748PI</u>	10/13/2017	Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings	11/14/2017	10226
<u>R738PI</u>	08/18/2017	Provider Error Rate Formula	09/19/2017	10210
<u>R732PI</u>	07/21/2017	Clarifying the Instructions for Amending or Correcting Entries in Medical Records	08/22/2017	10120
<u>R721PI</u>	06/09/2017	Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews	07/11/2017	9809
<u>R713PI</u>	05/05/2017	Scribe Services Signature Requirements	06/06/2017	10076
<u>R698PI</u>	01/20/2017	The Process of Prior Authorization	02/21/2017	9940
<u>R674PI</u>	09/02/2016	Duplicate Postpayment Claim Reviews	11/04/2016	9665
<u>R663PI</u>	07/15/2016	Denial Codes for Missing or Insufficient Documentation	08/16/2016	9690
<u>R657PI</u>	06/17/2016	Special Provisions for Lab Additional Documentation Requests (ADRs)	07/18/2016	9670
<u>R634PI</u>	01/22/2016	Reviewers' Credentials, Notifying the Provider, CARC Code Update	04/22/2016	9333
<u>R628PI</u>	12/04/2015	Update to CMS Publication 100-08, Chapter 3, Section 3.2.3.2 (Time Frames for Submission)	01/06/2016	9438
<u>R620PI</u>	10/16/2015	Pub. 100-08 Chapter 3 Updates: Section 3.2.3.2 Timeframes for Submission and Section 3.2.3.8 - No response to Additional Documentation Requests – Rescinded and not replaced	11/17/2015	9226
<u>R617PI</u>	10/09/2015	Update to Chapter 3 of Pub. 100-08	11/10/2015	9303
<u>R615PI</u>	10/02/2015	Signature Requirements	11/02/2015	9332
<u>R613PI</u>	09/25/2015	Postpayment Review Requirements	10/26/2015	9323
<u>R608PI</u>	08/14/2015	Update to Pub. 100-08 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	09/14/2015	8747
<u>R604PI</u>	07/24/2015	Signature Requirements	08/25/2015	9225
<u>R585PI</u>	04/03/2015	Coding Determinations	05/04/2015	8937
<u>R568PI</u>	02/04/2015	Review Timeliness Requirements for Complex Review	03/01/2015	8443
<u>R567PI</u>	02/04/2015	New Timeframe for Response to Additional Documentation Requests	04/06/2015	8583

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<u>R566PI</u>	01/07/2015	New Timeframe for Response to Additional Documentation Requests – Rescinded and replaced by Transmittal 567	04/06/2015	8583
<u>R565PI</u>	12/31/2014	Update to CMS Publication 100-08, Chapter 3, Section 3.2.3.2 (Time Frames for Submission)	02/02/2015	9012
<u>R557PI</u>	11/26/2014	Update to CMS Publication 100-08, Chapter 3, Section 3.2.3.4 (Additional Documentation Request Required and Optional Elements)	12/29/2014	8948
<u>R554PI</u>	11/14/2014	New Timeframe for Response to Additional Documentation Requests – Rescinded and replaced by Transmittal 566	04/06/2015	8583
<u>R547PI</u>	10/17/2014	Review Timeliness Requirements for Complex Review – Rescinded and replaced by Transmittal 566	02/24/2015	8443
<u>R543PI</u>	09/26/2014	Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings	10/27/2014	8501
<u>R541PI</u>	09/12/2014	Claims that are Related	09/08/2014	8802
<u>R540PI</u>	09/04/2014	Claims that are Related – Rescinded and replaced by Transmittal 541	09/08/2014	8802
<u>R534PI</u>	08/08/2014	Claims that are Related – Rescinded and replaced by Transmittal 540	09/08/2014	8802
<u>R527PI</u>	07/03/2014	Provider Notice on MAC Web sites	09/05/2014	8690
<u>R523PI</u>	04/20/2014	Update to CMS Pub. 100-08, Chapter 3 – Rescinded and not replaced	07/22/2014	8791
<u>R512PI</u>	04/18/2014	Revision to the Program Integrity Manual, Chapter 3 Section 3.3	05/19/2014	8716
<u>R505PI</u>	02/05/2014	Removing Prohibition - Rescinded	03/06/2014	8425
<u>R501PI</u>	01/09/2014	Complex Medical Review	10/07/2013	8429
<u>R500PI</u>	12/27/2013	Third-party Additional Documentation Request CERT Update	01/28/2014	8547
<u>R498PI</u>	12/27/2013	Notifying the Provider of Postpayment Review Results	01/28/2014	8541
<u>R496PI</u>	12/12/2013	Tracking Medicare Contractors' Postpayment Reviews	10/03/2013	8362
<u>R489PI</u>	10/18/2013	100% Prepayment Review and Random Review Instructions	11/19/2013	8427

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<u>R488PI</u>	09/20/2013	Acceptable Submission Methods for Responses to ADRs	10/21/2013	8436
<u>R487PI</u>	09/13/2013	Tracking Medicare Contractors' Postpayment Reviews	10/03/2013	8362
<u>R486PI</u>	09/06/2013	Complex Medical Review – Rescinded and replaced by Transmittal 501	10/07/2013	8429
<u>R485PI</u>	08/21/2013	Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification	01/29/2013	8079
<u>R484PI</u>	08/21/2013	OMB Collection Number	05/21/2012	7750
<u>R477PI</u>	08/02/2013	Tracking Medicare Contractors' Postpayment Reviews – Rescinded and replaced by Transmittal 487	10/03/2013	8362
<u>R465PI</u>	05/17/2013	Use of a Rubber Stamp for Signature	06/18/2013	8219
<u>R464PI</u>	05/17/2013	Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information	06/18/2013	8267
<u>R458PI</u>	04/12/2013	EsMD RC Public Announcement	05/13/2013	8208
<u>R455PI</u>	03/15/2013	Progress Notes and Forms	12/10/2012	8033
<u>R453PI</u>	03/13/2013	Progress Notes and Forms – Rescinded and replaced by Transmittal 455	12/10/2012	8033
<u>R447PI</u>	01/18/2013	Medical Review Timeliness Requirements	02/19/2013	8131
<u>R446PI</u>	12/28/2012	Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification – Rescinded and replaced by Transmittal 485	01/29/2013	8079
<u>R442PI</u>	12/07/2012	Update for Amendments, Corrections and Delayed Entries in Medical Documentation	01/08/2013	8105
<u>R438PI</u>	11/09/2012	Progress Notes and Forms – Rescinded and replaced by Transmittal 453	12/10/2012	8033
<u>R426PI</u>	06/15/2012	Process for Handling Electronic Submission of Medical Documentation (esMD)	07/16/2012	7835
<u>R422PI</u>	05/25/2012	Request Records Related to the Claim Being Reviewed	06/26/2012	7837
<u>R418PI</u>	04/20/2012	OMB Collection Number – Rescinded and replaced by Transmittal 484	05/21/2012	7750
<u>R399PI</u>	11/04/2011	Revision of PIM Chapter 3, Section 3.2.1 Setting Priorities and Targeting Reviews	12/05/2011	7622

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<u>R398PI</u>	11/04/2011	Revision of PIM Chapter 3, Section 3.7.5, Part B, Corrective Action Reporting on CMS and OIG Identified Vulnerabilities Spreadsheet Submission Instructions	12/05/2011	7479
<u>R396PI</u>	11/02/2011	Medical Review of PWK (paperwork)	04/02/2012	7330
<u>R383PI</u>	08/26/2011	Update to Pub. 100-08, Medicare Program Integrity Manual-Chapter 3	09/26/2011	7536
<u>R377PI</u>	05/27/2011	Program Integrity Manual Reorganization of Chapters 3 and 8	06/28/2011	6560
<u>R367PI</u>	02/25/2011	Use of Claims History Information in Claim Payment Determination	03/25/2011	7305
<u>R366PI</u>	02/04/2011	Auto Denial of Claim Line(s) Items Submitted with a GZ Modifier	07/05/2011	7228
<u>R360PI</u>	12/10/2010	Corrective Action Reporting	01/12/2011	7241
<u>R343PI</u>	06/18/2010	Medical Review Resolutions in the Absence of a Plan of Care (POC) and the Outcome Assessment Information Set (OASIS)	07/19/2010	6982
<u>R338PI</u>	05/14/2010	Clinical Review Judgment (CRJ)	06/15/2010	6954
<u>R327PI</u>	03/16/2010	Signature Guidelines for Medical Review Purposes	04/16/2010	6698
<u>R303PI</u>	09/25/2009	Local Coverage Determinations (LCD) Exceptions - Rescinded	10/13/2009	6586
<u>R302PI</u>	09/11/2009	Local Coverage Determinations (LCD) Exceptions - Rescinded and replaced by Transmittal 303	10/13/2009	6586
<u>R282PI</u>	01/08/2009	Zone Program Integrity Contractor (ZPIC) Updates	01/26/2009	6170
<u>R278PI</u>	12/19/2008	Zone Program Integrity Contractor (ZPIC) Updates - Rescinded and replaced by Transmittal 282	01/26/2009	6170
<u>R264PI</u>	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
<u>R248PI</u>	03/28/2008	Signature Requirements Clarification	04/28/2008	5971
<u>R245PI</u>	02/29/2008	Processing Part B Therapy Claims While the Therapy Cap Exceptions Process is in Effect	03/31/2008	5945
<u>R220PI</u>	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550

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<u>R185PI</u>	01/26/2007	Updating Financial Reporting Requirements for Workload and Cost Associated With the Return of Demand Bills	02/26/2007	4378
<u>R184PI</u>	01/26/2007	Revisions for MACs and PSCs	02/26/2007	5399
<u>R181PI</u>	12/29/2006	Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007	01/29/2007	5478
<u>R179PI</u>	12/15/2006	Revised Medical Review Timeliness and Reopening Requirements for Medical Review	01/16/2007	5252
<u>R174PI</u>	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
<u>R171PI</u>	11/09/2006	Outpatient Therapy Cap Clarifications	12/09/2006	5271
<u>R170PI</u>	11/03/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 174	10/06/2006	5275
<u>R167PI</u>	10/27/2006	New DMEPOS Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing	10/01/2006	4296
<u>R163PI</u>	09/29/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 170	10/06/2006	5275
<u>R159PI</u>	09/22/2006	New DMEPOS Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing - Replaced by Transmittal 167	10/02/2006	4296
<u>R149PI</u>	06/30/2006	Notification to Providers, Suppliers, and Beneficiaries of Postpayment Review Results	07/31/2006	5115
<u>R142PI</u>	03/02/2006	New DMEPOS Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFS) for Claims Processing – Replaced by Transmittal 159	10/02/2006	4296
<u>R140PI</u>	02/15/2006	Therapy Caps Exception Process	03/13/2006	4364
<u>R139PI</u>	02/13/2006	Therapy Caps Exception Process - Replaced by Transmittal 140	03/13/2006	4364
<u>R138PI</u>	02/10/2006	New DMEPOS Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFS) for Claims Processing - Replaced by Transmittal 142	10/03/2006	4296
<u>R135PI</u>	01/06/2006	Changes to the GTL Titles	02/06/2006	4228

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<u>R131PI</u>	10/10/2005	Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process	02/10/2006	4052
<u>R125PI</u>	09/30/2005	Medical Review Additional Documentation Requests	12/30/2005	4022
<u>R123PI</u>	09/23/2005	MMA Section 935	10/24/2005	3703
<u>R122PI</u>	09/16/2005	Medical Review Collection Number Requirements	10/17/2005	4091
<u>R120PI</u>	08/25/2005	Correction to Change Request (CR) 3222: Local Medical Review Policy/ Local Coverage Determination Medicare Summary Notice (MSN) Message Revision	N/A	3880
<u>R118PI</u>	08/12/2005	Various Benefit Integrity (BI) Clarifications	09/12/2005	3896
<u>R114PI</u>	06/10/2005	Change in Statistical Sampling Instructions	05/31/2005	3734
<u>R108PI</u>	04/29/2005	Change in Statistical Sampling Instructions	05/31/2005	3734
<u>R100PI</u>	01/21/2005	Review of Documentation During Medical Review	02/22/2005	3644
<u>R098PI</u>	01/21/2005	Psychotherapy Notes	02/22/2005	3457
<u>R096PI</u>	01/14/2005	Consent Settlements	02/14/2005	3626
<u>R094PI</u>	01/14/2005	Informing Beneficiaries About Which Local Medical Review Policy (LMRP) and/or Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) is Associated with Their Claim Denial	07/05/2005	3602
<u>R091PI</u>	12/10/2004	Revision of Program Integrity Manual (PIM), Section 3.11.1.4	01/03/2005	3560
<u>R090PI</u>	12/10/2004	Prepayment Review of Claims for MR Purposes	01/10/2005	3569
<u>R087PI</u>	11/05/2004	Informing Beneficiaries About Which Local Medical Review Policy (LMRP) and/or Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) is Associated with Their Claim Denial	04/04/2005	3363
<u>R086PI</u>	11/05/2005	Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services	11/22/2004	3437
<u>R85PI</u>	10/22/2004	Informing Beneficiaries About Which Local Medical Review Policy (LMRP) and/or Local Coverage Determination (LCD) and/or	04/04/2005	3363

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		National Coverage Determination (NCD) is Associated with Their Claim Denial - Replaced by Transmittal 87		
<u>R084PI</u>	10/22/2004	Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services - Replaced by Transmittal 86	11/22/2004	3437
<u>R079PI</u>	07/09/2004	Local Medical Review Policy/ Local Coverage Determination Medicare Summary Notice (MSN) Message Revision; Denial Notices	08/09/2004	3222
<u>R076PI</u>	05/28/2004	Clarification of Complex Medical Review	06/28/2004	3211
<u>R075PI</u>	05/14/2004	Informing Beneficiaries About Which Local Medical Review Policy (LMRP) and/or Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) is Associated with Their Claim Denial	10/04/2004	3089
<u>R072PI</u>	04/16/2004	Automated Prepayment Review	05/01/2004	3088
<u>R071PI</u>	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
<u>R070PI</u>	04/09/2004	New Requirements for Self-Administered Drug (SAD) Exclusion List Articles in the Medicare Coverage Database (MCD)	05/10/2004	3136
<u>R066PI</u>	02/20/2004	Progressive Corrective Action Program Memorandum and Updated Instructions on How Contractors Must Identify, Verify, and Correct Billing Errors	04/02/2004	3124
<u>R064PI</u>	01/30/2004	Role Conditions of Participation (COPs) Requirements When Making a Payment Decision	03/02/2004	3042
<u>R059PI</u>	11/28/2003	Documentation Specifications for Areas Selected for Prepayment or Postpayment MR	01/05/2004	2937
<u>R054PI</u>	10/31/2003	Denial Notices	04/05/2004	2936
<u>R053PI</u>	10/31/2003	Prepayment Edits	04/05/2004	2916
<u>R049PI</u>	09/26/2003	Changing the Use of Remittance Advice Code N109 From Mandatory to Contractor's Discretion	10/10/2003	2873
<u>R047PI</u>	07/25/2003	CMS Mandated Edits	08/08/2003	2517
<u>R046PI</u>	07/25/2003	Prepayment Edits	08/01/2003	2681

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<u>R039PI</u>	03/14/2003	MR Review and Documentation	04/01/2003	2417
<u>R038PI</u>	02/03/2003	When Contractors May Publish Coverage/Coding Articles In Their Bulletins And Web Sites	02/14/2003	2120
<u>R035PI</u>	11/29/2002	Types of Prepayment and Postpayment Review	01/01/2003	2418
<u>R033PI</u>	11/01/2002	FY 2003 Budget Performance Requirements	11/01/2002	2407
<u>R032PI</u>	10/25/2002	Consent Settlements, CMPs Delegated to CMS and Referrals to OIG	10/25/2002	2333
<u>R031PI</u>	10/25/2002	Revised Prepayment Edits	09/01/2002	1793
<u>R017PIM</u>	12/12/2001	Reorganizes chapter 3, sections 4, 5, and 6 and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.	04/01/2002	1891
<u>R016PIM</u>	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732
<u>R013PIM</u>	09/26/2001	Administrative Relief from Medical Review and Benefit Integrity in Disaster Situations	09/26/2001	1879
<u>R003PIM</u>	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
<u>R001PIM</u>	06/2000	Initial Release of Manual	NA	931

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EXHIBIT C

Medicare Managed Care Manual

Chapter 7 – Risk Adjustment

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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:

Payment year	MA plans	Evercare*	SHMO*	PACE and dual demonstrations*
2000-2003	10% risk/90% demographic	100% demographic	100% demographic	100% demographic
2004	30% risk/70% demographic			10% risk/90% demographic
2005	50% risk/50% demographic		30% risk/70% demographic	
2006	75% risk/25% demographic		50% risk/50% demographic	
2007	100% risk/0% demographic		75% risk/25% demographic	
2008 and later			100% risk/0% demographic	

*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 – ○ 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 ○ 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 beneficiary'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:

	<u>2007</u>	<u>2009</u>	
		<u>Non-Medicaid</u>	<u>Medicaid</u>
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

$$\text{Frailty score for payment} = 0.460*0.7 + 0.139 * 0.3 = 0.364$$

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

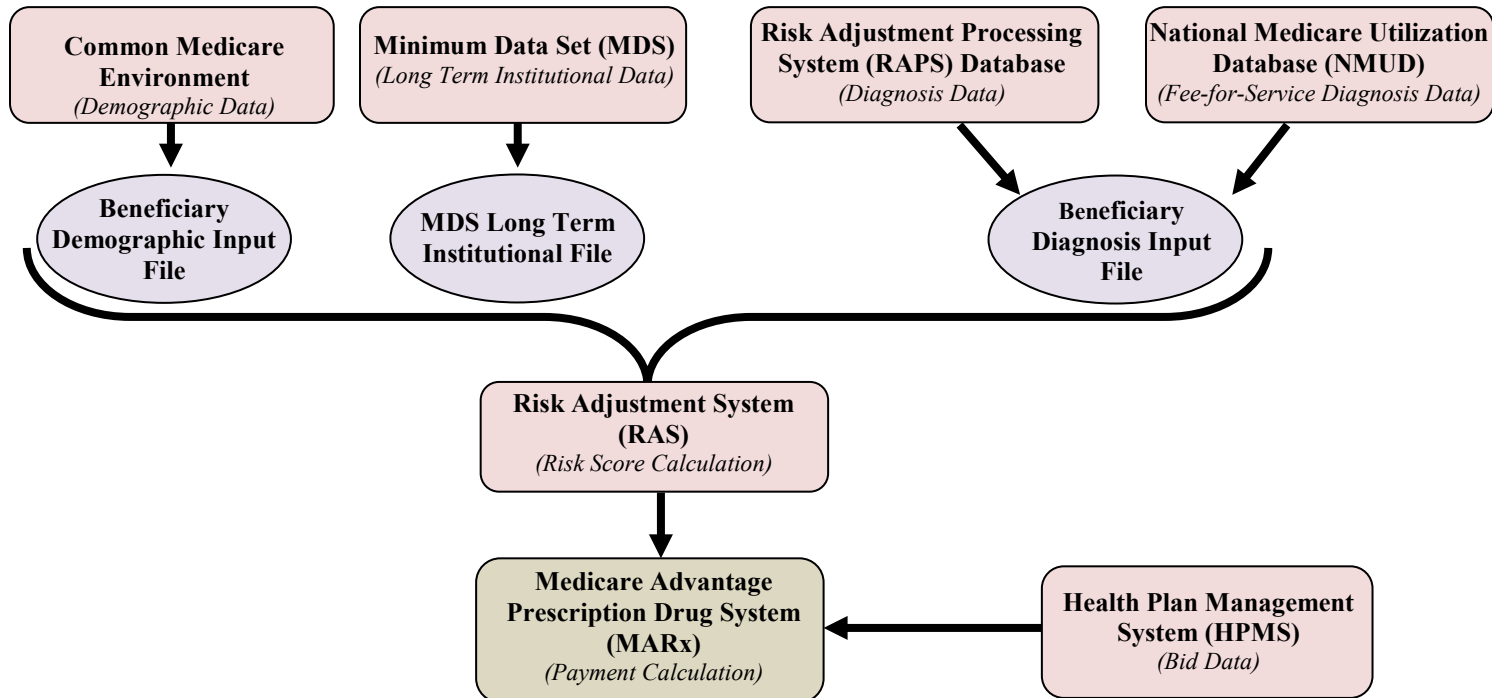
Diagnostic Data is used in risk score calculations and is obtained from both plans and FFS providers.

- 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	<i>International Classification of Diseases (ICD)</i> 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.

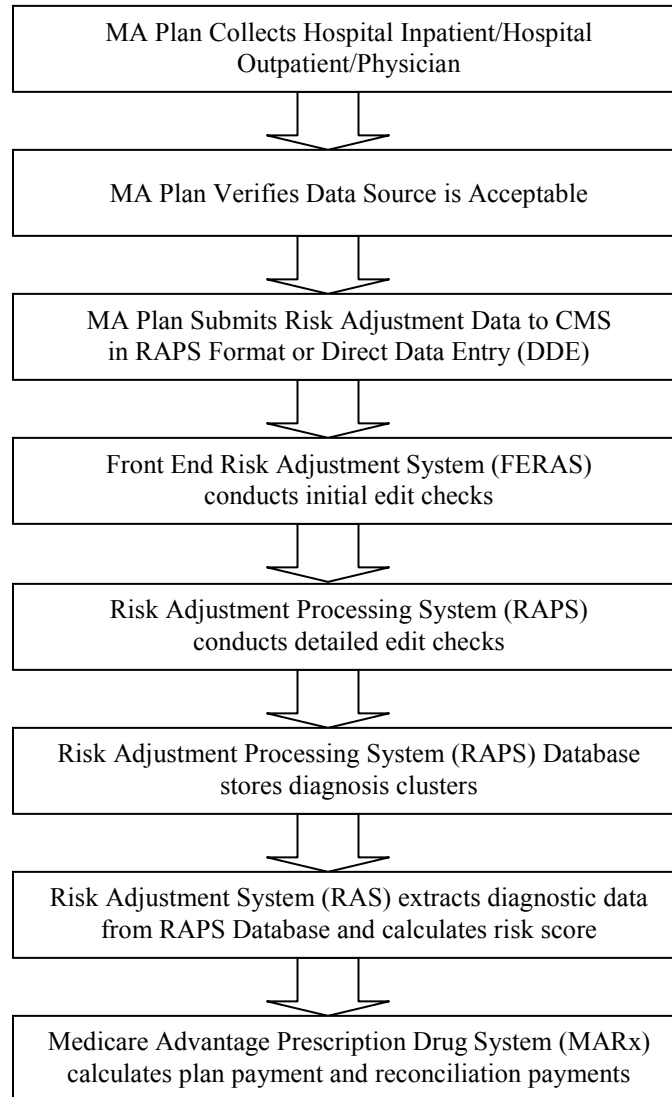
The FERAS and RAPS systems generate Transaction Reports describing the status of the transaction and any errors that occurred during processing. RAPS also provides Management Reports that identify the disposition of the submitted data so plans can verify their data and project their payment.

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*

RAPS Provider Type	Covered Facilities	Non-Covered Facilities*
Hospital Outpatient	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**	Free-standing Ambulatory Surgical Centers (ASCs) Home Health Care Free-standing Renal Dialysis Facilities
	Non-Covered Services	
	Laboratory Services Ambulance Durable Medical Equipment Prosthetics	Orthotics Supplies Radiology Services

* 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-edl.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 <i>when ICD-9-CM is used</i>	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). <i>Fill with spaces when ICD-9-CM is not used. Left justify.</i>
9.5		Required <i>when ICD-10-CM is used</i>	Diagnosis Code or Filler	<i>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</i>
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.csscooperations.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 Pneumonic 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.csscooperations.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/MedicareAdvtgSpec RateStats 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 ○ Payments and adjustments applicable to the organization’s Medicare membership, shows total number of payments for beneficiaries receiving hospice, ESRD or institutionalized status. • Detail ○ Detailed list of beneficiaries for who payment was made for a month (prospective for that month or an adjustment payment for a previous month). ○ Allows for comparison of organization’s beneficiary records with CMS’ records. • Non-Drug MMR ○ 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 ○ 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.

The information for L. Brown is reported as the following on the sample Drug MMR:

- Female
- between the ages of 55-59
- has a birth date of XXXXXXXXX
- Part D RA Factor of 1.2870
- Direct subsidy payment amount of \$80.39
- Total payment of \$80.39

Figure 5. Sample Non-Drug MMR - Key Fields

Non-Drug

***GROUP=H9999, CONTRACT=H9999
 RUN DATE:20051018
 PAYMENT MONTH:200601

MONTHLY MEMBERSHIP REPORT - NON DRUG
 PLAN(H9999) RRR(001) SEGMENT(000) CENTER INSURANCE

PAGE: 1

BASIC PREMIUM		COST	SHR REDUC	MAND	SUPP BENEFIT	PART D SUPP BENEFIT	PART B BAS PRM REDUC	PART D BAS PRM REDUC
PART A	PART B							
\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$10.25	\$0.00	\$0.00
\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$14.75	\$0.00	\$0.00

CLAIM NUMBER	AGE STATE	GRP CNTY	FLAGS	P P	M F	A D	S A	MTHS	DATES	START	END	LLS	FTYPE
SURNAME	F	DMG	BIRTH	O T T S R S H I I E	O A H R S	PIP	ADJ	REA	FCTR-A	FCTR-B	PART A	PART B	TOTAL PAYMENT
I	RA	DATE	A A B P D T C D L C	N U P C P D C G									
000000000A	F	5959	33700	Y Y Y Y			B	1 1	200601	200601	Y	D	
Doe J		5959	XXXXXXX						1.0280	1.0280	\$2733.53	\$3900.59	\$6634.12
000000000A	F	8084	10050	Y Y Y			B	1 1	200505	200705	Y		
First S		8084	XXXXXXX						2.963	2.963	\$209.41	\$186.29	\$395.70

Health Status

Adjustment Reason Code

Part A, B, and Total Payments

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 ◦ Displays HCCs used by RAS to calculate risk adjustment factors for each beneficiary. ◦ Displays the HCC Disease Groups used by the CMS-HCC model and disease and demographic interactions. ◦ 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.

- New enrollee

The HCCSOFT software supplies user parameters to the main SAS Macro program MACROSOFT. 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#
<u>R118MCM</u>	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
<u>R116MCM</u>	02/28/2014	Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010 – Rescinded and replaced by Transmittal 118	10/01/2014	N/A
<u>R114MCM</u>	06/07/2013	Chapter 7 – Risk Adjustment	06/07/2013	N/A
<u>R57MCM</u>	08/13/2004	Coverage of Clinical Trials, Hospital Inpatient Data, Diagnostic Coding, and Collection of Data	N/A	N/A
<u>R47MCM</u>	02/20/2004	Miscellaneous Changes	N/A	N/A
<u>R02MCM</u>	10/01/2001	Miscellaneous Changes	N/A	N/A
<u>R01MCM</u>	07/02/2001	Initial Issuance of Chapter	N/A	N/A

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EXHIBIT D

ICD-10-CM Official Guidelines for Coding and Reporting

FY 2022 -- UPDATED April 1, 2022

(October 1, 2021 - September 30, 2022)

Narrative changes appear in bold text

Items underlined have been moved within the guidelines since the FY 2021 version

***Italics* are used to indicate revisions to heading changes**

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, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. 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 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. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

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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-10-CM

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.

1. The Alphabetic Index and Tabular List

The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

See Section I.C2. General guidelines

See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference.

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50. Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

6. Abbreviations

a. Alphabetic Index abbreviations

NEC “Not elsewhere classifiable”
This abbreviation in the Alphabetic Index represents “other specified.” When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

NOS “Not otherwise specified”
This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations

NEC “Not elsewhere classifiable”
This abbreviation in the Tabular List represents “other specified”. When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

NOS “Not otherwise specified”
This abbreviation is the equivalent of unspecified.

7. Punctuation

- [] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.
- () Parentheses are used in both the Alphabetic Index and Tabular List 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. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic”.

- : 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.

8. Use of “and”.

See Section I.A.14. Use of the term “And”

9. Other and Unspecified codes

a. “Other” codes

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist.

Alphabetic Index entries with NEC in the line designate “other” codes in the Tabular List. These Alphabetic 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 titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

10. Includes Notes

This note appears immediately under a three-character code title to further define, or give examples of, the content of the category.

11. Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code 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 Alphabetic Index may also be assigned to a code.

12. Excludes Notes

The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use, but they are all similar in that they indicate that codes excluded from each other are independent of each other.

a. Excludes1

A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.

b. Excludes2

A type 2 Excludes note represents "Not included here." An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

13. 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-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, 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. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code, and the rules for sequencing apply.

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic 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.

An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson's disease,

and must be sequenced first, whereas code F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

“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.7. Multiple coding for a single condition.

14. **“And”**

The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

For example, cases of “tuberculosis of bones”, “tuberculosis of joints” and “tuberculosis of bones and joints” are classified to subcategory A18.0, Tuberculosis of bones and joints.

15. **“With”**

The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.

The word “with” in the Alphabetic Index is sequenced immediately following the main term or subterm, not in alphabetical order.

16. **“See” and “See Also”**

The “see” instruction following a main term in the Alphabetic 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 Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic 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.

17. “Code also” note

A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.

18. Default codes

A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

19. Code assignment and Clinical Criteria

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

B. General Coding Guidelines**1. Locating a code in the ICD-10-CM**

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

2. Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available **and to the highest level of specificity documented in the medical record.**

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

3. Code or codes from A00.0 through T88.9, Z00-Z99.8, U00-U85

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8, **and U00-U85** must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

4. 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 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all, codes for symptoms.

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

5. 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.

6. 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.

7. 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 List 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, if known.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, 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 there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first, if known.

“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 sequela, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

8. 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.

9. 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.

10. Sequela (Late Effects)

A sequela 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 sequela code can be used.

The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

See Section I.C.9. Sequelae of cerebrovascular disease

See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium

See Section I.C.19. Application of 7th characters for Chapter 19

11. 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.

12. Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter.

This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

13. Laterality

Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

When laterality is not documented by the patient’s provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient’s attending provider should be queried for clarification. Codes for “unspecified” side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

14. Documentation by Clinicians Other than the Patient’s Provider

Code assignment is based on the documentation by **the** patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions **when** 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). **In this context, “clinicians” other than the patient’s provider refer to healthcare professionals permitted, based on regulatory or**

accreditation requirements or internal hospital policies, to document in a patient's official medical record.

These exceptions include codes for:

- **Body Mass Index (BMI)**
- **Depth of non-pressure chronic ulcers**
- **Pressure ulcer stage**
- **Coma scale**
- **NIH stroke scale (NIHSS)**
- **Social determinants of health (SDOH)**
- **Laterality**
- **Blood alcohol level**

This information is typically, **or may be**, documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, **or a condition classifiable to category F10, Alcohol related disorders**) 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, coma scale, NIHSS, **blood alcohol level** codes and **codes for social determinants of health** should only be reported as secondary diagnoses.

See Section I.C.21.c.17 for additional information regarding coding social determinants of health.

15. Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

16. 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, unless otherwise instructed by the classification. 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.

17. Borderline Diagnosis

If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM,

it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

18. Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

As stated in the introductory section of these official coding guidelines, 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. 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.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

19. Coding for Healthcare Encounters in Hurricane Aftermath

a. Use of External Cause of Morbidity Codes

An external cause of morbidity code should be assigned to identify the cause of the injury(ies) incurred as a result of the hurricane. The use of external cause of morbidity codes is supplemental to the application of ICD-10-CM codes. External cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes. The external cause of morbidity codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person’s status (e.g., civilian, military). They should not be assigned for encounters to treat hurricane victims’ medical conditions when no injury, adverse effect or poisoning is involved. External cause of morbidity codes should be assigned for each encounter for care and treatment of the injury. External cause of morbidity codes may be

assigned in all health care settings. For the purpose of capturing complete and accurate ICD-10-CM data in the aftermath of the hurricane, a healthcare setting should be considered as any location where medical care is provided by licensed healthcare professionals.

b. Sequencing of External Causes of Morbidity Codes

Codes for cataclysmic events, such as a hurricane, take priority over all other external cause codes except child and adult abuse and terrorism and should be sequenced before other external cause of injury codes. Assign as many external cause of morbidity codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapse during the hurricane, external cause codes for both the hurricane and the building collapse should be assigned, with the external causes code for hurricane being sequenced as the first external cause code. For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by the code X37.0-, Hurricane (with the appropriate 7th character), and any other applicable external cause of injury codes. Code X37.0- also should be assigned when an injury is incurred as a result of flooding caused by a levee breaking related to the hurricane. Code X38.-, Flood (with the appropriate 7th character), should be assigned when an injury is from flooding resulting directly from the storm. Code X36.0.-, Collapse of dam or man-made structure, should not be assigned when the cause of the collapse is due to the hurricane. Use of code X36.0- is limited to collapses of man-made structures due to earth surface movements, not due to storm surges directly from a hurricane.

c. Other External Causes of Morbidity Code Issues

For injuries that are not a direct result of the hurricane, such as an evacuee that has incurred an injury as a result of a motor vehicle accident, assign the appropriate external cause of morbidity code(s) to describe the cause of the injury, but do not assign code X37.0-, Hurricane. If it is not clear whether the injury was a direct result of the hurricane, assume the injury is due to the hurricane and assign code X37.0-, Hurricane, as well as any other applicable external cause of morbidity codes. In addition to code X37.0-, Hurricane, other possible applicable external cause of morbidity codes include:

X30-, Exposure to excessive natural heat
X31-, Exposure to excessive natural cold
X38-, Flood

d. Use of Z codes

Z codes (other reasons for healthcare encounters) may be assigned as appropriate to further explain the reasons for presenting for healthcare services, including transfers between healthcare facilities, **or provide additional information relevant to a patient encounter.** The ICD-10-CM Official Guidelines for Coding and Reporting identify which codes may be assigned as principal or first-listed diagnosis only, secondary diagnosis only, or principal/first-listed or secondary (depending on the circumstances). Possible applicable Z codes include:

Z59.0-, Homelessness

Z59.1, Inadequate housing
 Z59.5, Extreme poverty
 Z75.1, Person awaiting admission to adequate facility elsewhere
 Z75.3, Unavailability and inaccessibility of health-care facilities
 Z75.4, Unavailability and inaccessibility of other helping agencies
 Z76.2, Encounter for health supervision and care of other healthy infant and child
 Z99.12, Encounter for respirator [ventilator] dependence during power failure

The external cause of morbidity codes and the Z codes listed above are not an all-inclusive list. Other codes may be applicable to the encounter based upon the documentation. Assign as many codes as necessary to fully explain each healthcare encounter. Since patient history information may be very limited, use any available documentation to assign the appropriate external cause of morbidity and Z codes.

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: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9

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 B20, Human immunodeficiency virus [HIV] disease 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 B20 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

Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, 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” or “HIV disease” 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 B20 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 R75, Inconclusive laboratory evidence of 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 B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

(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 O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by B20 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 O98.7- and Z21.

(h) Encounters for testing for HIV

If a patient is being seen to determine his/her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high-risk behavior, **if applicable**.

If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, 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 and the test result is negative, use code Z71.7, Human immunodeficiency virus [HIV] counseling.

If the results are positive, see previous guidelines and assign codes as appropriate.

(i) History of HIV managed by medication

If a patient with documented history of HIV disease is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease. Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications.

b. Infectious agents as the cause of diseases classified to other chapters

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

c. Infections resistant to antibiotics

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.

d. Sepsis, Severe Sepsis, and Septic Shock Infections resistant to antibiotics

1) Coding of Sepsis and Severe Sepsis

(a) Sepsis

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

(i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

(ii) Urosepsis

The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii) Sepsis with organ dysfunction

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

(iv) 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 a code from subcategory R65.2, 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.

(b) Severe sepsis

The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is

not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) 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 code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional codes for the 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.

3) Sequencing of severe sepsis

If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission), the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

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 severe sepsis was present on admission, the provider should be queried.

4) Sepsis or severe sepsis with a localized infection

If the reason for admission is sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn't develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

5) 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 a postprocedural infection

For infections following a procedure, a code from T81.40, to T81.43 Infection following a procedure, or a code from O86.00 to O86.03, Infection of obstetric surgical wound, that identifies the site of the infection should be coded first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2, Infections following infusion, transfusion, and therapeutic injection, or code T88.0-, Infection following immunization, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional codes(s) for any acute organ dysfunction.

(c) Postprocedural infection and postprocedural septic shock

If a postprocedural infection has resulted in postprocedural septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock. Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.

6) Sepsis and severe sepsis associated with a noninfectious process (condition)

In some cases, a noninfectious process (condition) 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 noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis is present, a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis, it should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.

See Section I.C.18. SIRS due to non-infectious process

7) Sepsis and septic shock complicating abortion, pregnancy, childbirth, and the puerperium

See Section I.C.15. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

8) Newborn sepsis

See Section I.C.16.f. Bacterial sepsis of Newborn

e. 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., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.02, Sepsis due to Methicillin resistant *Staphylococcus aureus* or code J15.212, Pneumonia due to Methicillin resistant *Staphylococcus aureus*). Do not assign code B95.62, Methicillin resistant *Staphylococcus aureus* infection as the cause of diseases classified elsewhere, as an additional code, because the combination code includes the type of infection and the MRSA organism. Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

See Section C.I. for instructions on coding and sequencing of sepsis and severe sepsis.

(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, assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant *Staphylococcus aureus* infection as the cause of diseases classified elsewhere for the MRSA infection. Do not assign a code from subcategory Z16.11, Resistance 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 MRSA 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 Z22.322, Carrier or suspected carrier of Methicillin resistant *Staphylococcus aureus*, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin susceptible *Staphylococcus aureus*, for patients 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.

(d) MRSA colonization and infection

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code Z22.322, Carrier or suspected carrier of Methicillin resistant *Staphylococcus aureus*, and a code for the MRSA infection may both be assigned.

f. Zika virus infections

1) Code only confirmed cases

Code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of the type of test performed; the provider’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.

If the provider documents “suspected”, “possible” or “probable” Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.821, Contact with and (suspected) exposure to Zika virus.

g. Coronavirus infections**1) COVID-19 infection (infection due to SARS-CoV-2)****(a) Code only confirmed cases**

Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, or documentation of a positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of a positive test result for COVID-19; the provider’s documentation that the individual has COVID-19 is sufficient.

If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

(b) Sequencing of codes

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium

See Section I.C.16.h. for COVID-19 infection in newborn

For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.

(c) Acute respiratory manifestations of COVID-19

When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.

The following conditions are examples of common respiratory manifestations of COVID-19.

(i) Pneumonia

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.82, Pneumonia due to coronavirus disease 2019.

(ii) Acute bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms.

Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

(iii) Lower respiratory infection

If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.

If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

(iv) Acute respiratory distress syndrome

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

(v) Acute respiratory failure

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

(d) Non-respiratory manifestations of COVID-19

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

(e) Exposure to COVID-19

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19.

For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. See guideline

I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

If COVID-19 is confirmed, see guideline I.C.1.g.1.a.

(f) Screening for COVID-19

During the COVID-19 pandemic, a screening code is generally not appropriate. Do not assign code Z11.52, Encounter for screening for COVID-19. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e).

Coding guidance will be updated as new information concerning any changes in the pandemic status becomes available.

(g) Signs and symptoms without definitive diagnosis of COVID-19

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

- R05.1, Acute cough, or R05.9, Cough, unspecified
- R06.02 Shortness of breath
- R50.9 Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822, Contact with and (suspected) exposure to COVID-19, as an additional code.

(h) Asymptomatic individuals who test positive for COVID-19

For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

(i) Personal history of COVID-19

For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.

(j) Follow-up visits after COVID-19 infection has resolved

For individuals who previously had COVID-19, **without residual symptom(s) or condition(s)**, and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19.

For follow-up visits for individuals with symptom(s) or condition(s) related to a previous COVID-19 infection, see guideline I.C.1.g.1.m.

See Section I.C.21.c.8, Factors influencing health states and contact with health services, Follow-up

(k) Encounter for antibody testing

For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination.

Follow the applicable guidelines above if the individual is being tested to confirm a current COVID-19 infection.

For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.

(l) Multisystem Inflammatory Syndrome

For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis.

If an individual with a history of COVID-19 develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and **U09.9, Post COVID-19 condition, unspecified.**

If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19.

Additional codes should be assigned for any associated complications of MIS.

(m) Post COVID-19 Condition

For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified.

Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection.

If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

(n) Underimmunization for COVID-19 Status

Code Z18.310, Unvaccinated for COVID-19, may be assigned when the patient has not received at least one dose of any COVID-19 vaccine. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention (CDC) definition of “fully vaccinated” in place at the time of the encounter. For information, visit the CDC’s website <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/>.

2. Chapter 2: Neoplasms (C00-D49)

General Guidelines

Chapter 2 of the ICD-10-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.

Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion'), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to malignant neoplasm of pancreas, unspecified (C25.9).

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 List 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.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.0, 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 external beam radiation therapy, assign the appropriate Z51.-- 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 code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5-, Adverse effect of antineoplastic and immunosuppressive drugs).

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy 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 at that site, a code from category Z85, 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 diagnosis with the Z85 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 code for the neoplasm should be assigned as principal or first-listed diagnosis.

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 external beam radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, 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.

If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned.

3) Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications

When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

When a patient is admitted for the purpose of insertion or implantation of radioactive elements (e.g., brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy 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 abnormal findings listed in Chapter 18 associated with neoplasms

Symptoms, signs, and ill-defined conditions listed in Chapter 18 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.

See section I.C.21. Factors influencing health status and contact with health services, Encounter for prophylactic organ removal.

h. Admission/encounter for pain control/management

See Section I.C.6. for information on coding admission/encounter for pain control/management.

i. Malignancy in two or more noncontiguous sites

A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be unclear, the provider should be queried as to the status of each tumor so that the correct codes can be assigned.

j. Disseminated malignant neoplasm, unspecified

Code C80.0, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

k. Malignant neoplasm without specification of site

Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. This code should rarely be used in the inpatient setting.

l. Sequencing of neoplasm codes**1) Encounter for treatment of primary malignancy**

If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal/first-listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.

2) Encounter for treatment of secondary malignancy

When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

3) Malignant neoplasm in a pregnant patient

When a pregnant **patient** has a malignant neoplasm, a code from subcategory O9A.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

4) Encounter for complication associated with a neoplasm

When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.

The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is

sequenced as the principal or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

5) Complication from surgical procedure for treatment of a neoplasm

When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first-listed diagnosis. See the guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

6) Pathologic fracture due to a neoplasm

When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

m. Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Codes from subcategories Z85.0 – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

n. Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history

The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of

lymphoid, hematopoietic and related tissues. If the documentation is unclear as to whether the leukemia has achieved remission, the provider should be queried.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

o. Aftercare following surgery for neoplasm

See Section I.C.21. Factors influencing health status and contact with health services, Aftercare

p. Follow-up care for completed treatment of a malignancy

See Section I.C.21. Factors influencing health status and contact with health services, Follow-up

q. Prophylactic organ removal for prevention of malignancy

See Section I.C. 21, Factors influencing health status and contact with health services, Prophylactic organ removal

r. 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 category T86.-, Complications of transplanted organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

s. Breast Implant Associated Anaplastic Large Cell Lymphoma

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a type of lymphoma that can develop around breast implants. Assign code C84.7A, Anaplastic large cell lymphoma, ALK-negative, breast, for BIA-ALCL. Do not assign a complication code from chapter 19.

3. Chapter 3: Disease of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)

Reserved for future guideline expansion

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

1) Type of diabetes

The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 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 E11.-, Type 2 diabetes mellitus.

3) Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned. **Additional** code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, **or injectable non-insulin antidiabetic, as follows:**

If the patient is treated with both oral medications and insulin, **both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs**, should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.899, Other long term (current) drug therapy.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

4) Diabetes mellitus in pregnancy and gestational diabetes

See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

5) Complications due to insulin pump malfunction

(a) Underdose of insulin due to insulin pump failure

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3X6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes

mellitus and any associated complications due to the underdosing should also be assigned.

(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 T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3X1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

6) Secondary diabetes mellitus

Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified 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) Secondary diabetes mellitus and the use of insulin, oral hypoglycemic drugs, or injectable non-insulin drugs

For patients with secondary diabetes mellitus who routinely use insulin, oral hypoglycemic drugs, **or injectable non-insulin drugs**, additional code(s) from category Z79 should be assigned to identify the long-term (current) use of insulin, oral hypoglycemic drugs, **or non-injectable non-insulin drugs as follows:**

If the patient is treated with both oral medications and insulin, **both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs**, should be assigned.

If the patient is treated with both insulin and an injectable non- insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.899, Other long-term (current) drug therapy.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter.

(b) 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 Tabular List instructions for categories E08, E09 and E13.

(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 E89.1, Postprocedural hypoinsulinemia. Assign a code from category E13 and a code from subcategory Z90.41, Acquired absence of pancreas, as additional codes.

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or sequela of poisoning.

See section I.C.19.e for coding of adverse effects and poisoning, and section I.C.20 for external cause code reporting.

5. Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01 – F99)

a. Pain disorders related to psychological factors

Assign code F45.41, for pain that is exclusively related to psychological disorders. As indicated by the Excludes 1 note under category G89, a code from category G89 should not be assigned with code F45.41.

Code F45.42, Pain disorders with related psychological factors, should be used with a code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

See Section I.C.6. Pain

b. Mental and behavioral disorders due to psychoactive substance use

1) In Remission

Selection of codes for “in remission” for categories F10-F19, Mental and behavioral disorders due to psychoactive substance use (categories F10-F19 with -.11, -.21) requires the provider’s clinical judgment. The appropriate codes for “in remission” are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification.

Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission, and moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission.

2) **Psychoactive Substance Use, Abuse and Dependence**

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

3) **Psychoactive Substance Use, Unspecified**

As with all other unspecified diagnoses, the codes for unspecified psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, F19.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a **substance related** disorder (chapter 5 **disorders** such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) **or medical condition**, and such a relationship is documented by the provider.

4) **Medical Conditions Due to Psychoactive Substance Use, Abuse and Dependence**

Medical conditions due to substance use, abuse, and dependence are not classified as substance-induced disorders. Assign the diagnosis code for the medical condition as directed by the Alphabetical Index along with the appropriate psychoactive substance use, abuse or dependence code. For example, for alcoholic pancreatitis due to alcohol dependence, assign the appropriate code from subcategory K85.2, Alcohol induced acute pancreatitis, and the appropriate code from subcategory F10.2, such as code F10.20, Alcohol dependence, uncomplicated. It would not be appropriate to assign code F10.288, Alcohol dependence with other alcohol-induced disorder.

5) **Blood Alcohol Level**

A code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, may be assigned when this information is documented and the patient's provider has documented a condition classifiable to category F10, Alcohol related disorders. The blood alcohol level does not need to be documented by the patient's provider in order for it to be coded.

c. Factitious Disorder

Factitious disorder imposed on self or Munchausen's syndrome is a disorder in which a person falsely reports or causes his or her own physical or psychological signs or symptoms. For patients with documented factitious disorder on self or Munchausen's syndrome, assign the appropriate code from subcategory F68.1-, Factitious disorder imposed on self.

Munchausen's syndrome by proxy (MSBP) is a disorder in which a caregiver (perpetrator) falsely reports or causes an illness or injury in another person (victim) under his or her care, such as a child, an elderly adult, or a person who has a disability. The condition is also referred to as "factitious disorder imposed on another" or "factitious disorder by proxy." The perpetrator, not the victim, receives this diagnosis. Assign code F68.A, Factitious disorder imposed on another, to the perpetrator's record. For the victim of a patient suffering from MSBP, assign the appropriate code from categories T74, Adult and child abuse, neglect and other maltreatment, confirmed, or T76, Adult and child abuse, neglect and other maltreatment, suspected.

See Section I.C.19.f. Adult and child abuse, neglect and other maltreatment

6. Chapter 6: Diseases of the Nervous System (G00-G99)

a. Dominant/nondominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

b. Pain - Category G89

1) General coding information

Codes in category G89, Pain, not elsewhere classified, 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, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 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.

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 G89 should be assigned.

(a) Category G89 Codes as Principal or First-Listed Diagnosis

Category G89 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 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 G89 Codes in Conjunction with Site Specific Pain Codes

(i) Assigning Category G89 and Site-Specific Pain Codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 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 G89 Codes with Site-Specific Pain Codes

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 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 G89 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 G89.11, Acute pain due to trauma, followed by code M54.2, 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 G89.

2) Pain due to devices, implants and grafts

See Section I.C.19. Pain due to medical devices

3) 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*.

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 G89.

(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 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

4) Chronic pain

Chronic pain is classified to subcategory G89.2. 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 G89.3 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 G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

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

Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term "chronic pain," and therefore codes should only be used when the provider has specifically documented this condition.

See Section I.C.5. Pain disorders related to psychological factors

7. Chapter 7: Diseases of the Eye and Adnexa (H00-H59)**a. Glaucoma****1) Assigning Glaucoma Codes**

Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage.

2) Bilateral glaucoma with same type and stage

When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and there is a code for bilateral glaucoma, report only the code for the type of glaucoma, bilateral, with the seventh character for the stage.

When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and the classification does not provide a code for bilateral glaucoma (i.e. subcategories H40.10, and H40.20)

report only one code for the type of glaucoma with the appropriate seventh character for the stage.

3) Bilateral glaucoma stage with different types or stages

When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

When a patient has bilateral glaucoma and each eye is documented as having a different type, and the classification does not distinguish laterality (i.e., subcategories H40.10, and H40.20), assign one code for each type of glaucoma with the appropriate seventh character for the stage.

When a patient has bilateral glaucoma and each eye is documented as having the same type, but different stage, and the classification does not distinguish laterality (i.e., subcategories H40.10 and H40.20), assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

4) 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.

5) Indeterminate stage glaucoma

Assignment of the seventh character “4” for “indeterminate stage” should be based on the clinical documentation. The seventh character “4” is used for glaucomas whose stage cannot be clinically determined. This seventh character should not be confused with the seventh character “0”, unspecified, which should be assigned when there is no documentation regarding the stage of the glaucoma.

b. Blindness

If “blindness” or “low vision” of both eyes is documented but the visual impairment category is not documented, assign code H54.3, Unqualified visual loss, both eyes. If “blindness” or “low vision” in one eye is documented but the visual impairment category is not documented, assign a code from H54.6-, Unqualified visual loss, one eye. If “blindness” or “visual loss” is documented without any information about whether one or both eyes are affected, assign code H54.7, Unspecified visual loss.

8. Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)

Reserved for future guideline expansion

9. Chapter 9: Diseases of the Circulatory System (I00-I99)

a. Hypertension

The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

1) Hypertension with Heart Disease

Hypertension with heart conditions classified to I50.- or I51.4- I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension. Sequence according to the circumstances of the admission/encounter.

2) Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

4) Hypertensive Cerebrovascular Disease

For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

5) Hypertensive Retinopathy

Subcategory H35.0, Background retinopathy and retinal vascular changes, should be used along with a code from categories I10 – I15, in the Hypertensive diseases section, to include the systemic hypertension. The sequencing is based on the reason for the encounter.

6) Hypertension, Secondary

Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

7) Hypertension, Transient

Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Pre-eclampsia, for transient hypertension of pregnancy.

8) Hypertension, Controlled

This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign the appropriate code from categories I10-I15, Hypertensive diseases.

9) 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 I10-I15, Hypertensive diseases.

10) Hypertensive Crisis

Assign a code from category I16, Hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15). The sequencing is based on the reason for the encounter.

11) Pulmonary Hypertension

Pulmonary hypertension is classified to category I27, Other pulmonary heart diseases. For secondary pulmonary hypertension (I27.1, I27.2-), code also any associated conditions or adverse effects of drugs or toxins. The sequencing is based on the reason for the encounter, except for adverse effects of drugs (See Section I.C.19.e.).

b. Atherosclerotic Coronary Artery Disease and Angina

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

See Section I.C.9. Acute myocardial infarction (AMI)

c. Intraoperative and Postprocedural Cerebrovascular Accident

Medical record documentation should clearly specify the cause- and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident.

Proper code assignment depends on whether it was an infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral hemorrhage, code assignment depends on the type of procedure performed.

d. Sequelae of Cerebrovascular Disease

1) Category I69, Sequelae of Cerebrovascular disease

Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. 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 categories I60-I67.

Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

2) Codes from category I69 with codes from I60-I67

Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.

3) Codes from category I69 and Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)

Codes from category I69 should not be assigned if the patient does not have neurologic deficits.

See Section I.C.21. 4. History (of) for use of personal history codes

e. Acute myocardial infarction (AMI)

1) Type 1 ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI)

The ICD-10-CM codes for type 1 acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for type 1 ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for type 1 non-ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

If a type 1 NSTEMI evolves to STEMI, assign the STEMI code. If a type 1 STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the myocardial infarction meets the definition for “other diagnoses” (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported. For encounters after the 4-week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

2) Acute myocardial infarction, unspecified

Code I21.9, Acute myocardial infarction, unspecified, is the default for unspecified acute myocardial infarction or unspecified type. If only type 1 STEMI or transmural MI without the site is documented, assign code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site.

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.

See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

4) Subsequent acute myocardial infarction

A code from category I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered a type 1 or unspecified AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified. For subsequent type 2 AMI assign only code I21.A1. For subsequent type 4 or type 5 AMI, assign only code I21.A9.

If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.

5) Other Types of Myocardial Infarction

The ICD-10-CM provides codes for different types of myocardial infarction. Type 1 myocardial infarctions are assigned to codes I21.0-I21.4.

Type 2 myocardial infarction (myocardial infarction due to demand ischemia or secondary to ischemic imbalance) is assigned to code I21.A1, Myocardial infarction type 2 with the underlying cause coded first. Do not assign code I24.8, Other forms of acute ischemic heart disease, for the demand ischemia. If a type 2 AMI is described as NSTEMI or STEMI, only assign code I21.A1. Codes I21.01-I21.4 should only be assigned for type 1 AMIs.

Acute myocardial infarctions type 3, 4a, 4b, 4c and 5 are assigned to code I21.A9, Other myocardial infarction type.

The "Code also" and "Code first" notes should be followed related to complications, and for coding of postprocedural myocardial infarctions during or following cardiac surgery.

10. Chapter 10: Diseases of the Respiratory System (J00-J99), U07.0

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

1) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes in categories J44 and J45 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.

b. Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis

A code from subcategory J96.0, Acute respiratory failure, or subcategory J96.2, Acute and chronic 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.

c. Influenza due to certain identified influenza viruses

Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). 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 or other novel influenza A or other identified influenza virus. However, coding should be based on the provider’s diagnostic statement that the patient has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10.

If the provider records “suspected” or “possible” or “probable” avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J11, Influenza due to unidentified influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned nor should a code from category J10, Influenza due to other identified influenza virus.

d. Ventilator associated Pneumonia

1) 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 J95.851, 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 B96.5) should also be assigned. Do not assign an

additional code from categories J12-J18 to identify the type of pneumonia.

Code J95.851 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator and 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.

2) Ventilator associated Pneumonia Develops after Admission

A patient may be admitted with one type of pneumonia (e.g., code J13, Pneumonia due to *Streptococcus pneumoniae*) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories J12-J18 for the pneumonia diagnosed at the time of admission. Code J95.851, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

e. Vaping-related disorders

For patients presenting with condition(s) related to vaping, assign code U07.0, Vaping-related disorder, as the principal diagnosis. For lung injury due to vaping, assign only code U07.0. Assign additional codes for other manifestations, such as acute respiratory failure (subcategory J96.0-) or pneumonitis (code J68.0).

Associated respiratory signs and symptoms due to vaping, such as cough, shortness of breath, etc., are not coded separately, when a definitive diagnosis has been established. However, it would be appropriate to code separately any gastrointestinal symptoms, such as diarrhea and abdominal pain.

See Section I.C.1.g.1.c.i. for Pneumonia confirmed as due to COVID-19

11. Chapter 11: Diseases of the Digestive System (K00-K95)

Reserved for future guideline expansion

12. Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Codes in category L89, Pressure ulcer, identify the site and stage of the pressure ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, deep tissue pressure injury, unspecified stage, and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

See Section I.B.14 for pressure ulcer stage documentation by clinicians other than patient's provider.

2) Unstageable pressure ulcers

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are 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). This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.-- 9).

If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.

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 Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

4) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed at the time of admission.

5) 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 the appropriate code for unspecified stage.

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.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

6) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

7) Pressure-induced deep tissue damage

For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).

b. Non-Pressure Chronic Ulcers**1) Patients admitted with non-pressure ulcers documented as healed**

No code is assigned if the documentation states that the non-pressure ulcer is completely healed at the time of admission.

2) Non-pressure ulcers documented as healing

Non-pressure ulcers described as healing should be assigned the appropriate non-pressure ulcer code based on the documentation in the medical record. If the documentation does not provide information about the severity of the healing non-pressure ulcer, assign the appropriate code for unspecified severity.

If the documentation is unclear as to whether the patient has a current (new) non-pressure ulcer or if the patient is being treated for a healing non-pressure ulcer, query the provider.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission.

3) Patient admitted with non-pressure ulcer that progresses to another severity level during the admission

If a patient is admitted to an inpatient hospital with a non-pressure ulcer at one severity level and it progresses to a higher severity level, two separate codes should be assigned: one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay.

See Section I.B.14 for pressure ulcer stage documentation by clinicians other than patient's provider

13. **Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)**

a. Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a “multiple sites” code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

b. Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

c. Coding of Pathologic Fractures

7th character A is for use as long as the patient is receiving active treatment for the fracture. While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

7th character D is to be used for encounters after the patient has completed active treatment for the fracture and is receiving routine care for the fracture during the healing or recovery phase. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

See Section I.C.19. Coding of traumatic fractures.

d. Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

1) Osteoporosis without pathological fracture

Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow the code from M81.

2) Osteoporosis with current pathological fracture

Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

e. Multisystem Inflammatory Syndrome

See Section I.C.1.g.1.1 for Multisystem Inflammatory Syndrome

14. Chapter 14: Diseases of Genitourinary System (N00-N99)**a. Chronic kidney disease****1) Stages of chronic kidney disease (CKD)**

The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, codes N18.30-N18.32, equate to moderate CKD; and stage 4, code N18.4, equates to severe CKD. Code N18.6, 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 N18.6 only.

2) Chronic kidney disease and kidney transplant status

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. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18

code for the patient's stage of CKD and code Z94.0, Kidney transplant status. If a transplant complication such as failure or rejection or other transplant complication is documented, see section I.C.19.g 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.9. Hypertensive chronic kidney disease.

See I.C.19. Chronic kidney disease and kidney transplant complications.

15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)

a. General Rules for Obstetric Cases

1) Codes from chapter 15 and sequencing priority

Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1, Pregnant state, incidental, should be used in place of any chapter 15 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

2) Chapter 15 codes used only on the maternal record

Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.

3) Final character for trimester

The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code, it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one.

Assignment of the final character for trimester should be based on the provider's documentation of the trimester (or number of weeks) for the current admission/encounter. This applies to the assignment of trimester

for pre-existing conditions as well as those that develop during or are due to the pregnancy. The provider's documentation of the number of weeks may be used to assign the appropriate code identifying the trimester.

Whenever delivery occurs during the current admission, and there is an "in childbirth" option for the obstetric complication being coded, the "in childbirth" code should be assigned. **When the classification does not provide an obstetric code with an "in childbirth" option, it is appropriate to assign a code describing the current trimester.**

4) Selection of trimester for inpatient admissions that encompass more than one trimester

In instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester of the discharge. If the condition developed prior to the current admission/encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission/encounter should be assigned.

5) Unspecified trimester

Each category that includes codes for trimester has a code for "unspecified trimester." The "unspecified trimester" code should rarely be used, such as when the documentation in the record is insufficient to determine the trimester and it is not possible to obtain clarification.

6) 7th character for Fetus Identification

Where applicable, a 7th character is to be assigned for certain categories (O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69) to identify the fetus for which the complication code applies.

Assign 7th character "0":

- For single gestations
- When the documentation in the record is insufficient to determine the fetus affected and it is not possible to obtain clarification.
- When it is not possible to clinically determine which fetus is affected.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.

2) Supervision of High-Risk Pregnancy

Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign code O80, Encounter for full-term uncomplicated delivery.

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 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 complication codes may be sequenced first.

4) When a delivery occurs

When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis. If multiple conditions prompted the admission, sequence the one most related to the delivery as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis. In cases of cesarean delivery, 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 was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission should be selected as the principal diagnosis.

5) Outcome of delivery

A code from category Z37, Outcome of delivery, 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. Pre-existing conditions versus conditions due to the pregnancy

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for

the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

d. Pre-existing hypertension in pregnancy

Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease.

See Section I.C.9. Hypertension.

e. Fetal Conditions Affecting the Management of the Mother

1) Codes from categories O35 and O36

Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, 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.

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.

No code from Chapter 16, 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.

f. 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 from subcategory O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by 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 O98.7- and Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

g. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant patients who are diabetic should be assigned a code from category O24,

Diabetes mellitus in pregnancy, childbirth, and the puerperium, first, followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4.

h. Long term use of insulin and oral hypoglycemics

See section I.C.4.a.3 for information on the long-term use of insulin and oral hypoglycemics.

i. Gestational (pregnancy induced) diabetes

Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in **patients** 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 **patient** at greater risk of developing diabetes after the pregnancy.

Codes for gestational diabetes are in subcategory O24.4, Gestational diabetes mellitus. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.

The codes under subcategory O24.4 include diet controlled, insulin controlled, and controlled by oral hypoglycemic drugs. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. If a patient with gestational diabetes is treated with both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required. Code Z79.4, Long-term (current) use of insulin or code Z79.84, Long-term (current) use of oral hypoglycemic drugs, should not be assigned with codes from subcategory O24.4.

An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

j. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

When assigning a chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis. If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction(s) should also be assigned as additional diagnoses.

k. Puerperal sepsis

Code O85, 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 B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A40, Streptococcal sepsis, or A41, Other sepsis, should not be used for puerperal sepsis. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

Code O85 should not be assigned for sepsis following an obstetrical procedure (See Section I.C.1.d.5.b., Sepsis due to a postprocedural infection).

I. Alcohol, tobacco and drug use during pregnancy, childbirth and the puerperium

1) Alcohol use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.31, Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a **patient** uses alcohol during the pregnancy or postpartum. A secondary code from category F10, Alcohol related disorders, should also be assigned to identify manifestations of the alcohol use.

2) Tobacco use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.33, Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a patient uses any type of tobacco product during the pregnancy or postpartum.

A secondary code from category F17, Nicotine dependence, should also be assigned to identify the type of nicotine dependence.

3) Drug use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.32, Drug use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a **patient** uses drugs during the pregnancy or postpartum. This can involve illegal drugs, or inappropriate use or abuse of prescription drugs. Secondary code(s) from categories F11-F16 and F18-F19 should also be assigned to identify manifestations of the drug use.

m. Poisoning, toxic effects, adverse effects and underdosing in a pregnant patient

A code from subcategory O9A.2, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate injury, poisoning, toxic effect, adverse effect or underdosing code, and then the additional code(s) that specifies the condition caused by the poisoning, toxic effect, adverse effect or underdosing.

See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects.

n. Normal Delivery, Code O80

1) Encounter for full term uncomplicated delivery

Code O80 should be assigned when a **patient** 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 O80 is always a principal diagnosis. It is not to be

used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or postnatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

2) Uncomplicated delivery with resolved antepartum complication

Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of the admission for delivery.

3) Outcome of delivery for O80

Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

o. The Peripartum and Postpartum Periods

1) Peripartum and Postpartum 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) Peripartum and postpartum complication

A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6-week period

Chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related.

4) 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 Z39.0, Encounter for care and examination of mother immediately after delivery, should be assigned as the principal diagnosis.

5) Pregnancy associated cardiomyopathy

Pregnancy associated cardiomyopathy, code O90.3, is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Code O90.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a **patient** who did not have pre-existing heart disease.

p. Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

1) Code O94

Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium, is for use in those cases when an initial complication of a pregnancy develops a **sequela or** 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 O94

This code, like all sequela codes, is to be sequenced following the code describing the sequelae of the complication.

q. Termination of Pregnancy and Spontaneous abortions

1) Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus, assign code Z33.2, Encounter for elective termination of pregnancy and a code from category Z37, Outcome of Delivery.

2) Retained Products of Conception following an abortion

Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy, without complications are assigned O03.4, Incomplete spontaneous abortion without complication, or code O07.4, Failed attempted termination of pregnancy without complication. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion. If the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy in addition to retained products of conception, assign the appropriate complication code (e.g., O03.-, O04.-, O07.-) instead of code O03.4 or O07.4.

3) Complications leading to abortion

Codes from Chapter 15 may be used as additional codes to identify any documented complications of the pregnancy in conjunction with codes in categories in O04, O07 and O08.

r. Abuse in a pregnant patient

For suspected or confirmed cases of abuse of a pregnant patient, a code(s) from subcategories O9A.3, Physical abuse complicating pregnancy, childbirth, and the puerperium, O9A.4, Sexual abuse complicating pregnancy, childbirth, and the puerperium, and O9A.5, Psychological abuse complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the

appropriate codes (if applicable) to identify any associated current injury due to physical abuse, sexual abuse, and the perpetrator of abuse.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment.

s. COVID-19 infection in pregnancy, childbirth, and the puerperium

During pregnancy, childbirth or the puerperium, when COVID-19 is the reason for admission/encounter, code O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, should be sequenced as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) should be assigned as additional diagnoses. Codes from Chapter 15 always take sequencing priority.

If the reason for admission/encounter is unrelated to COVID-19 but the patient tests positive for COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first-listed diagnosis, and codes O98.5- and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, should be assigned as additional diagnoses.

16. Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)

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.

a. General Perinatal Rules

1) Use of Chapter 16 Codes

Codes in this chapter are never for use on the maternal record. Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record. Chapter 16 codes may be used throughout the life of the patient if the condition is still present.

2) Principal Diagnosis for Birth Record

When coding the birth episode in a newborn record, assign a code from category Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth. If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital.

A code from category Z38 is used only on the newborn record, not on the mother's record.

3) Use of Codes from other Chapters with Codes from Chapter 16

Codes from other chapters may be used with codes from chapter 16 if the codes from the other chapters provide more specific detail. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established. If the reason for the encounter is a perinatal condition, the code from chapter 16 should be sequenced first.

4) Use of Chapter 16 Codes after the Perinatal Period

Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient's age.

5) 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 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned.

For COVID-19 infection in a newborn, see guideline I.C.16.h.

6) 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.

b. Observation and Evaluation of Newborns for Suspected Conditions not Found

1) Use of Z05 codes

Assign a code from category Z05, Observation and evaluation of newborns and infants for suspected conditions ruled out, 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 Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom.

2) Z05 on other than the birth record

A code from category Z05 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 code no longer applies. Codes from category Z05 are for use only for healthy newborns and infants for which no condition after study is found to be present.

3) Z05 on a birth record

A code from category Z05 is to be used as a secondary code after the code from category Z38, Liveborn infants according to place of birth and type of delivery.

c. 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.

d. Prematurity and Fetal Growth Retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age.

When both birth weight and gestational age are available, two codes from category P07 should be assigned, with the code for birth weight sequenced before the code for gestational age.

e. Low birth weight and immaturity status

Codes from category P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, are for use for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient's current health status.

See Section I.C.21. Factors influencing health status and contact with health services, Status.

f. Bacterial Sepsis of Newborn

Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

g. Stillbirth

Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother's record.

h. COVID-19 Infection in Newborn

For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19. When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

17. Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)

Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

When a malformation/deformation or chromosomal abnormality 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 malformation/deformation or chromosomal abnormality, 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 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, a malformation/deformation/or chromosomal abnormality may not be identified until later

in life. Whenever the condition is diagnosed by the provider, it is appropriate to assign a code from codes Q00-Q99. For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00-Q99.

18. Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point to a specific diagnosis have been assigned to a category in other chapters of the classification.

a. Use of symptom codes

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

b. Use of a symptom code with a definitive diagnosis code

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.

Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

c. Combination codes that include symptoms

ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.

d. Repeated falls

Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.

Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

e. Coma

Code R40.20, Unspecified coma, may be assigned in conjunction with codes for any medical condition.

Do not report codes for **unspecified coma**, individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.

1) Coma Scale

The coma scale codes (R40.21- to **R40.24-**) can be used in conjunction with traumatic brain injury codes. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.

At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.

Assign code R40.24-, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).

If multiple coma scores are captured within the first 24 hours after hospital admission, assign only the code for the score at the time of admission. ICD-10-CM does not classify coma scores that are reported after admission but less than 24 hours later.

See Section I.B.14 for coma scale documentation by clinicians other than patient's provider

f. Functional quadriplegia

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2017

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 R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction. If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. 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.

h. Death NOS

Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

i. NIHSS Stroke Scale

The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).

At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

See Section I.B.14 for NIHSS stroke scale documentation by clinicians other than patient's provider

19. Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)

a. Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

7th character “A”, initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

7th character “D” subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

See Section I.B.10 Sequelae, (Late Effects)

b. 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. Codes from category T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available. Traumatic injury codes (S00- T14.9) 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) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

3) Iatrogenic injuries

Injury codes from Chapter 19 should not be assigned for injuries that occur during, or as a result of, a medical intervention. Assign the appropriate complication code(s).

c. 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 S02, S12, S22, S32, S42,

S49, S52, S59, S62, S72, S79, S82, S89, S92 and the level of detail furnished by medical record content.

A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

More specific guidelines are as follows:

1) Initial vs. subsequent encounter for fractures

Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) for each encounter where the patient is receiving active treatment for the fracture. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Fractures are coded using the appropriate 7th character for subsequent care 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.

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 7th character for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R).

Malunion/nonunion: The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

The open fracture designations in the assignment of the 7th character for fractures of the forearm, femur and lower leg, including ankle are based on the Gustilo open fracture classification. When the Gustilo classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned (B, E, H, M, Q).

A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

See Section I.C.13. Osteoporosis.

The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

2) Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture.

3) Physeal fractures

For physeal fractures, assign only the code identifying the type of physeal fracture. Do not assign a separate code to identify the specific bone that is fractured.

d. Coding of Burns and Corrosions

The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

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 anatomic site

Classify burns of the same anatomic site and on the same side but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis (e.g., for second and third degree burns of right thigh, assign only code T24.311-).

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) Infected burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

Codes for burns of "multiple sites" should only be assigned when the medical record documentation does not specify the individual sites.

6) Burns and corrosions classified according to extent of body surface involved

Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, **for acute burns or corrosions** when the site of the burn **or corrosion** is not specified or when there is a need for additional data. It is advisable to use category T31 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 T31 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. **Codes from categories T31 and T32 should not be used for sequelae of burns or corrosions.**

Categories T31 and T32 are 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 sequela of burns

Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character "S" for sequela.

8) Sequelae with a late effect code and current burn

When appropriate, both a code for a current burn or corrosion with 7th character "A" or "D" and a burn or corrosion code with 7th character "S" may be assigned on the same record (when both a current burn and sequelae of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

See Section I.B.10 Sequela (Late Effects)

9) Use of an external cause code with burns and corruptions

An external cause code should be used with burns and corruptions to identify the source and intent of the burn, as well as the place where it occurred.

e. Adverse Effects, Poisoning, Underdosing and Toxic Effects

Codes in categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes.

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.

3) If the same code would describe the causative agent

If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, 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 taken, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.

If multiple unspecified drugs, medicinal or biological substances were taken, assign the appropriate code from subcategory T50.91, Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances.

5) The occurrence of drug toxicity is classified in ICD-10-CM as follows:

(a) Adverse Effect

When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should have a 5th or 6th character "5" (for example T36.0X5-) Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

(b) Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined). If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined. Use additional code(s) for all manifestations of poisonings.

If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an additional code.

Examples of poisoning include:

(i) 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.

(ii) 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.

(iii) 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.

(iv) 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.

See Section I.C.4. if poisoning is the result of insulin pump malfunctions.

(c) Underdosing

Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also

classified as an underdosing. For underdosing, assign the code from categories T36-T50 (fifth or sixth character “6”).

Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.

Noncompliance (Z91.12-, Z91.13- and Z91.14-) or complication of care (Y63.6-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

(d) Toxic Effects

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 T51-T65.

Toxic effect codes have an associated intent: accidental, intentional self-harm, assault and undetermined.

f. Adult and child abuse, neglect and other maltreatment

Sequence first the appropriate code from categories T74, Adult and child abuse, neglect and other maltreatment, confirmed, or T76, Adult and child abuse, neglect and other maltreatment, suspected, for abuse, neglect and other maltreatment, followed by any accompanying mental health or injury code(s).

If the documentation in the medical record states abuse or neglect, it is coded as confirmed (T74.-). It is coded as suspected if it is documented as suspected (T76.-).

For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y09) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter code Z04.71, Encounter for examination and observation following alleged physical adult abuse, ruled out, or code Z04.72, Encounter for examination and observation following alleged child physical abuse, ruled out, should be used, not a code from T76.

If a suspected case of alleged rape or sexual abuse is ruled out during an encounter code Z04.41, Encounter for examination and observation following alleged adult rape or code Z04.42, Encounter for examination and observation following alleged child rape, should be used, not a code from T76.

If a suspected case of forced sexual exploitation or forced labor exploitation is ruled out during an encounter, code Z04.81, Encounter for examination and observation of victim following forced sexual exploitation, or code Z04.82, Encounter for examination and observation of victim following forced labor exploitation, should be used, not a code from T76.

See Section I.C.15. Abuse in a pregnant patient.

g. Complications of care

1) General guidelines for complications of care

(a) Documentation of complications of care

See Section I.B.16. for information on documentation of complications of care.

2) Pain due to medical devices

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 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

3) Transplant complications

(a) Transplant complications other than kidney

Codes under category T86, Complications of transplanted organs and tissues, 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 category T86 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.21. for transplant organ removal status

See I.C.2. 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 T86.1- should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code T86.1- 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 a code from subcategory T86.1, 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.14. Chronic kidney disease and kidney transplant status.*

4) Complication codes that include the external cause

As with certain other T codes, some of the complications of care codes have the external cause included in the code. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary for these codes.

5) Complications of care codes within the body system chapters

Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

Complication codes from the body system chapters should be assigned for intraoperative and postprocedural complications (e.g., the appropriate complication code from chapter 9 would be assigned for a vascular intraoperative or postprocedural complication) unless the complication is specifically indexed to a T code in chapter 19.

20. Chapter 20: External Causes of Morbidity (V00-Y99)

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

a. General External Cause Coding Guidelines

1) Used with any code in the range of A00.0-T88.9, Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that represents a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient's status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g., T36.0X1-, Poisoning by penicillins, accidental (unintentional)).

b. Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity Code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

d. Place of Occurrence, Activity, and Status Codes Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, generally there should be only one place of occurrence code, one activity code, and one external cause status code assigned

to an encounter. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

e. If the Reporting Format Limits the Number of External Cause Codes

If the reporting format limits the number of external cause 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 external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f. Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

External codes for child and adult abuse take priority over all other external cause codes.

See Section I.C.19., Child and Adult abuse guidelines.

External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.

External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.

External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause 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.

g. Child and Adult Abuse Guideline

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse.

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment

h. Unknown or Undetermined Intent Guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

1) Use of undetermined intent

External cause codes for events of undetermined intent are only for use if the documentation in the record specifies that the intent cannot be determined.

i. Sequelae (Late Effects) of External Cause Guidelines

1) Sequelae external cause codes

Sequela are reported using the external cause code with the 7th character “S” for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

See Section I.B.10 Sequela (Late Effects)

2) Sequela external cause code with a related current injury

A sequela external cause code should never be used with a related current nature of injury code.

3) Use of sequela external cause codes for subsequent visits

Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury when no late effect of the injury has been documented.

j. 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 external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

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 Y38 should not be assigned. Suspected cases should be classified as assault.

3) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, 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.

It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

k. External Cause Status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, 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 Y99, 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 Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

21. Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z Codes in Any Healthcare Setting

Z codes are for use in any healthcare setting. Z 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 Z codes may only be used as first-listed or principal diagnosis.

b. Z Codes Indicate a Reason for an Encounter or Provide Additional Information about a Patient Encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. Categories of Z Codes

1) Contact/Exposure

Category Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, Other contact with and (suspected) exposures hazardous to health, indicates contact with and suspected exposures hazardous to health.

Contact/exposure 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.

2) Inoculations and vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 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 either a carrier of a disease or has the sequelae or residual of a past disease or condition. 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 Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign a code from subcategory J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator [ventilator] status.

The status Z codes/categories are:

Z14 Genetic carrier
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.

Z15 Genetic susceptibility to disease
Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category Z15 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, code Z31.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

Z16 Resistance to antimicrobial drugs
This code indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z18 Retained foreign body fragments

Z19 Hormone sensitivity malignancy status

Z21 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.

Z22 Carrier of infectious disease
Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z28.3 Underimmunization status

Z33.1 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.

Z66 Do not resuscitate

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.

Z67

Blood type

Z68

Body mass index (BMI)

BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity).

Do not assign BMI codes during pregnancy.

See Section I.B.14 for BMI documentation by clinicians other than the patient's provider.

Z74.01

Bed confinement status

Z76.82

Awaiting organ transplant status

Z78

Other specified health status

Code Z78.1, Physical restraint status, 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.

Z79

Long-term (current) drug therapy

Codes from this category 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 (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug use, abuse, or dependence instead.

Assign a code from Z79 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 category Z79 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).

Z88

Allergy status to drugs, medicaments and biological substances

Except: Z88.9, Allergy status to unspecified drugs, medicaments and biological substances status

Z89

Acquired absence of limb

Z90

Acquired absence of organs, not elsewhere classified

Z91.0-

Allergy status, other than to drugs and biological substances

Z92.82 Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Assign code Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to 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 Z92.82 is only applicable to the receiving facility record and not to the transferring facility record.

Z93 Artificial opening status

Z94 Transplanted organ and tissue status

Z95 Presence of cardiac and vascular implants and grafts

Z96 Presence of other functional implants

Z97 Presence of other devices

Z98 Other postprocedural states

Assign code Z98.85, Transplanted 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.C19. for information on the coding of organ transplant complications.

Z99 Dependence on enabling machines and devices, not elsewhere classified

Note: Categories Z89-Z90 and Z93-Z99 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.

4) History (of)

There are two types of history Z 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.

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 reason for the encounter (for example, screening or counseling) should be sequenced first and the appropriate personal and/or family history code(s) should be assigned as additional diagnos(es).

The history Z code categories are:

Z80	Family history of primary malignant neoplasm
Z81	Family history of mental and behavioral disorders
Z82	Family history of certain disabilities and chronic diseases (leading to disablement)
Z83	Family history of other specific disorders
Z84	Family history of other conditions
Z85	Personal history of malignant neoplasm
Z86	Personal history of certain other diseases
Z87	Personal history of other diseases and conditions
Z91.4-	Personal history of psychological trauma, not elsewhere classified
Z91.5-	Personal history of self-harm
Z91.81	History of falling
Z91.82	Personal history of military deployment
Z92	Personal history of medical treatment
	Except: Z92.0, Personal history of contraception
	Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

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 (e.g., screening mammogram).

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 Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11	Encounter for screening for infectious and parasitic diseases
Z12	Encounter for screening for malignant neoplasms
Z13	Encounter for screening for other diseases and disorders Except: Z13.9, Encounter for screening, unspecified
Z36	Encounter for antenatal screening for mother

6) Observation

There are three observation Z 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 external cause code.

The observation codes are primarily to be used as a principal/first-listed diagnosis. An observation code may be assigned as a secondary diagnosis code when the patient is being observed for a condition that is ruled out and is unrelated to the principal/first-listed diagnosis. Also, when the principal diagnosis is required to be a code from category Z38, Liveborn infants according to place of birth and type of delivery, then a code from category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is sequenced after the Z38 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 Z03.7, Encounter for suspected maternal and fetal conditions ruled out, 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 Z03.7, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory Z03.7 may not be used for encounters for antenatal screening of mother. *See Section I.C.21. Screening.*

For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category O35, O36, O40 or O41.

The observation Z code categories:

- Z03 Encounter for medical observation for suspected diseases and conditions ruled out
- Z04 Encounter for examination and observation for other reasons
Except: Z04.9, Encounter for examination and observation for unspecified reason
- Z05 Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out

7) Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease 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 Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases. Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter).

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 other aftercare codes or 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 depends on the circumstances of the encounter.

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is included in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example, code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare Z category/codes:

Z42	Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43	Encounter for attention to artificial openings
Z44	Encounter for fitting and adjustment of external prosthetic device
Z45	Encounter for adjustment and management of implanted device
Z46	Encounter for fitting and adjustment of other devices
Z47	Orthopedic aftercare
Z48	Encounter for other postprocedural aftercare
Z49	Encounter for care involving renal dialysis
Z51	Encounter for other aftercare and medical care

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, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of 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 multiple visits. Should a condition be found to have recurred on the follow-up visit, then the

diagnosis code for the condition should be assigned in place of the follow-up code.

The follow-up Z code categories:

- Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
- Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z39 Encounter for maternal postpartum care and examination

9) Donor

Codes in category Z52, Donors of organs and tissues, are used for living individuals who are donating blood or other body tissue. These codes are for individuals donating for others, **as well as** for self-donations. They are not used to identify cadaveric donations.

10) Counseling

Counseling Z 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.

The counseling Z codes/categories:

- Z30.0- Encounter for general counseling and advice on contraception
- Z31.5 Encounter for procreative genetic counseling
- Z31.6- Encounter for general counseling and advice on procreation
- Z32.2 Encounter for childbirth instruction
- Z32.3 Encounter for childcare instruction
- Z69 Encounter for mental health services for victim and perpetrator of abuse
- Z70 Counseling related to sexual attitude, behavior and orientation
- Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified

Note: Code Z71.84, Encounter for health counseling related to travel, is to be used for health risk and safety counseling for future travel purposes.

Code Z71.85, Encounter for immunization safety counseling, is to be used for counseling of the patient or caregiver regarding the safety of a vaccine. This code should not be used for the provision of general information regarding risks and potential side effects during routine encounters for the administration of vaccines.

- Z76.81 Expectant mother prebirth pediatrician visit

11) Encounters for Obstetrical and Reproductive Services

See Section I.C.15. Pregnancy, Childbirth, and the Puerperium, for further instruction on the use of these codes.

Z 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 in category Z34, Encounter for supervision of normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O00-O08), elective termination of pregnancy (code Z33.2), nor for postpartum conditions, as category Z3A is not applicable to these conditions. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.

The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code.

Codes in category Z37 should not be used on the newborn record.

Z 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.

Z codes/categories for obstetrical and reproductive services:

Z30	Encounter for contraceptive management
Z31	Encounter for procreative management
Z32.2	Encounter for childbirth instruction
Z32.3	Encounter for childcare instruction
Z33	Pregnant state
Z34	Encounter for supervision of normal pregnancy
Z36	Encounter for antenatal screening of mother
Z3A	Weeks of gestation
Z37	Outcome of delivery
Z39	Encounter for maternal postpartum care and examination
Z76.81	Expectant mother prebirth pediatrician visit

12) Newborns and Infants

See Section I.C.16. Newborn (Perinatal) Guidelines, for further instruction on the use of these codes.

Newborn Z codes/categories:

Z76.1	Encounter for health supervision and care of foundling
Z00.1-	Encounter for routine child health examination
Z38	Liveborn infants according to place of birth and type of delivery

13) Routine and Administrative Examinations

The Z 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.

Some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

Pre-operative examination and pre-procedural laboratory examination Z 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 Z codes/categories for routine and administrative examinations:

Z00	Encounter for general examination without complaint, suspected or reported diagnosis
Z01	Encounter for other special examination without complaint, suspected or reported diagnosis
Z02	Encounter for administrative examination Except: Z02.9, Encounter for administrative examinations, unspecified
Z32.0-	Encounter for pregnancy test

14) **Miscellaneous Z Codes**

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. **Some** 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 an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

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 Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 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 Z codes/categories:

Z28	Immunization not carried out Except: Z28.3, Underimmunization status
Z29	Encounter for other prophylactic measures
Z40	Encounter for prophylactic surgery
Z41	Encounter for procedures for purposes other than remedying health state Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified
Z53	Persons encountering health services for specific procedures and treatment, not carried out
Z72	Problems related to lifestyle Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem
Z73	Problems related to life management difficulty
Z74	Problems related to care provider dependency Except: Z74.01, Bed confinement status
Z75	Problems related to medical facilities and other health care
Z76.0	Encounter for issue of repeat prescription
Z76.3	Healthy person accompanying sick person
Z76.4	Other boarder to healthcare facility
Z76.5	Malingerer [conscious simulation]
Z91.1-	Patient's noncompliance with medical treatment and regimen
Z91.83	Wandering in diseases classified elsewhere
Z91.84-	Oral health risk factors
Z91.89	Other specified personal risk factors, not elsewhere classified

See Section I.B.14 for Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances, documentation by clinicians other than the patient's provider

15) Nonspecific Z Codes

Certain Z 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 Z codes/categories:

Z02.9	Encounter for administrative examinations, unspecified
Z04.9	Encounter for examination and observation for unspecified reason
Z13.9	Encounter for screening, unspecified
Z41.9	Encounter for procedure for purposes other than remedying health state, unspecified
Z52.9	Donor of unspecified organ or tissue
Z86.59	Personal history of other mental and behavioral disorders
Z88.9	Allergy status to unspecified drugs, medicaments and biological substances status
Z92.0	Personal history of contraception

16) Z Codes That May Only be Principal/First-Listed Diagnosis

The following Z codes/categories 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:

Z00	Encounter for general examination without complaint, suspected or reported diagnosis Except: Z00.6
Z01	Encounter for other special examination without complaint, suspected or reported diagnosis
Z02	Encounter for administrative examination
Z04	Encounter for examination and observation for other reasons
Z33.2	Encounter for elective termination of pregnancy
Z31.81	Encounter for male factor infertility in female patient
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.84	Encounter for fertility preservation procedure
Z34	Encounter for supervision of normal pregnancy
Z39	Encounter for maternal postpartum care and examination
Z38	Liveborn infants according to place of birth and type of delivery
Z40	Encounter for prophylactic surgery
Z42	Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z52	Donors of organs and tissues Except: Z52.9, Donor of unspecified organ or tissue
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z99.12	Encounter for respirator [ventilator] dependence during power failure

17) Social Determinants of Health

Codes describing social determinants of health (SDOH) should be assigned when this information is documented.

For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Social determinants of health codes are located primarily in these Z code categories:

Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

See Section I.B.14. Documentation by Clinicians Other than the Patient's Provider.

22. Chapter 22: Codes for Special Purposes (U00-U85)

U07.0	Vaping-related disorder (see Section I.C.10.e., Vaping-related disorders)
U07.1	COVID-19 (see Section I.C.1.g.1., COVID-19 infection)
U09.9	Post COVID-19 condition, unspecified (see Section I.C.1.g.1.m)

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.). The UHDDS definitions also apply to hospice services (all levels of care).

In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines.

(See Section I.A., Conventions for the ICD-10-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 18 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-10-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

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014

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 T80-T88 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,” “compatible with,” “consistent with,” 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.

K. Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.

See Section I.C.21.c.7, Factors influencing health states and contact with health services, Aftercare.

See Section I.C.19.a, for additional information about the use of 7th characters for injury codes.

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 UHDDS definitions also apply to hospice services (all levels of care).

The following guidelines are to be applied in designating “other diagnoses” when neither the Alphabetic Index nor the Tabular List in ICD-10-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 admissions 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 (categories Z80-Z87) 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,” “compatible with,” “consistent with,” 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. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines,

under “Conventions Used in the Tabular List.” Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. 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 does not apply to hospital-based outpatient services and provider-based office visits.

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-10-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 (same day 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 A00.0 through T88.9, Z00-Z99, U00-U85

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 and U00-U85 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-10-CM diagnosis codes

For accurate reporting of ICD-10-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-10-CM codes to describe all of these.

D. 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 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.

E. Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

See Section I.C.21. Factors influencing health status and contact with health services.

F. Level of Detail in Coding**1. ICD-10-CM codes with 3, 4, 5, 6 or 7 characters**

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.

2. Use of full number of characters required for a code

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

3. Highest level of specificity

Code to the highest level of specificity when supported by the medical record documentation.

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-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 provider.

H. Uncertain diagnosis

Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” “compatible with,” “consistent with,” 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.

I. 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)

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. 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 Z01.89, Encounter for other specified special examinations. 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 Z 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.

L. 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 or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural 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.

N. 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.

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0- and encounter for routine child health examination, Z00.12-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

See Section I.C.21. Factors influencing health status and contact with health services, Screening

Appendix I

Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-10-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-10-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-10-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-10-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.

Please see the CDC website for the detailed list of ICD-10-CM codes that do not require the use of a POA indicator (<https://www.cdc.gov/nchs/icd/icd10cm.htm>). The codes and categories on this exempt list are for circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or that describe conditions that are always present on admission.

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 – (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-10-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 a single code identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to codes that contain multiple clinical concepts.

If a single 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 codes that contain multiple clinical concepts.

Codes That Contain Multiple Clinical Concepts

Assign “N” if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD 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 of the clinical concepts included in the code were present on admission (e.g., duodenal ulcer that perforates prior to admission).

For infection codes that include the causal organism, assign “Y” if the infection (or signs of the infection) were 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-10-CM diagnosis code applies to two or more conditions during the same encounter (e.g. two separate conditions classified to the same ICD-10-CM diagnosis code):

Assign “Y” if all conditions represented by the single ICD-10-CM code were present on admission (e.g. bilateral unspecified age-related cataracts).

Assign “N” if any of the conditions represented by the single ICD-10-CM code was not present on admission (e.g. traumatic secondary and recurrent hemorrhage and seroma is assigned to a single code T79.2, but only one of the 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., Category O11, Pre-existing hypertension with pre-eclampsia)

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 Q00-Q99, Congenital anomalies, which are on the exempt list. Congenital conditions are always considered present on admission.

External cause of injury codes

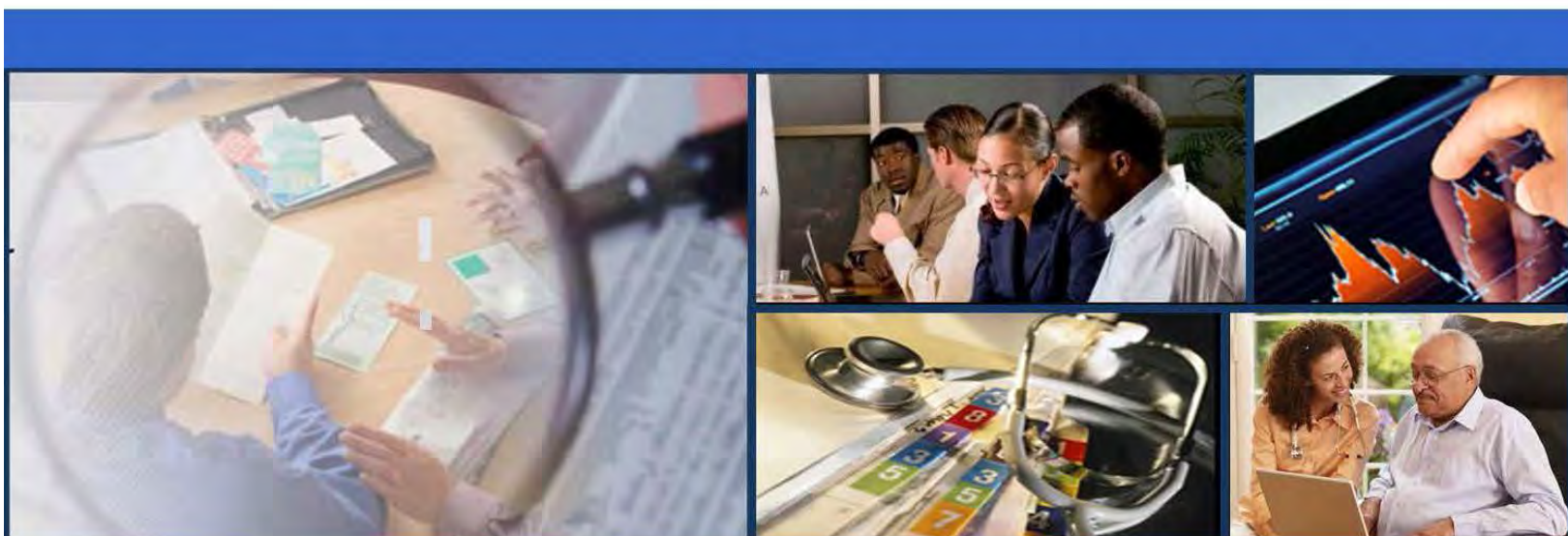
Assign “Y” for any external cause code representing an external cause of morbidity that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign “N” for any external cause code representing an external cause of morbidity 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).

EXHIBIT E

Risk Adjustment 101

Participant Guide



2013 NATIONAL TECHNICAL ASSISTANCE

July 23, 2013



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Introduction

INTRODUCTION

Purpose

The Risk Adjustment 101 session provides an introduction and overview of the risk adjustment process and is intended to be a primer for National Technical Assistance. The session addresses connectivity/testing, key data elements for submission, the Risk Adjustment Processing System (RAPS), and reports. Participants will also be introduced to essential terminology, online resources, and contacts for risk adjustment.

About this Training

This Risk Adjustment training is organized into six modules:

1. **Overview** - Defines risk adjustment and its purpose while also providing essential terminology and acronyms.
2. **Connectivity and Testing** - Discusses the process for connecting to and testing the Risk Adjustment Processing System.
3. **Key Data Elements** - Provides an overview of the types of data required for risk adjustment, as well as acceptable sources for data collection.
4. **The Risk Adjustment Processing System (RAPS)** - Introduces the Risk Adjustment Processing System (RAPS), the format and flow for submitting risk adjustment data, and the timeline for RAPS submissions.
5. **Reports** - Presents the Front-End Risk Adjustment System (FERAS) and the CMS RAPS data logic and editing processes while describing FERAS and RAPS reports used by plans for risk adjustment.
6. **Resources** - Provides access to key resources and important links to ensure a foundation for understanding risk adjustment.

Risk Adjustment 101 Tools

The materials provided in this training include this participant guide and presentation slides. Table 1 provides a description of the materials included as part of this training.

TABLE 1 – RISK ADJUSTMENT 101 TOOLS

TOOLS	DESCRIPTION
Participant Guide	Provides supplemental information to assist participants during the session and to serve as a reference for future use.
Presentation Slides	Guide participants through the session by highlighting the information in the Participant Guide.



Introduction

Throughout the participant guide, four icons are used to emphasize information. Figure A provides the meaning for each icon.

Figure 1 – Icon Key

ICON KEY	
Definition	
Example	
Reminder	
Resource	

Audience

This Risk Adjustment 101 program is designed for individuals who are either new to the risk adjustment process or desire a refresher of the basics. The primary audience for this program includes:

- Medicare Advantage (MA) and Medicare Advantage-Prescription Drug (MA-PD) organizations;
- Regional and Employer Group Health plans;
- Demonstration projects;
- Program of All-Inclusive Care for the Elderly (PACE) organizations;
- Specialty plans; and
- Third party submitters contracted to submit data on behalf of risk adjustment organizations.

Learning Objectives

At the completion of the Risk Adjustment 101 training, participants will be able to:

- Explain the history and purpose of risk adjustment.
- Define important risk adjustment terms and acronyms.
- Describe and access connectivity options for plans to submit risk adjustment data.
- List the required data elements for risk adjustment.
- Identify acceptable sources for data collection.
- Define RAPS and be familiar with the RAPS format.
- Follow the data flow for risk adjustment.
- Access the RAPS submission timeline.
- Discuss the logic applied by FERAS and RAPS.
- Identify RAPS transaction and management reports.
- Access valuable resources relating to risk adjustment.



MODULE 1 – OVERVIEW

Purpose

This Overview Module defines risk adjustment and focuses on its purpose and basic terminology in order to set the stage for the rest of the Risk Adjustment 101 session.

Learning Objectives

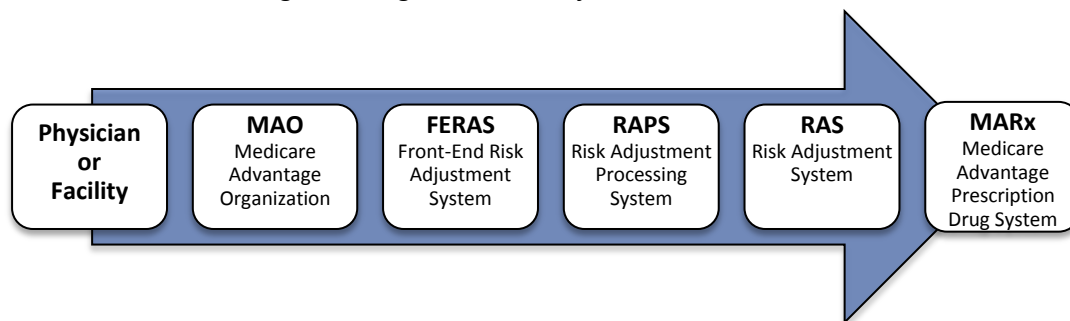
At the completion of this module, participants will be able to:

- Explain the history and purpose of risk adjustment.
- Define important risk adjustment terms and acronyms.
- Understand the practice of using models to calculate risk scores.

1.1 Risk Adjustment Definition

Risk adjustment is the method used to adjust bidding and payment to health plans based on demographics (i.e., age and sex) as well as actual health status of a plan's enrollees. Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs, and adjust payment. Figure 2 provides a high-level flow of risk adjustment data from submission to payment. This process is explained in more detail throughout this document.

Figure 2 – High-Level Risk Adjustment Data Flow



1.2 The Purpose of Risk Adjustment

Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Increased accuracy benefits patients, providers, health plans, and the nation as a whole.

1.3 The History of Risk Adjustment

Risk adjustment methodology for Medicare Advantage (formerly Medicare + Choice) was first required in 1997 by the Balanced Budget Act (BBA). When CMS first implemented risk adjustment, hospital inpatient diagnoses were collected to determine payment to Medicare Advantage organizations. In 2000, with the Benefits Improvement and Protection Act of 2000 (BIPA), Congress mandated that ambulatory data also be collected. This change occurred gradually, and was fully implemented in 2007 with completion of 100% risk adjusted payments for the majority of MA organizations. Some demonstration plans, however, were not fully phased in until 2008.



Overview

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established the prescription drug benefit (Part D) to go into effect under risk adjustment methodology in 2006.

1.4 Risk Adjustment Terms and Acronyms

Table 2 provides definitions of acronyms and terms used throughout this participant guide.

TABLE 2 – RISK ADJUSTMENT TERMS

ACRONYM OR TERM	DESCRIPTION
Demographics	Characteristics of a beneficiary such as age, sex, Medicaid status, and disability.
FERAS	Submitters send risk adjustment data to the Front-End Risk Adjustment System (FERAS) where front-end edits are performed.
HCC	The Hierarchical Condition Category is a diagnosis grouping with a single relative factor assigned to it for each model segment.
MARx UI	The Medicare Advantage Prescription Drug System (MARx) User Interface (UI) maintains Medicare beneficiary eligibility and payment data, and calculates the risk payment.
Model Run	The risk adjustment model is run to calculate risk scores for all beneficiaries with available data. This occurs three times each payment year: once for initial risk score, once for the mid-year update, and once for final reconciliation.
RAPS	Risk Adjustment Processing System (RAPS) processes risk adjustment data.
RAS	The Risk Adjustment System (RAS) that calculates the risk score.
Risk Adjustment Model	The risk adjustment model adjusts Medicare capitation payments to Medicare Advantage Organizations (MAOs) for expected health expenditures risk of their enrollees.
Status	Referred to as "Flags" on the MMR, these include additional characteristics of an enrollee that affect payment calculation, such as frailty, Medicaid, ESRD status, Medicare Secondary Payer (MSP) status, and Institutional status.

Connectivity and Testing

MODULE 2 – CONNECTIVITY AND TESTING

Purpose

Prior to submitting risk adjustment data, plans must establish a connection to CMS systems. In addition to submitting risk adjustment data to CMS, MA organizations use the electronic connection to receive reports. This module introduces the process for connecting to and testing the connection to CMS systems with the submission of test data.

Learning Objectives

At the completion of this module, participants will be able to:

- Access the Electronic Data Interchange (EDI) Agreement required for plans to participate in risk adjustment.
- Describe connectivity options for plans to submit risk adjustment data.
- Identify the testing requirements for connectivity.



Connectivity refers to the electronic connection between an MA organization and CMS.

2.1 Enrollment Package

New MA organizations must complete an Electronic Data Interchange (EDI) Agreement with CMS and submit it to the FERAS contractor, CMS Customer Service and Support Center (CSSC or also referred to as Palmetto), prior to submitting risk adjustment data. The EDI Agreement is a contract between the MA organization and CMS attesting to the accuracy of the data submitted by the MA organization. An officer (e.g., CEO) that represents the MA organization must sign this document and properly submit it to CSSC with an original signature. New plans must submit the EDI Agreement within one (1) month of their Health Plan Management System (HPMS) effective date.

MA organizations must make special arrangements to be able to use a third party submitter. If the submitter is an entity other than an MA organization, the submitter must complete the Submitter ID Application Form, and an EDI Agreement form. Plans using a third party submitter must have a letter on file with CSSC indicating that the third party submitter has permission to submit on behalf of the plan. CMS holds the MA organization accountable for the content of submissions regardless of who submits the data.

MA organizations must complete, sign, and return the EDI Agreement for each plan number submitting data. If a new contract number is assigned, the MA organization must submit a new EDI Agreement.



RAPS Introduction Letter: This document provides instructions for completing the EDI Enrollment and Submitter Applications for Risk Adjustment Data Processing.



EDI Agreement: A CMS EDI Agreement must be completed for the specific data type, Risk Adjustment (RA) or Prescription Drug Event (PDE), by each contract, and be on file with CSSC, prior to submitting Test or Production Data.



Submitter ID Assignment: Submitter IDs are assigned to plans by CSSC and remain effective for ongoing submission of RA. This is the unique ID assigned to the contract that allows data submission and report retrieval. Plans must complete the Submitter Application and return it to CSSC with the completed EDI Agreement.

Connectivity and Testing



RAPS Connect:Direct Application: This document provides the Connect:Direct node connection information for CSSC's file transfer software product.



For forms and necessary documentation for connecting to CMS systems for submission of risk adjustment data, refer to the CSSC website at <http://www.csscooperations.com> > Risk Adjustment Processing System > Enroll to Submit Risk Adjustment Data.

2.2 Connectivity

All third party submitters and large plans that submit their own data must establish a connection to the Front End Risk Adjustment System (FERAS) through the AT&T Global Network Services (AGNS). To become connected, plans should contact AT&T or an AT&T re-seller.

In order to submit claims to FERAS, plans must be enrolled with CSSC. To become enrolled, plans should contact CSSC. As mentioned in the previous section, once plans are enrolled with CSSC to submit and retrieve data electronically, they receive a Submitter ID and a password.



For more information on Data Exchange Preparation Procedures, refer to <http://www.cms.gov> > Research, Statistics, Data and Systems: CMS Information Technology > MAPD Helpdesk > Plan Reference Guide for CMS Part C/D Systems > Connectivity Preparation > Downloads: Data Exchange Preparation Procedures (DEPP)

Table 3 describes the three connectivity options available to plans.

TABLE 3 – CONNECTIVITY OPTIONS

CONNECTION OPTION	DESCRIPTION
Connect:Direct (File transfer software Product)	- For larger plans with enrollment of 100,000 or more - Formerly Network Data Mover (NDM) - Provides mainframe-to-mainframe connection - Provides next day receipt of FERAS response
File Transfer Protocol (FTP)	- For plans of varying sizes - Provides modem-to-modem (dial-up) or lease line connection - Requires password and phone line - Provides same day receipt of FERAS response
Gentran (CMS Enterprise File Transfer)	- For smaller plans with enrollment of 100,000 or less - Offers two connectivity options: - Secure File Transfer Protocol (SFTP); standards based protocol via a vender - Secure Hyper Text Transfer Protocol (HTTPS), secure web interface - Provides next day receipt of FERAS response
TIBCO MFT Internet Server	- For smaller plans with less than 100,000 in enrollment - Provides IP transmissions over the Internet - Trading Partners must use an SFTP Client to transmit files to CMS - Provides next day receipt of FERAS response - Offers new option in 2013 (2012 was a transition year)

Connectivity and Testing

2.3 Testing Requirements

Submitter testing is required to ensure the flow of data from the submitter to FERAS works properly. Testing also ensures the data submitted is valid and formatted correctly. To send data in a test format, plans should contact CSSC at 877-534-2772 to notify them of their test submission. Test data will be processed at CMS, and reports will be available the next morning. When a plan calls CSSC prior to transmission of the first production or test file, a CSSC representative will be able to provide information on how to properly submit a test and/or production file.

New MA organizations must submit test data within three (3) months of the HPMS effective date and a production file must be submitted within four (4) months of the effective date.

If a new contract number is assigned to a plan and the submitter's system successfully submitted test data previously, CMS does not require additional testing.



Technical specifications are available based on the communication medium that is in use. The FERAS User Guide are available at <http://www.csscooperations.com/> > Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS). Testing instructions for each medium are included within the document.

MODULE 3 – KEY DATA ELEMENTS

Purpose

For the purpose of risk adjustment, Medicare Advantage (MA) organizations must collect certain data from hospital inpatient facilities, hospital outpatient facilities, and physicians. The collection of data from the appropriate risk adjustment sources is critical for accurate risk adjusted payments. This module provides a high-level overview of the specific types of data that must be collected and submitted for risk adjustment.

Learning Objectives

At the completion of this module, participants will be able to:

- List the five (5) data elements required to be submitted for risk adjustment, plus the additional data element that will be required beginning with dates of service January 1, 2014
- Identify acceptable sources for data collection.

3.1 Data Elements

Risk scores are based on a combination of demographic and disease data. The demographic data is provided to CMS by the Social Security Administration, while the disease data is submitted by the MA Organizations in the form of diagnosis codes. All of this information is used in the risk adjustment models to calculate a risk score for each beneficiary in order to adjust payments to MA organizations and Prescription Drug Plans (PDPs).

CMS uses the following demographic factors when calculating a risk score:

- Age
- Sex
- Disability
- Original Reason for Entitlement (OREC)
- Medicaid Status
- Institutionalization
- Frailty

Beginning with dates of service January 1, 2014, there will be a new field that MAOs will be required to populate. This new field will identify diagnoses obtained from enrollee risk assessments. More information and guidance will be provided on the process for flagging enrollee risk assessments in the Risk Adjustment Processing System submissions.

The Social Security Administration (SSA) provides demographic information such as age and disability status to CMS. If a plan identifies a discrepancy for a beneficiary, the beneficiary may need to contact SSA to correct the error.



For detailed information on the use of demographics in risk score calculation, refer to the *2012 Risk Adjustment Regional Technical Assistance Participant Guide* at <http://www.csscooperations.com/> > Risk Adjustment Processing System > Training

3.2 Submitted Data Elements

MA organizations must collect certain data elements from the sources (providers/physicians) of risk adjustment data. The five (5) minimum data elements that must be collected and submitted are:

- HIC (Health Insurance Claim) number,
- Provider Type
- From Date of Services,
- Through Date of Services, and
- Diagnosis Code.

Key Data Elements

3.2.1 HIC Number

A HIC number (HICN) is a Medicare beneficiary's identification number. Both CMS and the Railroad Retirement Board (RRB) issue Medicare HIC numbers. The format of a HIC number issued by CMS is a Social Security number followed by an alpha or alphanumeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are six-digit numbers preceded by an alpha character. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha character. Table 4 shows the characteristics for each HIC type.

TABLE 4 – DESCRIPTION OF HIC NUMBERS

HIC TYPE	DESCRIPTION
CMS	9-Digit Social Security number - alpha suffix "A" beneficiary "B" spouse "C" children "D" divorced spouse, widow, widower - alpha-numeric suffix - - indicates number of children (e.g., "C1" first child)
RRB pre-1964	- alpha prefix 6-digit random numbers
RRB post-1964	- alpha prefix 9-digit Social Security number



Example 1 – HIC Numbers

A plan wanted to know why HIC numbers might change, so they searched the online FAQs at <https://askriskadjustment.com/>. They found out that in addition to being a patient's unique identification code, a HIC number also identifies the relationship between the beneficiary and the Medicare primary beneficiary. The SSN or RRB number is the code assigned to the wage earner under whose benefits the eligible person is receiving Medicare. Unlike a SSN, which is assigned only once during a person's lifetime, it is possible for a HIC to change throughout a person's life, when the relationship to the wage earner changes. HICs usually change because of a major life event, such as the death of a spouse. CMS systems crosswalk HIC numbers when they change.



The full FAQ can be found in the "Other" category under the FAQs tab at <https://askriskadjustment.com/>.



For an article about HIC number naming conventions see the SSA website at http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1366/~meaning-of-the-letters-after-a-social-security-or-medicare-number.

3.2.2 Provider Type

MA organizations may only submit data from acceptable sources. Diagnoses must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility, as determined by CMS.

3.2.2.1 Acceptable Sources for Data Collection

MA organizations are responsible for ensuring that the data they collect comes from acceptable sources. Acceptable provider types are broken into three categories: hospital inpatient, hospital outpatient, and physician services.

Key Data Elements

3.2.2.2 Hospital Inpatient Data

Hospital inpatient services include those for which the patient is admitted to the facility for at least one overnight stay. Covered and non-covered hospital inpatient facilities are listed below.

Covered Facilities

- Short-term (general and specialty) Hospitals
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Medical Assistance Facilities/ Critical Access Hospitals

Non-Covered Facilities*

- 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.

3.2.2.3 Hospital Outpatient Data

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization. Covered and non-covered hospital outpatient facilities are listed below.

Covered Facilities

- Short-term (general and specialty) Hospitals
- Medical Assistance Facilities/Critical Access Hospitals
- Community Mental Health Centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Rural Health Clinic (Free-standing and Provider-Based)

Non-Covered Facilities*

- Free-standing Ambulatory Surgical Centers (ASCs)
- Home Health Care
- Free-standing Renal Dialysis Facilities
- Non-Covered Services
- Laboratory Services
- Ambulance
- Durable Medical Equipment
- Prosthetics
- Orthotics
- Supplies
- Radiology Services

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

Regardless of the type of diagnostic radiology bill (outpatient department or physician component), this hospital outpatient service is 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.



Example 2 – Acceptable Providers

A plan asked if a claim from an outpatient hospital encounter must be accompanied by a face-to-face physician visit in order to be eligible for risk adjustment submission. They learned that diagnoses submitted to the Risk Adjustment Processing System (RAPS) must result from a face-to-face encounter either with an acceptable physician specialty or from an encounter in an acceptable facility. When a claim is received, a plan needs to determine whether the claim is from a facility or a professional. If the claim is from a facility (outpatient or inpatient), plans should determine whether that facility is acceptable for risk adjustment.

Key Data Elements



For detailed information on determining whether facilities are acceptable for risk adjustment, refer to the 2008 Participant Guide at <http://www.csscooperations.com/> > Archives > Risk Adjustment Processing System > Training

Please bear in mind that Inpatient coding guidelines differ from Outpatient coding guidelines, so plans should ensure that the diagnoses they submit are acceptable using the appropriate coding guidelines.

3.2.2.4 Provider Data

The collection of provider data for risk adjustment is associated with the provider's specialty. That is, all diagnoses that are required for the risk adjustment models and rendered as a result of face-to-face visits must be collected by MA organizations. This includes data collected from non-network as well as network providers. Table 5 provides the preliminary list of acceptable physician specialty types and their associated specialty codes for the 2014 Payment Year.

**TABLE 5 – PRELIMINARY LIST OF ACCEPTABLE PHYSICIAN SPECIALTY TYPES
For 2014 Payment Year (2013 Dates of Service) Risk Adjustment Data Submission**

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	25	Physical Medicine and Rehabilitation	67	Occupational Therapist
2	General Surgery	26	Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	27	Geriatric Psychiatry	72*	Pain Management
4	Otolaryngology	28	Colorectal Surgery	76*	Peripheral Vascular Disease
5	Anesthesiology	29	Pulmonary Disease	77	Vascular Surgery
6	Cardiology	33*	Thoracic Surgery	78	Cardiac Surgery
7	Dermatology	34	Urology	79	Addiction Medicine
8	Family Practice	35	Chiropractic	80	Licensed Clinical Social Worker
9	Interventional Pain Management (IPM)	36	Nuclear Medicine	81	Critical Care (intensivists)
10	Gastroenterology	37	Pediatric Medicine	82	Hematology
11	Internal Medicine	38	Geriatric Medicine	83	Hematology/Oncology
12	Osteopathic Manipulative Medicine	39	Nephrology	84	Preventive Medicine
13	Neurology	40	Hand Surgery	85	Maxillofacial Surgery
14	Neurosurgery	41	Optometry	86	Neuropsychiatry
15	Speech Language Pathologist	42	Certified Nurse Midwife	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	43	Certified Registered Nurse Anesthetist	90	Medical Oncology
17	Hospice And Palliative Care	44	Infectious Disease	91	Surgical Oncology
18	Ophthalmology	46*	Endocrinology	92	Radiation Oncology
19	Oral Surgery	48*	Podiatry	93	Emergency Medicine
20	Orthopedic Surgery	50*	Nurse Practitioner	94	Interventional Radiology
21	Cardiac Electrophysiology	62*	Psychologist	97*	Physician Assistant
22	Pathology	64*	Audiologist	98	Gynecologist/Oncologist
23	Sports Medicine	65	Physical Therapist	99	Unknown Physician Specialty
24	Plastic And Reconstructive Surgery	66	Rheumatology	C0	Sleep Medicine

* Indicates that a preceding number(s) has been skipped.

Key Data Elements



Example 3 – Acceptable Physician Specialty Types

A plan asked if the multispecialty code (70) that they used to submit was no longer allowable for submission. They were told that the multispecialty type was no longer on the list of acceptable physician specialty types for risk adjustment data submission and therefore, should not be used.



For previous and current lists of Acceptable Physician Specialty Types, refer to the CSSC website at <http://www.csscooperations.com> > Risk Adjustment Processing System > References.

3.2.3 Dates of Service

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 different from each other, and reflect the dates of admission to and discharge from a facility.

The dates of service submitted must be within the data collection year.

3.2.4 Diagnosis Code

Diagnoses must be supported by appropriate medical record documentation. Diagnosis codes are provided to CMS in the RAPS format. The diagnoses are currently in International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) coding, but are scheduled to be transitioned to the 10th Edition, or ICD-10, on October 1, 2014. Plans do not submit procedure codes [i.e., Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes] to RAPS, but only diagnosis codes.



RISK ADJUSTMENT PROCESSING SYSTEM

MODULE 4 – RISK ADJUSTMENT PROCESSING SYSTEM

Purpose

This module provides a definition of the Risk Adjustment Processing System (RAPS), a description of how the data flows through this system, the format for submitting risk adjustment data, and the timeline for RAPS submissions.

Learning Objectives

At the completion of this module, participants will be able to:

- Define RAPS.
- Describe the elements contained within a diagnosis cluster in the RAPS format.
- Follow the data flow for risk adjustment.
- Access and interpret the RAPS submission timeline.

4.1 RAPS Definition



RAPS is the Risk Adjustment Processing System through which risk adjustment data are processed.

After the data submitted by Medicare Advantage (MA) organizations passes the checks in the Front-End Risk Adjustment System (FERAS), the data is sent to the CMS data center for RAPS processing. RAPS performs complete editing of all detail records which are then stored in the RAPS database.

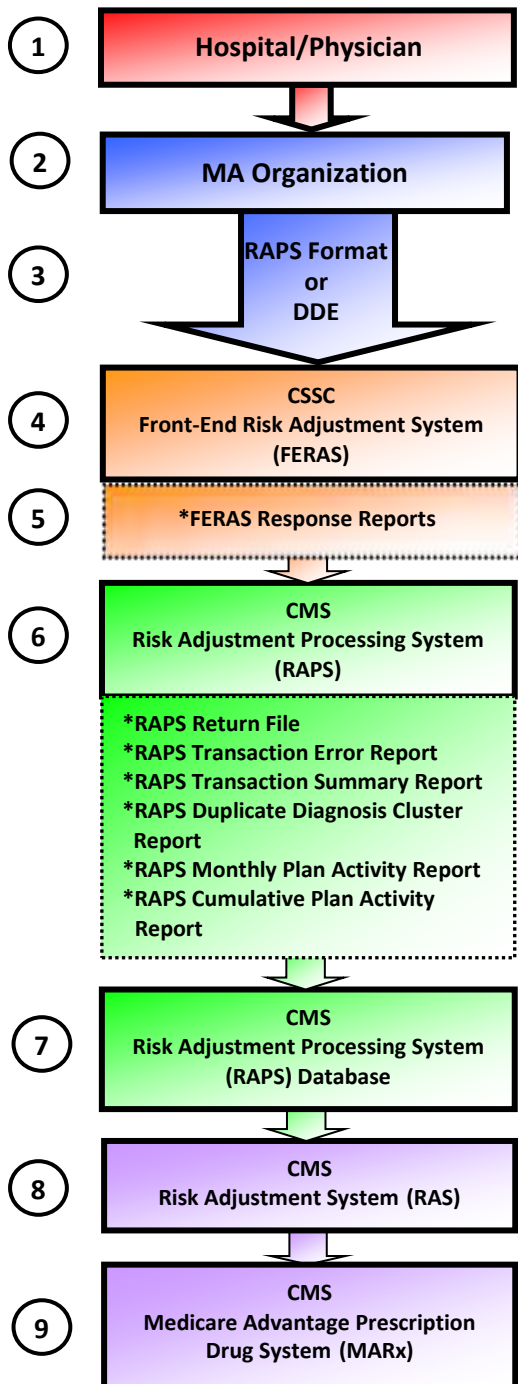
- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from FERAS prior to editing data.
- The RAPS system performs editing on the detail record transactions.
- Data elements edited include HIC Number, Provider Type, From Date, Through Date, and Diagnosis Code.
- If Date of Birth is submitted, RAPS also performs an edit on that field.



The CSSC website, <http://www.csscooperations.com/> is the gateway to FERAS and RAPS resources. Visitors to the site can access information about FERAS and RAPS, including opportunities to enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts.

4.2 Data Flow for Risk Adjustment

Risk scores measure individual beneficiaries' relative risk and are used to adjust payments for each beneficiary's expected expenditures. In order to calculate individual risk scores, plans must submit data to RAPS based on beneficiary diagnoses. Accurate risk-adjusted payments rely on the diagnosis coding derived from the member's medical record. Figure 3 is a diagram of risk adjustment processing showing the sources of data and the flow of risk adjustment data from submission to payment.

**RISK ADJUSTMENT PROCESSING SYSTEM****Figure 3 – Risk Adjustment Dataflow**

1. A physician documents a patient's visit in their medical record.
2. The physician's office or hospital codes the claim from the medical record and submits the data to the MA organization.
3. The MA organization converts and sends the diagnosis clusters in RAPS format or via Direct Data Entry (DDE) to CSSC's Front-End Risk Adjustment System (FERAS) at least quarterly.
4. The data goes to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
5. If any data are rejected, then data are reported on the FERAS Response Report.
6. After passing the FERAS checks, the file is submitted to the CMS Risk Adjustment Processing System (RAPS) where detail editing is performed.
 - The RAPS Return File is returned daily and shows all records approved and where errors occurred.
 - The RAPS Transaction Error Report displays records on which errors occurred.
 - The RAPS Transaction Summary Report is sent to the MA organization daily and identifies data that have been finalized in RAPS database.
 - The Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster.
 - The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report provide a summary of all diagnoses stored for a given time period.
 - Distributed monthly and quarterly, the Error Frequency Report provides an overview of all errors associated with files submitted in test and production.
7. The RAPS database stores all finalized diagnosis clusters.
8. The Risk Adjustment System (RAS) executes the risk adjustment models and calculates the risk score using the SAS model.
9. The Medicare Advantage Prescription Drug System (MARx) processes payments to plans and issues the MMR and MOR (Reports).
10. CMS conducts annual data validation audits on selected plans that may have to request medical record documentation from the providers to support the submitted diagnoses.

*These reports/files are returned to the MA organization.

**RISK ADJUSTMENT PROCESSING SYSTEM****4.3 RAPS Format**

For RAPS processing, plans are required to submit accurate diagnostic data using the RAPS format. These submissions are organized into three levels of data. File-level information identifies the submitter, batch-level information identifies the MA organization, and detail-level information identifies the beneficiary.

There may be more than one batch per file, and more than one claim, or detail record, per batch. Within one file, a submitter may submit data for many MA organizations and many different beneficiaries. The RAPS format allows for up to 9,999,000 batches, and batches may contain up to 9,999,999 detail records. If submitters are going to submit files with greater than one million records in a day, CMS requests that the plan inform the CSSC in advance so that the CMS data center can be notified to expect the large file, and if necessary schedule the submission. Figure 4 provides a graphic representation of the RAPS file logic.

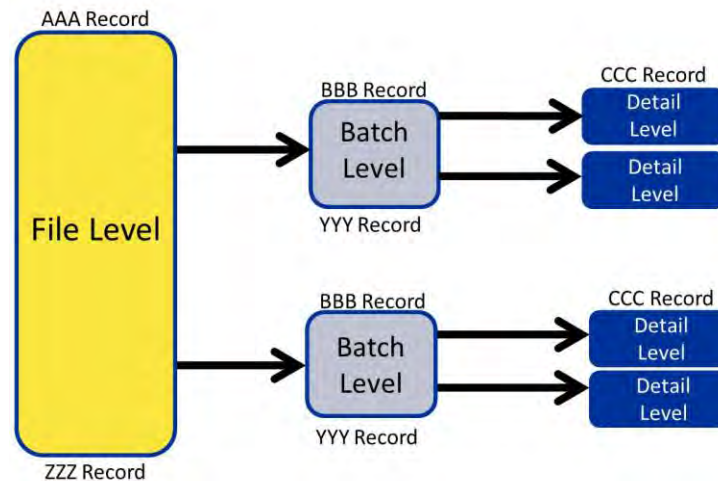
Figure 4 – RAPS File Logic

Table 6 shows the record types in the RAPS file layout and includes a brief description of the data included at each level. Tables 7, 8, 9, 10, and 11 show the full RAPS layout.

TABLE 6 – RAPS FILE LAYOUT RECORD TYPES

RECORD LEVEL	RECORD TYPE	DESCRIPTION	# OF FIELDS
File Header	AAA	Contains submitter and file information.	7
Batch Header	BBB	Contains plan and batch information.	4
Detail	CCC	Contains patient information and diagnosis clusters.	17
Batch Trailer	YYY	Contains plan and record trailer information.	5
File Trailer	ZZZ	Contains submitter and batch trailer information.	5



RISK ADJUSTMENT PROCESSING SYSTEM

TABLE 7 – AAA RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'AAA'
2	SUBMITTER-ID	4-9	X(6)	'Shnnnn'
3	FILE-ID	10-19	X(10)	
4	TRANSACTION-DATE	20-27	9(8)	'CCYYMMDD'
5	PROD-TEST-IND	28-31	X(4)	'PROD' Or 'TEST' Or 'CERT'
6	FILE-DIAG-TYPE	32-36	X(5)	'ICD9' Or 'ICD10'
7	FILLER	37-512	X(476)	SPACES

TABLE 8 – BBB RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'BBB'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001'
3	PLAN-NO	11-15	X(5)	'Hnnnn'
4	FILLER	16-512	X(497)	SPACES

TABLE 9 – CCC RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'CCC'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001'
3	SEQ-ERROR-CODE	11-13	X(3)	SPACES
4	PATIENT-CONTROL-NO	14-53	X(40)	Optional
5	HIC-NO	54-78	X(25)	
6	HIC-ERROR-CODE	79-81	X(3)	SPACES
7	PATIENT-DOB	82-89	X(8)	'CCYYMMDD'
8	DOB-ERROR-CODE	90-92	X(3)	SPACES
9 – 15	DIAGNOSIS-CLUSTER (10 OCCURRENCES)	93-412		
9.0	PROVIDER-TYPE		X(2)	HOSPITAL IP PRINCIPAL = 01 HOSPITAL IP OTHER = 02 HOSPITAL OP = 10 PHYSICIAN = 20
9.1	FROM-DATE		9(8)	'CCYYMMDD'
9.2	THRU-DATE		9(8)	'CCYYMMDD'
9.3	DELETE-IND		X(1)	SPACE or 'D'
9.4	DIAGNOSIS-CODE		X(7)	ICD-9 or ICD-10
9.5	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.6	DIAG-CLSTR-ERROR-2		X(3)	SPACES
16	CORRECTED-HIC-NO	413-437	X(35)	SPACES
17	FILLER	438-512	X(75)	SPACES

TABLE 10 – YYY RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'YYY'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001'
3	PLAN-NO	11-15	X(5)	'Hnnnn'
4	CCC-RECORD-TOTAL	16-22	9(7)	
5	FILLER	23-512	X(490)	SPACES

TABLE 11 – ZZZ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'ZZZ'
2	SUBMITTER-ID	4-9	X(6)	'SHnnnn'
3	FILE-ID	10-19	X(10)	
4	BBB-RECORD-TOTAL	20-26	9(7)	
5	FILLER	27-512	X(486)	SPACES



RISK ADJUSTMENT PROCESSING SYSTEM



This full RAPS format is also available on the Risk Adjustment section of the CSSC website at: <http://www.csscooperations.com> > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).

The AAA, or File Header record contains submitter and file related information. Data such as the Submitter ID will remain consistent and can be pre-populated. A file ID cannot be reused in a rolling 12-month period.

The BBB, or Batch Header record contains plan and batch information such as the sequence number which identifies the batch submitted since there may be multiple batches in a file. Also included here is the plan number which identifies the MA organization. If a submitter submits for multiple organizations, the plan number will change when they submit for different plans.

The CCC, or detail, record file contains identifying information such as the patient HIC number and date of birth. This record also includes the diagnosis cluster which contains the core information for calculating the risk factor. Table 12 describes the elements contained within the diagnosis cluster.

TABLE 12 – DIAGNOSIS CLUSTER

DATA ELEMENT	DESCRIPTION
Provider Type	Codes created for risk adjustment and assigned to each source of data: Hospital inpatient (01 for principle diagnosis or 02 for secondary diagnosis) Hospital outpatient (10) Physician (20)
From Date of Service and Through Date of Service	- From and Through Dates of Service must be submitted in CCYMMDD format. - The “Through Date” defines the data used in the data collection year for risk adjustment purposes.
Delete Indicator	- Allows the MA organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. - This field is filled with a space when not being used.
Diagnosis Code	- Each required diagnosis code must be submitted at least once during a reporting period. - The decimal is implied in the format.



Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition.

A maximum of 10 diagnosis clusters are allowed per detail record. Each cluster must include the items identified above. If a cluster with the same HIC number, provider type, from and through dates, and diagnosis are submitted more than once, a duplicate diagnosis cluster error will occur.

The YYY record, or batch trailer, follows the detail record. The YYY record has many of the same fields with the same information as the BBB, or batch header record.

The ZZZ record is the trailer to the AAA record, and therefore has similar fields. The ZZZ record informs CMS that it is the end of the file being submitted.



RISK ADJUSTMENT PROCESSING SYSTEM

4.4 RAPS Submission Timeline



Model Run: The risk adjustment model is run to calculate risk scores for all beneficiaries with available data. This occurs three times each payment year: once for initial risk score, once for the mid-year update, and once for final reconciliation.

In order for data to be included in the model run, MA organizations must meet three submission deadlines each year: the first Friday in September, the first Friday in March, and January 31 after the payment year. It is important for plans to recognize the connection between the model runs and the dates of service. Table 13 shows the timetable for risk adjustment submission.

TABLE 13 – RISK ADJUSTMENT SUBMISSION TIMETABLE

PAYMENT YEAR	MODEL RUN	DATES OF SERVICE	Deadline
2013	Initial	7/1/2011 - 6/30/2012	9/7/2012
2013	Mid-Year	1/1/2012 - 12/31/2012	3/1/2013
2013	Final Reconciliation	1/1/2012 - 12/31/2012	1/31/2014
2014	Initial	7/1/2012 - 6/30/2013	9/6/2013
2014	Mid-Year	1/1/2013 - 12/31/2013	3/7/2014
2014	Final Reconciliation	1/1/2013 - 12/31/2013	1/31/2015

Plans should keep in mind that the model run timetable includes not only diagnosis information, but all statuses that affect risk adjustment. For example, if a beneficiary has a Medicaid status change that was received by CMS in November 2012, then the status change would not be included in the Initial 2013 model run, but would be retroactively adjusted in the Mid-Year 2013 model run.

**Example 4 – Risk Adjustment Submission Deadlines**

A plan received a diagnosis from a provider in December 2012, but did not submit the diagnosis to RAPS by the March 2013 deadline. The plan asked when the beneficiary's risk score would be adjusted.

The plan was told that since the plan missed the March deadline, the diagnosis would not be included when the beneficiary's risk score was updated in July 2013. In this case, the payment adjustment based on that diagnosis will not be included in the plan's payment until the final reconciliation payment in August of 2014.



The Risk Adjustment Submission Timetable along with a process overview is available on the CSSC website at: <http://www.csscooperations.com> > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).



For more information on risk adjustment timing and payment, refer to the 2012 Regional Technical Assistance Participant Guides for Risk Adjustment and Payment on the CSSC website at: <http://www.csscooperations.com> > Risk Adjustment Processing System > Training.



MODULE 5 – REPORTS

Purpose

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation. Transaction reports provide the outcome of the editing and disposition of the submitted diagnosis clusters. Management reports provide monthly and cumulative summaries of the transactions. This module provides a high-level overview of the Front-End Risk Adjustment System (FERAS) and the Risk Adjustment Processing System (RAPS) data logic and editing processes, and introduces the FERAS and RAPS transaction and management reports used by plans for risk adjustment to manage their data.

Learning Objectives

At the completion of this module, participants will be able to:

- Discuss the logic applied by FERAS and RAPS.
- Identify RAPS transaction and management reports.

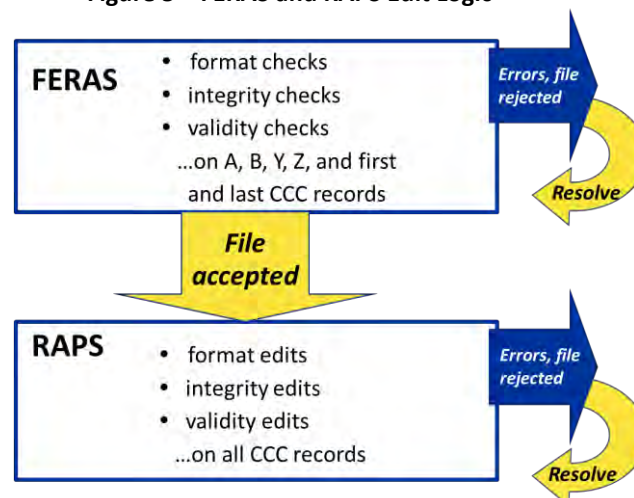
5.1 Edit Logic for FERAS and RAPS

Plans are required to comply with CMS requirements to submit accurate data in a timely manner, which includes submitting diagnoses, meeting the quarterly submission requirement, and not submitting duplicate diagnosis clusters. Plans attest when signing EDI Agreements that they will, to the best of their knowledge, information, and belief, submit risk adjustment data that are accurate, complete, and truthful.

Non-compliance may result in CMS restricting future risk adjustment submissions by an MA organization, so it is important for plans to understand the types of errors that are identified.

To assist plans in ensuring that they submit RAPS compliant files, FERAS first checks the file and batch-level for errors such as duplicate, missing, or invalid data. FERAS also checks the first and last detail record to see if the totals agree and for other edits. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed. FERAS returns a response report to plans detailing any errors found. Only after a file passes the checks in FERAS, does the file move to RAPS where all of the detail records are edited for format, integrity, and validity. Figure 5 illustrates these FERAS and RAPS edits.

Figure 5 – FERAS and RAPS Edit Logic





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5.1.1 Error Codes

When a Medicare Advantage (MA) organization submits a RAPS file to FERAS, FERAS performs the format and integrity checks. Format and integrity checks include verification that the layout of the file is correct, that valid plan numbers are included, that sequence numbering is correct, and many other general checks to the AAA and ZZZ records. FERAS also checks to ensure that there is at least one CCC record with a diagnosis cluster within a batch in the file.

If all checks pass, the submission continues in RAPS. If any of the data fail, FERAS rejects the complete file and generates the FERAS Response Report. The FERAS Response Report identifies the errors discovered during the edit check. Table 14 provides an overview of the FERAS error codes ranges.

TABLE 14 – FERAS ERROR CODE RANGES

ERROR CODE LEVEL	EXPLANATION
100	File-level errors on the AAA or ZZZ records
200	Batch-level errors on the BBB or YYY records
300 and 400	Detail-level errors on the CCC records – first and last only in FERAS



A complete list of all FERAS error codes as well as a FERAS User Guide are available on the CSSC website at <http://www.csscoperations.com/> > Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS).

**Example 5 – FERAS Error Codes**

An MA organization submitted a file and entered “AA1” in record type AAA, field 1. They did not understand why FERAS rejected the entire file with error message 100, so they asked for assistance investigating the issue. The plan was then informed that the field must always be populated with “AAA”.

Generally, FERAS errors occur during the initial establishment of the system and risk adjustment process in MA organizations. After data are processed, and automated formats are programmed and tested, FERAS errors occur less frequently.

In addition to the FERAS error codes, plans receive RAPS error codes. These error codes notify plans of errors in the detail, or CCC, level of the RAPS file, including errors in the diagnosis cluster. RAPS edits include 300, 400, and 500 level edits. The 300 level edits relate to the record while the 400 level relate to the diagnosis cluster within the record. The 500 level edits are informational. Table 15 provides the RAPS error code ranges with explanations and consequences.

TABLE 15 – RAPS ERRORS AND CONSEQUENCES

ERROR SERIES	EXPLANATION AND CONSEQUENCES
300-349	Record-level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record-level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
400-489	Diagnosis cluster error. All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error; diagnosis was not deleted.
500-599	Informational message, all edits were performed; diagnosis cluster was stored unless some other error is noted.



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**Example 6 – RAPS Error Codes**

A plan received a RAPS error code 411, and searched the online FAQs at <http://www.askriskadjustment.com>. They learned that error code 411 refers to the date of death, and that plans receive the 411 error code if the date of death is prior to the service through date. The FAQ offers options for resolving the error.

5.1.2 RAPS Edits Rules

The RAPS editing process takes place in four logical stages.

5.1.2.1 Stage 1- Field Validity and Integrity Edits

RAPS performs format and integrity checks on all CCC-level fields as a first level of editing. If there are data in the “HIC Error Code” or “Diagnosis Code - Filler” fields, the entire detail record is rejected with no further editing performed. If a record fails this stage of editing, it is assumed that the data are corrupt.

The dates also are checked at this stage. If the dates within a diagnosis cluster are not valid dates, then RAPS stops the editing process for that diagnosis cluster because all other data edits within a diagnosis cluster depend upon the validity of the dates.

5.1.2.2 Stage 2 - Field-to-Field Edits

After RAPS checks format and integrity of the fields, the field-to-field editing takes place.

- RAPS ensures that the “from date” is equal or prior to the “through date.”
- RAPS also checks all diagnosis clusters for hospital outpatient and physician provider types to ensure compliance with the 31-day span rule.
- RAPS checks all data to make certain that MA organizations submit the reconciliation data properly.



For dates of service included in each data submission period, see the Risk Adjustment Submission Timetable on the CSSC website at: <http://www.csscoperations.com> > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).

5.1.2.3 Stage 3 - Eligibility Edits

The next stage of editing cross checks the appropriate fields against the common tables in the Medicare Beneficiary Database (MBD) and the Medicare Advantage and Part D Inquiry System (MARx). MA organizations may check CMS records of enrollment in MARx, and should also check the organization’s internal records. For risk adjustment purposes, these common tables are the authoritative source of beneficiary information, and support managed care enrollments to MA organizations.

In this editing stage, the HIC number, date of birth, and Medicare entitlement are checked. For example, in Stage 1 editing, the system ensured that a valid HIC number was present in field 5 of the CCC record. In Stage 3 editing, the system makes certain that the HIC number exists on the common tables.

5.1.2.4 Stage 4 - Diagnosis Code Edits

After RAPS edits the integrity of the individual fields and validates the HIC number and eligibility, it edits the diagnosis code against the Diagnosis Lookup Table in RAPS. In this stage, the system first ensures that each diagnosis code is valid. Then the system checks each diagnosis code against service dates and sex. If any of these edits fail, the diagnosis cluster is not stored in the RAPS database. The edits at this stage also include an edit to check if the diagnosis code is in the risk adjustment model. If the diagnosis code is not in the model, an



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informational error is returned. The diagnosis cluster is stored if an information-only error is returned, and no further action by the MA organization is required.



Explanations of error codes and their consequences, RAPS error codes, informational edits, and duplicate diagnosis cluster edit are presented in the 2008 Participant Guide found at <http://www.csscooperations.com/> > Archives > Risk Adjustment Processing System > Training.

5.1.3 Duplicate Submissions

When submitting a RAPS file, if all attributes of the diagnosis clusters (HIC number, from and through dates of service, diagnosis, and provider type) are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur. Plans are encouraged to check for duplicates prior to submission in order to reduce the number of duplicate cluster submissions and burden on the processing system.



Example 7 – Duplicate Diagnosis Clusters

A plan asked if diagnosis clusters could be duplicated over time. In other words, a member might go to the doctor on separate occasions and receive the same diagnosis each time. Since the plan submits RAPS records every month, they wonder if that diagnosis is stored each time a RAPS record is sent/received by CMS, or only the first time the diagnosis cluster was submitted.

The plan learned that in this example, each of the clusters would be unique diagnosis clusters because they have different dates of service. (Duplicate diagnosis clusters are those that have the same HIC, from and through dates of service, diagnosis code, and provider type). Therefore, they will appear on the report in the counts for total stored. The diagnosis would be stored, but later de-duped when the model was run.



Example 8 – Assistance with Duplicate Diagnosis Clusters

Another plan received 502 errors for a member, but could not locate where the diagnosis cluster had been sent on the return file. They learned that plans may contact CSSC at 1-877-534-CSSC for assistance locating the files that triggered the duplicate diagnosis cluster.



For tips on avoiding duplicate submissions, refer to the *2012 Regional Technical Assistance Risk Adjustment Participant Guide* found at <http://www.csscooperations.com/> > Risk Adjustment Processing System > Training.

5.2 FERAS and RAPS Transaction and Management Reports

Throughout the year, plans receive reports to communicate activity for their enrolled beneficiaries regarding issues from enrollment to payment. Both the FERAS and RAPS systems generate reports that provide the results of the edit checks. Some reports present summary-level data, while others present details about individual diagnosis clusters, including whether or not a cluster generated an error in RAPS. In addition, RAPS generates a series of management reports to assist plans with managing data collection and submission. It is essential that the appropriate staff at MA organizations understand how to read the reports and resolve any issues identified.

The various reports display the results of the data submitted to RAPS, such as diagnoses submitted, accepted, and rejected, as well as errors. Tables 16, 17, and 18 provide an overview of the reports that FERAS and RAPS send to plans. Figures 6 and 7 show examples of the reports.

TABLE 16 – FERAS REPORT

REPORT	DESCRIPTION
FERAS Response Report	• Indicates file is accepted or rejected • Identifies reasons for rejection • Report layout • Secured Website and FTP users receive reports the same business day • Connect:Direct users receive reports the next business day • Gentran users currently receive reports the next business day • TIBCO users receive reports the next business day

REPORT: FERAS-RESP		FRONT END RISK ADJUSTMENT SYSTEM	
RUN DATE: 20040304		FERAS RESPONSE REPORT	
SUBMITTER ID: SH9999		REJECTED PROD	
FILE-ID: 000000001			
RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
AAA		113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
BBB	0000002	203	MISSING/INVALID PLAN NUMBER ON BBB RECORD
CCC	0000001	310	MISSING/INVALID HIC NUMBER ON CCC RECORD
YYY	0000004	263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD

TABLE 17 – RAPS TRANSACTION PROCESSING REPORTS

REPORT	DESCRIPTION
RAPS Return File	- Contains the entire submitted transaction - Identifies 300, 400, and 500-level errors - A flat file layout - Received the next business day after submission
RAPS Transaction Error Report	- Communicates errors found in CCC records during processing - Displays only 300, 400, and 500-level error codes - A report layout - Received the next business day after submission
RAPS Transaction Summary Report	- Summarizes the disposition of diagnosis clusters - A report layout - Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	- Identifies diagnosis clusters with 502-error message - Clusters accepted, but not stored - A report layout - Received the next business day after submission

Figure 7 – RAPS Transaction Error Report

REPORT: RAPS002		RISK ADJUSTMENT PROCESSING SYSTEM												PAGE: 22	
RUN DATE: 20040523		TRANSACTION ERROR REPORT												TRANS DATE: 20040521	
SUBMITTER ID: SH9999		FILE ID: 0000000001		PLAN: H9999 BATCH NUMBER: 0000001											
SEQ NO	SEQ ERR	PATIENT CONTROL NUMBER	HIC NUMBER	HIC ERR	DOB	DOB ERR	PVDR TYPE	FROM DATE	THRU DATE	DEL IND	DGNS CODE	DGNS ERR1	DGNS ERR2	CORRECTED HIC	
0000003		999999999A	353	19301206			01	20040101	20040105		4823				
0000005		00000000000000000000012345678901234567890					01	20040212	20040225		486	408			
		880888888A		19260217											
		000000000000000000000012345675675675675675					02	20040212	20040225		2508	408			
							02	20040312	20040325		486				
0000007		666666666D		19301206			20	20040101	20040105	D	25004	491			
							20	20040411	20040422		25004	408	409		
END OF FILE															



REPORTS

The RAPS Return File is a flat file format that includes all the records and diagnosis clusters submitted by the MA organization. Any errors identified during the RAPS process will appear next to the field in which the error was found. Unique diagnosis clusters that are 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 risk adjustment models. Since this report is a flat file, MA organizations may download the file into a Microsoft Access or Excel database to sort and analyze, and establish a record of each diagnosis that was stored in the risk adjustment model for each enrollee. Larger organizations also use this file in mainframe databases. Organizations that employ automated update processes for their databases typically use the Return File. When trying to avoid submitting duplicate submissions, plans can review current and previous RAPS Return Files to determine which clusters RAPS stored.

The RAPS Transaction Error Report contains only those records that contain errors, causing one or more diagnosis clusters to be rejected. The RAPS Transaction Error Report is typically used by organizations that employ a non-automated update process when maintaining their diagnosis files. To use this report, an individual at the health plan normally downloads the report, prints it, and then manually updates the diagnosis records to indicate which diagnoses were rejected.

The RAPS Transaction Summary Report reflects all finalized data sent to the RAPS database along with all rejected data. The MA organization receives the RAPS Transaction Summary Report each time RAPS processes a submitted file. This report identifies the number of clusters received for each provider type, and summarizes the disposition of all diagnosis clusters that were present on the submitted file.

The RAPS Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster. This report is similar to the RAPS Transaction Error Report, but only lists diagnosis clusters with a 502-error information message (diagnosis cluster was accepted but not stored) appearing on the RAPS Return File and the RAPS Transaction Error Report. Clusters appearing on this report were submitted previously to CMS; that is, a cluster with the same HIC number, provider type, from and through dates, and diagnosis is already stored in the RAPS database.

Table 18 provides a list and descriptions of the four RAPS Management Reports.

TABLE 18 – RAPS MANAGEMENT REPORTS

REPORT	DESCRIPTION
RAPS Monthly Plan Activity Report	- Provides monthly summary of the status of submissions by Submitter ID and Plan Number - A report layout - Available for download the second business day of the month - Generated only when plan has activity in current month
RAPS Cumulative Plan Activity Report	- Provides cumulative summary of the status of submissions by Submitter ID and Plan Number - A report layout - Available for download the second business day of the month - Generated only when plan has activity for the month of the report
RAPS Monthly Error Frequency Report	- Provides a monthly summary of all errors associated with files submitted in test and production - A report layout - Available for download the second business day of the month
RAPS Quarterly Error Frequency Report	- Provides a quarterly summary of all errors on all file submissions within the 3-month quarter - A report layout - Available for download the second business day of the month following each quarter



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The RAPS Monthly Plan Activity Report provides a summary of the status of submissions and is organized by submitter ID and plan number (H number). This allows MA organizations to validate the diagnoses submitted for a one (1) month period based on the date of service (through date). The report is arrayed by provider type and month (determined by through date of service), and displays six months of data on each page.

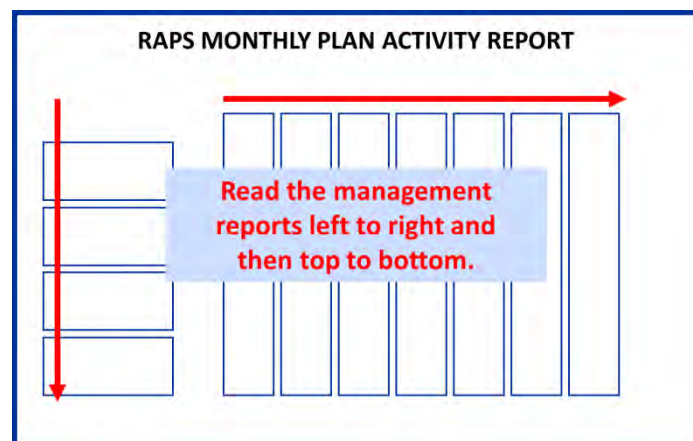
Using this report, MA organizations can determine the number of clusters sent and processed during the month, and the status of that data (accepted, rejected, stored, model stored, and accepted and rejected deletes) by source. By analyzing this report, the MA organization can determine if they are receiving and submitting sufficient data from sources, and the rejection rates for each data source. All this information is helpful in managing the data collection, data submission, and error resolution processes.

The RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions over time, and is organized by plan number. The report is arrayed by provider type and month (determined by through date of service), and reports information by submitter ID and H number. The RAPS Cumulative Plan Activity Reports will now be distributed to plans in ICD-9 and ICD-10 versions following the ICD-10 implementation. Plans can identify each report by the “**ICD9**” or “**ICD10**” label in the report header. This report is not generated if there is no plan activity to be reported for that period.

The RAPS Error Frequency Reports are distributed monthly and quarterly. They provide a summary of the number of errors submitted during the reporting period. This includes files submitted in test and production arrayed by error code and provider type. The reports are generated by submitter ID and plan number (H number). These reports are an effective tool that MA organizations can use to analyze error codes and frequency and reconcile data submissions. In addition, the reports include the total number of CCC records, total diagnoses, and total accepted and rejected diagnosis clusters. The monthly report provides summary information for a month; the quarterly report provides summary information for a three (3) month period.

Figure 8 provides instructions for reading the RAPS Management Reports.

Figure 8 – Analysis of RAPS Management Reports



When analyzing the monthly RAPS management reports, CMS urges MA organizations to consider the following questions:

- “Is my organization collecting enough data from physicians and providers?”
- “Is my organization collecting the correct data from physicians and providers?”
- “Are external issues affecting data collection?”
- “Are internal processes supporting data submissions?”



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It is the plans' responsibility to download and save all reports received. Plans may want to work with their IT Departments to establish a process for downloading and maintaining reports over time. Plans should keep reports for future reference of diagnosis cluster acceptance and other activity, as it is their responsibility to ensure the RAPS data is accepted. If a plan receives errors, they should correct and resubmit as soon as possible because waiting until a submission deadline does not guarantee the diagnosis will be accepted and included in risk score calculation.

It is important to understand that the timing of when plans receive reports is related to the cut-off time for file transfer. The cut-off time for data submission and completion of file transfer is 5:00 PM ET, Monday through Friday. So, if a plan submits a RAPS File, but does not receive the RAPS report the next morning, then the plan did not meet the cut-off. Any files submitted after 5:00 PM ET will be processed the next day, and the reports will come the following morning. If a file is received on Friday after 5:00 PM ET, the file will not go to CMS until Monday, and the reports will be returned Tuesday morning.

CSSC retains reports for seven (7) years. If needed, plans may contact CSSC at csscooperations@palmettogba.com to request a report be restored. When requesting to restore reports, the plan must provide the File ID and the date the file was submitted. However, if requesting many reports from previous years, CSSC will first contact CMS to obtain permission before restoring the reports.

In addition to the reports generated by FERAS and RAPS, plans receive monthly reports from MARx that can be used in reconciling risk score and payment information; specifically the Monthly Membership Report (MMR) and Model Output Report (MOR).

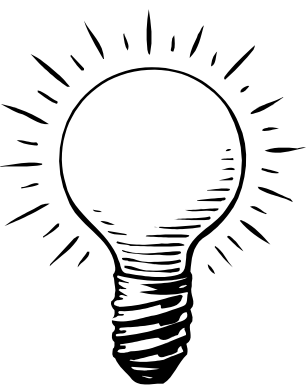


For information on MARx reporting, refer to the *2012 Regional Technical Assistance Risk Adjustment Participant Guide* found at <http://www.csscooperations.com/> > Risk Adjustment Processing System > Training.



The MMR and MOR reports and data file layouts are available in the *Plan Communications User Guide (PCUG) Appendices* on the CMS MAPD Helpdesk website at <http://www.cms.gov> > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide.

Plans should regularly check the MAPD Helpdesk for updates.





RESOURCES

MODULE 6 – RESOURCES

Purpose

This module provides Medicare Advantage (MA) organizations guidance in locating information specific to risk adjustment. It identifies and provides key resources and important links to facilitate the submission of risk adjustment data.

Learning Objectives

At the completion of this module, participants will be able to:

- Locate valuable resources relating to risk adjustment.
- Access online risk adjustment information.
- Identify appropriate contacts for communications regarding risk adjustment.

6.1 Links

6.1.1 CMS Website

The Centers for Medicare & Medicaid Services website (<http://www.cms.gov>) provides visitors with valuable information regarding Medicare and Medicaid.

Table 19 provides the paths to important risk adjustment resources on the CMS website.



TABLE 19 – RISK ADJUSTMENT INFORMATION ON THE CMS WEBSITE

PAGE NAME	PATH	CONTENTS
Risk Adjustment	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Risk Adjustment	Medicare information on risk adjustment, including evaluation of the CMS-HCC Risk Adjustment Model; model diagnosis codes; risk adjustment model software; information on customer support for risk adjustment; and HCC, RxHCC, and ESRD software
Announcements and Documents	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Announcements and Documents	Medicare Advantage (MA) and Medicare+Choice (M+C) advance notices of methodological changes, announcements issued with MA or M+C rates, and special reports
Ratebooks & Supporting Data	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Ratebooks & Supporting Data	Medicare Advantage (MA) ratebooks, rate calculation data, and risk adjusters



TABLE 19 – RISK ADJUSTMENT INFORMATION ON THE CMS WEBSITE, (continued)

PAGE NAME	PATH	CONTENTS
Medicare Advantage and Prescription Drug Plans Communications User Guide (PCUG)	http://www.cms.gov > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide	The Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) provides information to plans about the CMS enrollment system and other pertinent CMS system exchanges. It also references information relative to the User Interface (UI) plans use to obtain eligibility and enrollment information online and other information about establishing connections for communication with CMS. The PCUG Appendices present the schedules, report layouts, codes, report files and other system specific information for plans to reference
ICD-9-CM	http://www.cms.gov > Medicare > Coding: ICD-9-CM	Provides information related to ICD-9-CM, including updates to ICD-9-CM (addendum), the process for requesting a new/revised code, ICD-9-CM Coordination and Maintenance Committee meeting agendas and summary reports, registering to attend an ICD-9-CM Coordination and Maintenance Committee meeting, official coding guidelines, lists of new/revised and deleted codes, downloadable files of diagnosis and procedure codes and their abbreviated titles, conversion table (mapping of changes to ICD-9-CM), and information on ICD-10-PCS
ICD-10-CM	http://www.cms.gov > Medicare > Coding: ICD-10	Provides information related to the October 1, 2014, transition to the ICD-10 code sets

6.1.2 Centers for Disease Control and Prevention (CDC)

Information on the ICD-9-CM coding can be found on the Center for Disease Control and Prevention website at

<http://www.cdc.gov/nchs/icd/icd9cm.htm>.

Information on the ICD-10 coding can also be found there at <http://www.cdc.gov/nchs/icd/icd10cm.htm>.



6.1.3 CMS Customer Service and Support Center (CSSC)

The CMS Customer Service and Support Center (<http://www.csscoperations.com/>) is the gateway to Medicare Advantage and Prescription Drug Programs. Visitors to the site can access information about Risk Adjustment, Encounter Data and Prescription Drug Programs; including opportunities to enroll to submit data and obtain comprehensive information about data submission and reporting. The site provides valuable links to CMS instructions, past training materials, and other official resources.





RESOURCES

Table 20 provides the paths to important risk adjustment resources on the CSSC website.

TABLE 20 – RISK ADJUSTMENT INFORMATION ON THE CSSC WEBSITE

PAGE NAME	PATH	CONTENTS
Enroll to Submit Risk Adjustment Data	http://www.csscooperations.com/ > Risk Adjustment Processing System > Enroll to Submit Risk Adjustment Data	Forms and instructions for EDI Enrollment and Submitter Application for Risk Adjustment Data Processing
Front-End Risk Adjustment System (FERAS)	http://www.csscooperations.com/ > Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS)	FERAS Error Codes and FERAS User Guide
Job Aids	http://www.csscooperations.com/ > Risk Adjustment Processing System > Job Aids	New Enrollee Job Aid
References	http://www.csscooperations.com/ > Risk Adjustment Processing System > References	Acceptable Physician Specialty Types
Risk Adjustment Processing System (RAPS)	http://www.csscooperations.com/ > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS)	RAPS Error Code Listing, RAPS Format, Risk Adjustment Submission Timetable, RAPS-FERAS Error Code Lookup, RAPS-FERAS Report Names, and Risk Adjustment System Reports
Training	http://www.csscooperations.com/ > Risk Adjustment Processing System > Training	Participant Guides, Presentation Slides, and Job Aids from 2012 Regional Technical Assistance covering topics such as Risk Adjustment, Enrollment, and Payment
Training (archived)	http://www.csscooperations.com/ > Archives > Risk Adjustment Processing System > Training	Participant Guides, Presentation Slides, and Job Aids from previous years' Technical Assistance. The 2008 Participant Guide has comprehensive information for plans regarding risk adjustment data collection.

6.1.4 Technical Assistance Registration Service Center (TARSC)

The CMS Technical Assistance Registration Service Center (<http://www.tarsc.info>) provides information on industry outreach efforts for Risk Adjustment, Encounter Data, Prescription Drug Event (PDE) Data, and Payment. On this site, plans can access information about training opportunities and register to participate.



6.1.5 The Health Plan Management System (HPMS)

The Health Plan Management System (HPMS) (<https://gateway.cms.hhs.gov/>) is a CMS system available only to registered users. HPMS provides users with access to several modules, important guidance, policy, and regulations. HPMS also serves as the mechanism with which plans submit bids.

To register to use HPMS, plans must submit the Application for Access to CMS Computer Systems found at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/downloads/EUAacc_essform.pdf.





RESOURCES

6.1.6 Medicare Advantage and Prescription Drug System User Interface (MARx UI)

The MARx UI maintains Medicare beneficiary eligibility and payment data. MARx also generates reports for plans of data used to calculate risk scores used in payment. It is these reports that plans can use to verify their enrollee's risk scores.



To use the MARx system, users must first register in the Individuals Authorized Access to CMS Computer Services (IACS) system at <http://www.cms.gov> > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > IACS, or by calling the MAPD Help Desk for assistance at 1-800-927-8069.

The Plan Communication Users Guide (PCUG) also provides information to plans regarding the use of MARx systems at <http://www.cms.gov> > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide.

6.2 Important Contacts

Table 21 provides the roles and contact information for important resources.

TABLE 21 – RISK ADJUSTMENT POINTS OF CONTACT

RESOURCE	ROLE	CONTACT INFORMATION
Centers for Medicare & Medicaid Services (CMS) Medicare Plan Payment Group (MPPG)	Develops and implements the risk adjustment payment methodology. In addition, they monitor plans to improve the quality of data.	riskadjustment@cms.hhs.gov
MAPD Help Desk	Provides technical customer support for all connectivity needs, as well as aids in resolving technical application issues.	1-800-927-8069 mapdhelp@cms.hhs.gov
Customer Service and Support Center (CSSC)	Manages the Front-End Risk Adjustment System (FERAS) and hosts technical assistance materials from the sessions as well as connectivity guidance for risk adjustment related systems.	877-534-2772 (toll-free) csscooperations@palmettogba.com www.csscooperations.com
Technical Assistance Registration Center (TARSC)	Provides registration services for Technical Assistance sessions and support information on a variety of topics.	1-888-330-9994 TARegistration@tarsc.info www.tarsc.info
ICD-10 PMO Mailbox	Responds to questions regarding ICD-10.	ICD10.PMO@noblis.org
Risk Adjustment Data Validation (RADV)	Responds to questions regarding RADV.	RADV@cms.hhs.gov

6.2 RISK ADJUSTMENT ACRONYMS

Table 22 provides the terms associated with many of the acronyms used in risk adjustment.

TABLE 22 – 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



RESOURCES

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
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
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
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



RESOURCES

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
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
RHC	Rural Health Clinic
RPT	Report
RRB	Railroad Retirement Board



RESOURCES

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
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

EXHIBIT F

Appendix C

AHIMA Practice Brief: Developing a Physician Query Process

Principles of Medical Record Documentation

Medical record documentation is used for a multitude of purposes, including:

- serving as a means of communication between the physician and the other members of the healthcare team providing care to the patient
- serving as a basis for evaluating the adequacy and appropriateness of patient care
- providing data to support insurance claims
- assisting in protecting the legal interests of patients, healthcare professionals, and healthcare facilities
- providing clinical data for research and education

To support these various uses, it is imperative that medical record documentation be complete, accurate, and timely. Facilities are expected to comply with a number of standards regarding medical record completion and content promulgated by multiple regulatory agencies.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission's *2000 Hospital Accreditation Standards* state, "the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity among health care providers" (IM.7.2).¹ The Joint Commission Standards also state, "medical record data and information are managed in a timely manner" (IM.7.6).

Timely entries are essential if a medical record is to be useful in a patient's care. A complete medical record is also important when a patient is discharged, because information in the record may be needed for clinical, legal, or performance improvement purposes. The Joint Commission requires hospitals to have policy and procedures on the timely entry of all significant clinical

Source: Prophet, Sue. 2001 (October). Practice brief: Developing a physician query process. *Journal of American Health Information Management Association* 72(9):88I-M.

information into the patient's medical record, and they do not consider a medical record complete until all final diagnoses and complications are recorded without the use of symbols or abbreviations.

Joint Commission standards also require medical records to be reviewed on an ongoing basis for completeness of timeliness of information, and action is taken to improve the quality and timeliness of documentation that affects patient care (IM.7.10). This review must address the presence, timeliness, legibility, and authentication of the final diagnoses and conclusions at termination of hospitalization.

Medicare

The Medicare Conditions of Participation require medical records to be accurately written, promptly completed, properly filed and retained, and accessible.² Records must document, as appropriate, complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia. The conditions also stipulate that all records must document the final diagnosis with completion of medical records within 30 days following discharge.

Relationship Between Coding and Documentation

Complete and accurate diagnostic and procedural coded data must be available, in a timely manner, in order to:

- improve the quality and effectiveness of patient care
- ensure equitable healthcare reimbursement
- expand the body of medical knowledge
- make appropriate decisions regarding healthcare policies, delivery systems, funding, expansion, and education
- monitor resource utilization
- permit identification and resolution of medical errors
- improve clinical decision making
- facilitate tracking of fraud and abuse
- permit valid clinical research, epidemiological studies, outcomes and statistical analyses, and provider profiling
- provide comparative data to consumers regarding costs and outcomes, average charges, and outcomes by procedure

Physician documentation is the cornerstone of accurate coding. Therefore, assuring the accuracy of coded data is a shared responsibility between coding professionals and physicians. Accurate diagnostic and procedural coded data originate from collaboration between physicians, who have a clinical background, and coding professionals, who have an understanding of classification systems.

Expectations of Physicians

Physicians are expected to provide complete, accurate, timely, and legible documentation of pertinent facts and observations about an individual's health history, including past and present illnesses, tests, treatments, and outcomes. Medical record entries should be documented at the time service is provided. Medical record entries should be authenticated. If subsequent additions to documentation are needed, they should be identified as such and dated. (Often these expectations are included in the medical staff or house staff rules and regulations.) Medical record documentation should:

- address the clinical significance of abnormal test results
- support the intensity of patient evaluation and treatment and describe the thought processes and complexity of decision making
- include all diagnostic and therapeutic procedures, treatments, and tests performed, in addition to their results
- include any changes in the patient's condition, including psychosocial and physical symptoms
- include all conditions that coexist at the time of admission, that subsequently develop, or that affect the treatment received and the length of stay. This encompasses all conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and monitoring³
- be updated as necessary to reflect all diagnoses relevant to the care or services provided
- be consistent and discuss and reconcile any discrepancies (this reconciliation should be documented in the medical record)
- be legible and written in ink, typewritten, or electronically signed, stored, and printed

Expectations of Coding Professionals

The AHIMA Code of Ethics sets forth ethical principles for the HIM profession. HIM professionals are responsible for maintaining and promoting ethical practices. This Code of Ethics states, in part: "Health information management professionals promote high standards for health information management practice, education, and research." Another standard in this code states, "Health information management professionals strive to provide accurate and timely information." Data accuracy and integrity are fundamental values of HIM that are advanced by:

- employing practices that produce complete, accurate, and timely information to meet the health and related needs of individuals
- following the guidelines set forth in the organization's compliance plan for reporting improper preparation, alteration, or suppression of information or data by others
- not participating in any improper preparation, alteration, or suppression of health record information or other organization data

A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. AHIMA's Standards of Ethical Coding were developed to guide coding professionals in this process. As stated in the standards, coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data. These standards also indicate that coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the medical record. It is the responsibility of coding professionals to assess physician documentation to assure that it supports the diagnosis and procedure codes reported on claims. Dialogue between coding professionals and clinicians is encouraged, because it improves coding professionals' clinical knowledge and educates the physicians on documentation practice issues. AHIMA's Standards of Ethical Coding state that coding professionals are expected to consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record. Coding professionals should also assist and educate physicians by advocating proper documentation practices, further specificity, and resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events. It is recommended that coding be performed by credentialed HIM professionals.⁴ It is inappropriate for coding professionals to misrepresent the patient's clinical picture through incorrect coding or add diagnoses or procedures unsupported by the documentation to maximize reimbursement or meet insurance policy coverage requirements. Coding professionals should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded, because payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.

Proper Use of Physician Queries

The process of querying physicians is an effective and, in today's healthcare environment, necessary mechanism for improving the quality of coding and medical record documentation and capturing complete clinical data. Query forms have become an accepted tool for communicating with physicians on documentation issues influencing proper code assignment. Query forms should be used in a judicious and appropriate manner. They must be used as a communication tool to improve the accuracy of code assignment and the quality of physician documentation, not to inappropriately maximize reimbursement. The query process should be guided by AHIMA's Standards of Ethical Coding and the official coding guidelines. An inappropriate query—such as a form that is poorly constructed or asks leading questions—or overuse of the query process can result in quality-of-care, legal, and ethical concerns.

The Query Process

The goal of the query process should be to improve physician documentation and coding professionals' understanding of the unique clinical situation, not to improve reimbursement. Each facility should establish a policy and procedure for obtaining physician clarification of documentation that affects code assignment. The process of querying physicians must be a patient-specific process, not a general process. Asking "blanket" questions is not appropriate. Policies regarding the circumstances when physicians will be queried should be designed to promote timely, complete, and accurate coding and documentation. Physicians should not be

asked to provide clarification of their medical record documentation without the opportunity to access the patient's medical record. Each facility also needs to determine if physicians will be queried concurrently (during the patient's hospitalization) or after discharge. Both methods are acceptable. Querying physicians concurrently allows the documentation deficiency to be corrected while the patient is still in-house and can positively influence patient care. The policy and procedure should stipulate who is authorized to contact the physician for clarifications regarding a coding issue. Coding professionals should be allowed to contact physicians directly for clarification, rather than limiting this responsibility to supervisory personnel or a designated individual. The facility may wish to use a designated physician liaison to resolve conflicts between physicians and coding professionals. The appropriate use of the physician liaison should be described in the facility's policy and procedures.

Query Format

Each facility should develop a standard format for the query form. No "sticky notes" or scratch paper should be allowed. Each facility should develop a standard design and format for physician queries to ensure clear, consistent, appropriate queries. The query form should:

- be clearly and concisely written
- contain precise language
- present the facts from the medical record and identify why clarification is needed
- present the scenario and state a question that asks the physician to make a clinical interpretation of a given diagnosis or condition based on treatment, evaluation, monitoring, and/or services provided. "Open-ended" questions that allow the physician to document the specific diagnosis are preferable to multiple-choice questions or questions requiring only a "yes" or "no" response. Queries that appear to lead the physician to provide a particular response could lead to allegations of inappropriate upcoding
- be phrased such that the physician is allowed to specify the correct diagnosis. It should not indicate the financial impact of the response to the query. The form should not be designed so that all that is required is a physician signature
- include:
 - patient name
 - admission date
 - medical record number
 - name and contact information (phone number and e-mail address) of the coding professional
 - specific question and rationale (that is, relevant documentation or clinical findings)
 - place for physician to document his or her response
 - place for the physician to sign and date his or her response

The query forms should not:

- "lead" the physician
- sound presumptive, directing, prodding, probing, or as though the physician is being led to make an assumption

- ask questions that can be responded to in a “yes” or “no” fashion
- indicate the financial impact of the response to the query
- be designed so that all that is required is a physician signature

When Is a Query Appropriate?

Physicians should be queried whenever there is conflicting, ambiguous, or incomplete information in the medical record regarding any significant reportable condition or procedure. Querying the physician only when reimbursement is affected will skew national healthcare data and might lead to allegations of upcoding.

Every discrepancy or issue not addressed in the physician documentation should not necessarily result in the physician being queried. Each facility needs to develop policies and procedures regarding the clinical conditions and documentation situations warranting a request for physician clarification. For example, insignificant or irrelevant findings may not warrant querying the physician regarding the assignment of an additional diagnosis code. Also, if the maximum number of codes that can be entered in the hospital information system has already been assigned, the facility may decide that it is not necessary to query the physician regarding an additional code. Facilities need to balance the value of marginal data being collected against the administrative burden of obtaining the additional documentation.

Members of the medical staff in consultation with coding professionals should develop the specific clinical criteria for a valid query. The specific clinical documentation that must be present in the patient’s record to generate a query should be described. For example, anemia, septicemia, and respiratory failure are conditions that often require physician clarification. The medical staff can assist the coding staff in determining when it would be appropriate to query a physician regarding the reporting of these conditions by describing the specific clinical indications in the medical record documentation that raise the possibility that the condition in question may be present.

When Is a Query Not Necessary?

Queries are not necessary if a physician involved in the care and treatment of the patient, including consulting physicians, has documented a diagnosis and there is no conflicting documentation from another physician. Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. If documentation from different physicians conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis.

Queries are also not necessary when a physician has documented a final diagnosis and clinical indicator—such as test results—do not appear to support this diagnosis. While coding professionals are expected to advocate complete and accurate physician documentation and to collaborate with physicians to realize this goal, they are not expected to challenge the physician’s medical judgment in establishing the patient’s diagnosis. However, because a discrepancy between clinical findings and a final diagnosis is a clinical issue, a facility may choose to establish a policy that the physician will be queried in these instances.

Documentation of Query Response

The physician’s response to the query must be documented in the patient’s medical record. Each facility must develop a policy regarding the specific process for incorporating this addi-

tional documentation in the medical record. For example, this policy might stipulate that the physician is required to add the additional information to the body of the medical record. As an alternative, a form, such as a medical record “progress note” form, might be attached to the query form and the attachment is then filed in the medical record. However, another alternative is to file the query form itself in the permanent medical record. Any documentation obtained post-discharge must be included in the discharge summary or identified as a late entry or addendum.

Any decision to file this form in the medical record should involve the advice of the facility’s corporate compliance officer and legal counsel, due to potential compliance and legal risks related to incorporating the actual query form into the permanent medical record (such as its potential use as evidence of poor documentation in an audit, investigation, or malpractice suit, risks related to naming a nonclinician in the medical record, or quality of care concerns if the physician response on a query form is not clearly supported by the rest of the medical record documentation).

If the query form will serve as the only documentation of the physician’s clarification, the use of “open-ended” questions (that require the physician to specifically document the additional information) are preferable to multiple choice questions or the use of questions requiring only a “yes” or “no” answer. The query form would need to be approved by the medical staff/medical records committee before implementation of a policy allowing this form to be maintained in the medical record. Also keep in mind that the Joint Commission hospital accreditation standards stipulate that only authorized individuals may make entries in medical records (IM.7.1.1). Therefore, the facility needs to consider modifying the medical staff bylaws to specify coding professionals as individuals authorized to make medical record entries prior to allowing query forms to become a permanent part of the medical record.

Auditing, Monitoring, and Corrective Action

Ideally, complete and accurate physician documentation should occur at the time care is rendered. The need for a query form results from incomplete, conflicting, or ambiguous documentation, which is an indication of poor documentation. Therefore, query form usage should be the exception rather than the norm. If physicians are being queried frequently, facility management or an appropriate medical staff committee should investigate the reasons why.

A periodic review of the query practice should include a determination of what percentage of the query forms are eliciting negative and positive responses from the physicians. A high negative response rate may be an indication that the coding staff are not using the query process judiciously and are being overzealous.

A high positive response rate may indicate that there are widespread poor documentation habits that need to be addressed. It may also indicate that the absence of certain reports (for example, discharge summary, operative report) at the time of coding is forcing the coding staff to query the physicians to obtain the information they need for proper coding.

If this is the case, the facility may wish to reconsider its policy regarding the availability of certain reports prior to coding. Waiting for these reports may make more sense in terms of turnaround time and productivity rather than finding it necessary to frequently query the physicians. The question of why final diagnoses are not available at the time of discharge may arise at the time of an audit, review by the peer review organization, or investigation.

The use of query forms should also be monitored for patterns, and any identified patterns should be used to educate physicians on improving their documentation at the point of care. If a pattern is identified, such as a particular physician or diagnosis, appropriate steps should be taken to correct the problem so the necessary documentation is present prior to coding in the future and the need to query this physician, or to query physicians regarding a particular

diagnosis, is reduced. Corrective action might include targeted education for one physician or education for the entire medical staff on the proper documentation necessary for accurate code assignment.

Patterns of poor documentation that have not been addressed through education or other corrective action are signs of an ineffective compliance program. The Department of Health and Human Services Office of Inspector General has noted in its Compliance Program Guidance for Hospitals that “accurate coding depends upon the quality of completeness of the physician’s documentation” and “active staff physician participation in educational programs focusing on coding and documentation should be emphasized by the hospital.”⁵

The format of the queries should also be monitored on a regular basis to ensure that they are not inappropriately leading the physician to provide a particular response. Inappropriately written queries should be used to educate the coding staff on a properly written query. Patterns of inappropriately written queries should be referred to the corporate compliance officer.

Prepared by

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Acknowledgments

AHIMA Advocacy and Policy Task Force
 AHIMA’s Coding Practice Team
 AHIMA Coding Policy and Strategy Committee
 AHIMA Society for Clinical Coding
 Dan Rode, MBA, FHFMA

Notes

1. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Oakbrook Terrace, IL: Joint Commission, 2000.
2. Health Care Financing Administration, Department of Health and Human Services. “Conditions of Participation for Hospitals.” Code of Federal Regulations, 2000. 42 CFR, Chapter IV, Part 482.
3. *Official ICD-9-CM Guidelines for Coding and Reporting* developed and approved by the American Hospital Association, American Health Information Management Association, Health Care Financing Administration, and the National Center for Health Statistics.
4. AHIMA is the professional organization responsible for issuing several credentials in health information management: Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), and Certified Coding Specialist–Physician-based (CCS-P).
5. Office of Inspector General, Department of Health and Human Services. “Compliance Program Guidance for Hospitals.” Washington, DC: Office of Inspector General, 1998.

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DO NOT DISCARD—SEND WITH THE MEDICAL RECORD AT DISCHARGE

EXHIBIT G

Managing an Effective Query Process

Note: This practice brief updates the 2001 practice brief “Developing a Physician Query Process,” with a continued focus on compliance.

In today’s changing healthcare environment, health information management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective query process is an integral component of ensuring data integrity. A query is defined as a question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient’s health record. Documentation can be greatly improved by a properly functioning query process.

This practice brief offers HIM professionals important components to consider in the management of an effective query process. It is intended to offer guiding principles to implement the query process while in no way prescribing what must be done.

Background

The “ICD-9-CM Official Guidelines for Coding and Reporting” are the official rules for coding and reporting ICD-9-CM. They are approved by the four organizations that make up the ICD-9-CM Cooperating Parties: the American Hospital Association, the American Health Information Management Association, the Centers for Medicare and Medicaid Services, and the National Center for Health Statistics. The guidelines may be used as a companion document to the official current version of the ICD-9-CM coding conventions and instructions.

The guidelines state:

A joint effort between the health care provider and the coding professional 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 coding professional 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.¹

A provider is defined as any physician or other qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis. The guidelines apply to all healthcare providers, organizations, facilities, and entities (referred to throughout this document collectively as “healthcare entities”), regardless of size and function. They

are clear in their directive regarding the relationship between documentation and the accurate, consistent coding and reporting of healthcare services.

Individuals who perform the query function should be familiar with the AHIMA Standards of Ethical Coding, which direct coders to “assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines.”² The standards further state:

Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator).

Organizations should establish a process for “ensuring that the physician documents in the health record any clarification or additional information resulting from communication with coding staff,” according to Sue Bowman, AHIMA director of coding policy and compliance, in the book *Health Information Management Compliance: A Model Program for Healthcare Organizations*. “Communication tools between coding personnel and physicians, such as coding summary sheets, attestation forms, or coding clarification forms (e.g., physician query forms), should never be used as a substitute for appropriate physician documentation in the health record.”³

The electronic health record creates new challenges for compliance in clinical documentation. The issues to address include the use of electronic templates, generating and responding to electronic queries, and input from the appropriate staff regarding the electronic record documentation process.

The Expectations for Documentation

The primary purpose of health record documentation is continuity of patient care, serving as a means of communication among all healthcare providers. Documentation is also used to evaluate the adequacy and appropriateness of quality care, provide clinical data for research and education, and support reimbursement, medical necessity, quality of care measures, and public reporting for services rendered by a healthcare entity.⁴

practice brief *Managing an Effective Query Process (cont.)*

Documentation and Coding

As a result of the disparity in documentation practices by providers, querying has become a common communication and educational method to advocate proper documentation practices. Queries may be made in situations such as the following:

- Clinical indicators of a diagnosis but no documentation of the condition
- Clinical evidence for a higher degree of specificity or severity
- A cause-and-effect relationship between two conditions or organism
- An underlying cause when admitted with symptoms
- Only the treatment is documented (without a diagnosis documented)
- Present on admission (POA) indicator status

Lack of accurate and complete documentation can result in the use of nonspecific and general codes, which can impact data integrity and reimbursement and present potential compliance risks.

Expectation of the Provider

According to the Centers for Medicare and Medicaid Services and the Joint Commission, providers are expected to provide legible, complete, clear, consistent, precise, and reliable documentation of the patient's health history, present illness, and course of treatment. This includes observations, evidence of medical decision-making in determining a diagnosis, and treatment plan, as well as the outcomes of all tests, procedures, and treatments. This documentation should be as complete and specific as possible, including information such as the level of severity, specificity of anatomical sites involved, and etiologies of symptoms.

Providers are expected to follow medical staff bylaws and assist in developing documentation and query policies and procedures. The query policy may include a statement regarding timely response and consequences for noncompliance or lack of response to queries.

Expectation of Individuals Performing the Query Function

Individuals performing the query function should follow their healthcare entity's internal policies related to documentation, querying, coding, and compliance, keeping in mind that data accuracy and integrity are fundamental HIM values. Only diagnosis codes that are clearly and consistently supported by provider documentation should be assigned and reported. A query should be initiated when there is conflicting, incomplete, or ambiguous documentation in the health record or additional information is needed for correct assignment of the POA indicator.

Expectation of the Healthcare Entity

The query process improves the quality of documentation and coding for complete clinical data capture. Queries may

be initiated for all payer types regardless of the impact on reimbursement or quality reporting. The healthcare entity's documentation or compliance policies can address situations such as unnecessary queries, leading queries, repetitive overuse of queries without measureable improvement in documentation, and methods for provider education.

A provider's response to a query can be documented in the progress note, discharge summary, or on the query form as a part of the formal health record. Addendums to the discharge summary or the progress note should include appropriate date and authentication.

Permanence and retention of the completed query form should be addressed in the healthcare entity's policy, taking into account applicable state and quality improvement organization guidelines. The policy should specify whether the completed query will be a permanent part of the patient's health record. If it will not be considered a permanent part of the patient's health record (e.g., it might be considered a separate business record for the purpose of auditing, monitoring, and compliance), it is not subject to health record retention guidelines.

It is recommended that healthcare entities employ, educate, and train qualified individuals to perform the query process who have strong competencies in the following areas:

- Knowledge of healthcare regulations, including reimbursement and documentation requirements
- Clinical knowledge with training in pathophysiology
- Ability to read and analyze all information in a patient's health record
- Established channels of communication with providers and other clinicians
- Demonstrated skills in clinical terminology, coding, and classification systems
- Ability to apply coding conventions, official guidelines, and *Coding Clinic* advice to health record documentation

The Query Process

Who to Query

A healthcare entity's query policy should address the question of who to query. The query is directed to the provider who originated the progress note or other report in question. This could include the attending physician, consulting physician, or the surgeon. In most cases, a query for abnormal test results would be directed to the attending physician.

Documentation from providers involved in the care and treatment of the patient is appropriate for code assignment; however, a query may be necessary if the documentation conflicts with that of another provider. If such a conflict exists, the attending physician is queried for clarification, as that provider is ultimately responsible for the final diagnosis.

When to Query

Providers should be queried whenever there is conflicting, ambiguous, or incomplete information in the health

record regarding any *significant* reportable condition or procedure.

Queries are not necessary for every discrepancy or unaddressed issue in physician documentation. Healthcare entities should develop policies and procedures that clarify which clinical conditions and documentation situations warrant a request for physician clarification. Insignificant or irrelevant findings may not warrant a query regarding the assignment of an additional diagnosis code, for example. Entities must balance the value of collecting marginal data against the administrative burden of obtaining the additional documentation.

Healthcare entities could consider a policy in which queries may be appropriate when documentation in the patient's record fails to meet one of the following five criteria:

- **Legibility.** This might include an illegible handwritten entry in the provider's progress notes, and the reader cannot determine the provider's assessment on the date of discharge.
- **Completeness.** This might include a report indicating abnormal test results without notation of the clinical significance of these results (e.g., an x-ray shows a compression fracture of lumbar vertebrae in a patient with osteoporosis and no evidence of injury).
- **Clarity.** This might include patient diagnosis noted without statement of a cause or suspected cause (e.g., the patient is admitted with abdominal pain, fever, and chest pain and no underlying cause or suspected cause is documented).
- **Consistency.** This might include a disagreement between two or more treating providers with respect to a diagnosis (e.g., the patient presents with shortness of breath. The pulmonologist documents pneumonia as the cause, and the attending documents congestive heart failure as the cause).
- **Precision.** This might include an instance where clinical reports and clinical condition suggest a more specific diagnosis than is documented (e.g., congestive heart failure is documented when an echocardiogram and the patient's documented clinical condition on admission suggest acute or chronic diastolic congestive heart failure).

Healthcare entities may design their query programs to be concurrent, retrospective, post-bill, or a combination of any of these. Concurrent queries are initiated while the patient is still present. Retrospective queries are initiated after discharge and before the bill is submitted; post-bill queries are initiated after the bill has been submitted.

Concurrent queries are initiated "real time," during the course of the patient encounter or hospitalization, at the time the documentation is naturally done. They thus encourage more timely, accurate, and reliable responses. Retrospective queries are effective in cases where additional information is available in the health record, in short stays where concurrent

review was not completed, or whenever a concurrent query process is not feasible.

Post-bill queries are initiated after the claim is submitted or remittance advice is paid. Post-bill queries generally occur as a result of an audit or other internal monitor. Healthcare entities can develop a policy regarding whether they will generate post-bill queries and the timeframe following claims generation that queries may be initiated. They may consider the following three concepts in the development of a post-bill (including query) policy:

- Applying normal course of business guidelines⁵
- Using payer-specific rules on rebilling timeframes
- Determining reliability of query response over time

When Not to Query

Codes assigned to clinical data should be clearly and consistently supported by provider documentation. Providers often make clinical diagnoses that may not appear to be consistent with test results. For example, the provider may make a clinical determination that the patient has pneumonia when the results of the chest x-ray may be negative. Queries should not be used to question a provider's clinical judgment, but rather to clarify documentation when it fails to meet any of the five criteria listed above—legibility, completeness, clarity, consistency, or precision.

A query may not be appropriate simply because the clinical information or clinical picture does not appear to support the documentation of a condition or procedure (e.g., documentation of acute respiratory failure in a patient whose laboratory findings do not appear to support this diagnosis). In situations where the provider's documented diagnosis does not appear to be supported by clinical findings, a healthcare entity's policies can provide guidance on a process for addressing the issue without querying the attending physician.

The Query Format

It is recommended that the healthcare entity's policy address the query format. A query generally includes the following information:

- Patient name
- Admission date and/or date of service
- Health record number
- Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart (e.g., history and physical states urosepsis, lab reports WBC of 14,400. Emergency department report fever of 102)

It is not advisable to record queries on handwritten sticky notes, scratch paper, or other notes that can be removed and discarded. The preferred formats for capturing the query

practice brief *Managing an Effective Query Process (cont.)*

include facility-approved query form, facsimile transmission, electronic communication on secure e-mail, or secure IT messaging system.

Verbal queries have become more common as a component of the concurrent query process. The desired result of a verbal query is documentation by the provider that supports the coding of a condition, diagnosis, or procedure. Therefore entities should develop specific policies to clearly address this practice and avoid potential compliance risks.

It is recommended that queries be written with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case. Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.

Examples of leading queries include:

Dr. Smith—Based on your documentation, this patient has anemia and was transfused 2 units of blood. Also, there was a 10 point drop in hematocrit following surgery. Please document “Acute Blood Loss Anemia,” as this patient clearly meets the clinical criteria for this diagnosis.

Dr. Jones—This patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Please document “Chronic Respiratory Failure.”

In these examples the provider is not given any documentation option other than the specific diagnosis requested. The statements are directive in nature, indicating what the provider should document, rather than querying the provider for his or her professional determination of the clinical facts. In the first example, the statement “the patient has anemia” may be presumptive, and the statement “please document ‘acute blood loss anemia’” is directive and clearly leading the provider. In the second example, the provider is inappropriately asked to document chronic respiratory failure.

Examples of the above queries correctly written could include the following:

Dr. Smith—In your progress note on 6/20, you documented anemia and ordered transfusion of 2 units of blood. Also, according to the lab work done on xx/xx, the patient had a 10 point drop in hematocrit following surgery. Based on these indications, please document, in the discharge summary, the type of anemia you were treating.

Dr. Jones—This patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Based on these indications, please indicate if you were treating one of the following diagnoses:

- Chronic Respiratory Failure
- Acute Respiratory Failure

- Acute on Chronic Respiratory Failure
- Hypoxia
- Unable to determine
- Other: _____

The introduction of new information not previously documented in the medical record is inappropriate in a provider query. For example:

Dr. Harvey—According to the patient’s emergency room record from last week, the patient was placed on antibiotics for cellulitis of her leg. If the patient is still taking antibiotics, please document the cellulitis.

In this case, if this diagnosis was not documented in the current admission and is not affecting the patient’s care, it does not meet the definition of a secondary diagnosis.⁶ Querying for this new information, which does not meet coding and reporting requirements, is inappropriate.

In general, query forms should not be designed to ask questions about a diagnosis or procedure that can be responded to in a yes/no fashion. The exception is present on admission (POA) queries when the diagnosis has already been documented.

It is recommended that healthcare entities should address the issue of yes/no queries in their policies. When setting this policy, the entity should consider the compliance risk. In general, it is a much safer practice to ask the provider to document the diagnosis he or she is agreeing to. Concerns about yes/no queries are less of an issue if the entity requires the provider to document the diagnosis in the health record rather than relying on the query form for the final documentation.

Multiple choice formats that employ checkboxes may be used as long as all clinically reasonable choices are listed, regardless of the impact on reimbursement or quality reporting. The choices should also include an “other” option, with a line that allows the provider to add free text. Providers should also be given the choice of “unable to determine.” This format is designed to make multiple choice questions as open ended as possible.

A single query form can be used to address multiple questions. If it is, a distinct question should be asked for each issue (e.g., if three questions exist based on clinical indications in the health record, there should be three distinct questions clearly identified on the query form).

For example, insulin-dependent diabetes with high blood sugars on admission is documented in a patient with renal failure. The three questions identified on the query might be related to type of diabetes (type I or II, or secondary); relationship of diabetes to renal failure; and whether the diabetes is controlled or uncontrolled.

Finally, the query should never indicate that a particular response would favorably or unfavorably affect reimbursement or quality reporting.

Methods of Auditing and Monitoring

Healthcare entities should consider establishing an auditing and monitoring program as a means to improve their query processes. They can consider several methods for this ongoing process.

Queries can be reviewed retrospectively to ensure that they are completed according to documented policies. This might include reviewing:

- That the query was necessary
- That the language used in the query was not leading or otherwise inappropriate
- That the query did not introduce new information from the health record

Based on the results of this review, the healthcare entity may need to identify follow-up actions. For example, cases identified as inappropriate queries resulting in inaccurate code assignment will require that codes be corrected at the level supported by the documentation without the leading query. Inappropriate queries should be tracked and trended, followed by appropriate education and training.

In order for the query process to be effective, auditing and monitoring should be conducted on a regular basis. This process can include a representative sample of total queries as well as a sampling by individuals initiating the query. Effective elements of an auditing and monitoring program include:

- Auditing for percentage of negative and positive provider responses. A high negative response rate may indicate overuse of the query by the coding staff; a high positive response rate may indicate a pattern of incomplete documentation that needs further investigation.
- Auditing the format of query forms. Discovery of inappropriate query formats can be used as an educational tool for coding staff.
- Auditing of individual providers to indicate improvement in health record documentation. Improvement in documentation should result in a decreased number of queries for an individual provider.
- Auditing of high-risk or problem diagnoses. The results may determine whether additional education resulted in a decreased number of queries for a particular diagnosis.

Auditing and monitoring programs should establish the data fields to be collected and reported. When reviewing both performance measures and compliance monitors, the errors related to documentation will become apparent.

Healthcare entities should have a process in place to support and educate the staff involved in conducting provider queries. Ongoing education and training is a key component of the auditing and monitoring process.

Conclusion

HIM professionals are constantly challenged to improve the accuracy of coded data to meet regulatory, state, and

federal requirements. In addition, electronic records pose new challenges in the collection and maintenance of quality data.

The quality of coding is driven directly by the documentation contained in the patient's health record. Establishing and managing a query process can be an effective tool to improve clinical documentation and thereby increase the accuracy of coded data. Typically, both concurrent and retrospective query processes are needed. An effective query process, using an appropriate format, will enable the facility to obtain needed documentation without compromising coding compliance standards.

Since the query process has become a tool to improve provider documentation, it is critical that the design of these processes be maintained with legal, regulatory, and ethical issues in mind. Healthcare entities can create and maintain a compliant query process by:

- Creating comprehensive policies and procedures for query processes
- Generating queries only when documentation is conflicting, incomplete, or ambiguous
- Conducting auditing and monitoring activities to determine the effectiveness of the query process
- Providing education and training for the staff involved in conducting provider queries ❖

Notes

1. Centers for Medicare and Medicaid Services and the National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/datawh/ftp/ftp9/ftp9cd9.htm#guidelines.
2. American Health Information Management Association. "Standards of Ethical Coding." 2008. Available online at www.ahima.org/infocenter/guidelines.
3. Prophet, Sue. *Health Information Management Compliance: A Model Program for Healthcare Organizations*. 2d edition. Chicago, IL: AHIMA, 2002.
4. For the purposes of this practice brief, *healthcare entity* encompasses all providers: short-term acute care hospitals; long-term acute care hospitals; skilled nursing facility and hospice; inpatient and outpatient psychiatric and rehabilitation; home-health; hospital-based outpatient and clinic; and all professional providers such as physician practice as well as any other healthcare entity or professional provider that serves patient care solo or part of a corporation. The healthcare entity uses the same policies and procedures throughout the components of the organization.
5. Normal course of business guidelines include ensuring that the post-bill query process is conducted in the healthcare entity's normal timeframe for completing health records in accordance with medical staff bylaws and rules and regulations for health record completion.

practice brief

Managing an Effective Query Process (cont.)

6. For reporting purposes, the term *other diagnoses* is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. 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 related to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

Reference

Prophet, Sue. “Developing a Physician Query Process.” *Journal of AHIMA* 72, no. 9 (Oct. 2001): 88I–M.

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EXHIBIT H

PRACTICE BRIEF

practice guidelines for managing health information

Guidelines for Achieving a Compliant Query Practice

IN COURT AN ATTORNEY CAN'T "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists can't lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

The guidance of this practice brief augments and, where applicable, supersedes prior AHIMA guidance on queries. The intent of this practice brief is not to limit clinical communication for purposes of patient care. Rather it is to maintain the integrity of the coded healthcare data. All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances.

Query Example: Clarification for Specificity of a Diagnosis

Documentation:

Obtunded patient admitted with three-day history of nausea and vomiting. CXR revealed right lower lobe (RLL) pneumonia. Clindamycin ordered.

Leading query:

Is the patient's pneumonia due to aspiration?

Nonleading query:

Can the etiology of the patient's pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.

Source: AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): expanded web version.

To support why a query was initiated, all queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested. Although AHA's *Coding Clinic* for ICD-9-CM often references clinical indicators associated with particular diagnoses, it is not an authoritative source for establishing the clinical indicators of a given diagnosis. A recent *Coding Clinic* issue also stated that it is not intended for such a purpose. Clinical indicators should be derived from the specific medical record under review and the unique episode of care. Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions.

A query should include the clinical indicators, as discussed above, and should not indicate the impact on reimbursement. A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure. The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format.

Because the patient record should provide a sequence of events, best practice is to capture the content of a verbal and/or written query, as well as any practitioner response to the query. This practice allows reviewers to account for the presence documentation that might otherwise appear out of context.

If the practitioner documents his or her query response directly into the health record and there is a lack of supporting clinical information, it is recommended the practitioner provide the clinical rationale for the diagnosis (i.e. "Patient transfused four days ago due to acute blood loss anemia") unless the query is maintained as a permanent part of the health record. Lack of clinical rationale may raise questions in the event of any secondary review. Organizations that opt to not maintain queries as part of the permanent health record are encouraged to maintain copies as part of the administrative, business record. If the practitioner documents his or her response only on the query form, then the query form should become part of the permanent health record.

Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option. As such, providing a new diagnosis as an option in a multiple choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information. Multiple choice query formats should also include additional options such as "clinically undetermined" and "other" that would allow the provider to add free text. Additional options such as "not clinically significant" and "integral to" may be included on the query form if appropriate.

The "yes/no" query format should be constructed to include the additional options associated with multiple choice queries (i.e., "other," "clinically undetermined," and "not clinically significant and integral to"). Yes/no queries may not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record. Also new diagnoses cannot be derived from a yes/no query.

In such circumstances, open-ended or multiple choice query formats must be used. It is not considered leading to include a new diagnosis as part of a multiple choice format when supported by clinical indicators (see "Query Example: Yes/No Format"). In addition to present on admission (POA) determinations, yes/no queries may be utilized under the following circumstances:

- Substantiating or further specifying a diagnosis that is already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician
- Establishing a cause and effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus and chronic kidney disease)
- Resolving conflicting documentation from multiple practitioners

Query Example: Yes/No Format

Compliant Example 1

Clinical scenario: In the impression of the pathology report, ovarian cancer is documented; however, only ovarian mass is documented in the final discharge statement by the provider.

Query: Do you agree with the pathology report specifying the "ovarian mass" as an "ovarian cancer"? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: This yes/no query involves confirming a diagnosis that is already present as an interpretation of a pathology specimen in the health record.

Compliant Example 2

Clinical scenario: Consulting pulmonologist documents pneumonia as an impression based on the chest X-ray. However, the attending physician documents bronchitis throughout the record, including in the discharge summary.

Query: Do you agree with the pulmonologist's impression that the patient has pneumonia? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: This is an example of a yes/no query resolving conflicting practitioner documentation.

Unlike other qualifiers listed under the official coding guidelines for inpatient reporting of uncertain diagnoses, "possible" is a very broad term and therefore its use in a query is discouraged.

Verbal Queries and Missing Clinical Indicators

Verbal queries should contain the same clinical indicators and follow the same format as written queries to ensure compliance and consistency in policy and process. Documentation of the verbal query may be condensed to reflect the stated information, but should identify the clinical indicators that support the query as well as the actual question posed to the practitioner.

Query Example: Documented Conditions Without Clinical Indicators

THESE EXAMPLES PROVIDE sample wording for documentation cases that include a diagnosis without an accompanying clinical indicator.

Clinical Scenario 1

Documentation: Laboratory finding of serum sodium of 120 mmol/L and the attending physician documents hypernatremia in the final diagnostic statement.

Query: Please review the laboratory section of the present record to confirm your discharge diagnosis of hypernatremia. Laboratory findings indicate a serum sodium of 120 mmol/L.

Clinical Scenario 2

Documentation: Four-year-old child sustains a cautery injury to upper lip during maxillofacial surgery. Silvadene and dressing is applied to the affected area at the completion of the procedure and plastic surgery was consulted. The surgeon documented in the operative report that there were “no intraoperative complications.”

Query: Please review the operative note notation of “a cautery lesion to the upper lip,” subsequent treatment with Silvadene and clarify your documentation of “no intraoperative complications.”

Verbal queries should be documented at the time of the discussion or immediately following.

The focus of external audits has expanded in recent years to include clinical validation review. The Centers for Medicare and Medicaid Services (CMS) has instructed coders to “refer to the *Coding Clinic* guidelines and query the physician when clinical validation is required.”¹ The practitioner does not have to use the criteria specifically outlined by *Coding Clinic*, but reasonable support within the health record for the diagnosis must be present.

When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility’s escalation policy.

CMS recommends that each facility develop an escalation policy for unanswered queries and to address any staff concerns regarding queries. In the event that a query does not receive a professional response, the case should be referred for further review in accordance with the facility’s escalation policy. The escalation process may include, but is not limited to, referral to a physician advisor, the chief medical officer, or other administrative personnel.

Develop Query Retention Policies

Each organization should develop internal policies regarding query retention. Ideally, a practitioner’s response to a query is documented in the health record, which may include the progress notes or the discharge summary. If the record has been completed, this may be an addendum and should be authenticated. As noted in AHIMA’s toolkit, “Amendments in the Electronic Health Record,” “the addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.”

Organizational policies should specifically address query retention consistent with statutory or regulatory guidelines. The policy should indicate if the query is part of the patient’s permanent health record or stored as a separate business record. If the query form is not part of the health record, the policy should specify where it will be filed and the length of time it will be retained. It may be necessary to retain the query indefinitely if it contains information not documented in the health record. Auditors may request copies of any queries in order to validate query wording, even if they are not considered part of the legal health record.

An important consideration in query retention is the ability to collect data for trend analysis, which provides the opportunity for process improvement and identification of educational needs.

Always Follow Best Practices

Healthcare professionals that work alongside practitioners to ensure accuracy in health record documentation should follow established facility policies and procedures that are congruent with recognized professional guidelines. This practice brief represents the joint efforts of AHIMA and the Association for Clinical Documentation Improvement Specialists to provide ongoing guidance related to querying. It specifies updates to previous AHIMA practice briefs and provides support for an appropriate query process. As healthcare delivery continues to evolve, it is expected that future revisions will be required.

More Examples Online

View examples of different forms of queries (open ended, multiple choice, etc.) on the *Journal of AHIMA* website at <http://journal.ahima.org>.

These examples are also available in an appendix, “Appendix A: Query Examples,” in the online version of this practice brief in the AHIMA Body of Knowledge at www.ahima.org. ●

Note

1. Centers for Medicare and Medicaid Services. “Medicare Quarterly Provider Compliance Newsletter.” Volume 1, Issue 4. July 2011.

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 AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): 45-50.
 AHIMA. "Managing an Effective Query Process" *Journal of AHIMA* 79, no.10 (October 2008): 83-88.

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The information contained in this practice brief reflects the consensus opinion of the professionals who developed it. It has not been validated through scientific research.

EXHIBIT I

Case 3:13-cv-03891-EMC Document 179-1 Filed 06/21/22 Page 602 of 625
**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0524)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

KAISER FOUNDATION HP, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2015, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2014 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2014 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2014 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability 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 beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary 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 beneficiary enrollees. **[422.504(g)(1)]**

(b) 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 the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, 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. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, 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, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (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 request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that 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 attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that 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 attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that 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 attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

4. The MA Organization must certify based on best knowledge, information, and belief, that the information provided for the purposes of reporting and returning of overpayments under 42 CFR §422.326 is accurate, complete, and truthful. The form for this certification will be determined by CMS. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. 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 related entities related to CMS contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, to related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. 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.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. 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.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors 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. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) 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 benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA 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 benefit and price bid proposal.

(v) Establish component rates of the benefit and price 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

(b) 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 ten prior periods.
- (iii) Federal income tax or informational returns for the current contract period and ten prior periods.
- (iv) Asset acquisition, lease, sale, or other action.
- (v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) 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. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

- (i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;
- (ii) The facilities of the MA Organization; and
- (iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, 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.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the 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 fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit 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:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

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

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

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

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

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

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

(viii) Information about beneficiary appeals and their disposition;

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

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the following occur:

(i) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(ii) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(iii) substantially failed to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(iv) failed to provide CMS with valid data as required under 42 CFR §§422.310.

(v) failed to implement an acceptable quality assessment and performance improvement program as required under 42 CFR Part 422 Subpart D.

(vi) substantially failed to comply with the prompt payment requirements in 42 CFR §422.520.

(vii) substantially failed to comply with the service access requirements in 42 CFR §422.112.

(viii) failed to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(ix) substantially failed to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(x) Failed to comply with regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xi) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xii) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years.

(xiii) Has failed to report MLR data in a timely and accurate manner in accordance with 42 CFR §422.2460.

(c) Notice. If CMS decides to terminate a contract, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organizations Web site.

(d) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(b)(i) or (b)(ii) of this paragraph or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. 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 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees 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 as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

EXHIBIT J

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Title 1: Organization and Functions

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1-19.000 – PRINCIPLES FOR ISSUANCE AND USE OF GUIDANCE DOCUMENTS

A guidance document is a statement of general applicability issued by an agency to inform the public of its policies or legal interpretations. Guidance documents may take a variety of forms, including certain interpretive memoranda and manuals, policy statements, opinion letters of general applicability, and other similar materials. As it is used here, the term “guidance document” does not include legislative rules; adjudicatory or administrative actions; rulings; legal advice or trainings directed at other federal agencies; internal policies and guidelines; or litigation filings.

By definition, guidance documents “do not have the force and effect of law.” *Perez v. Mortgage Bankers Ass’n*, 575 U.S. 92, 97 (2015) (quoting *Shalala v. Guernsey Mem’l Hosp.*, 514 U.S. 87, 99 (1995)). Unlike rules promulgated through the notice and comment process, therefore, guidance documents do not bind the public and are not treated as binding by the courts. But guidance documents still serve many valuable functions. For example, interpretive guidance can “‘advise the public’ of how the agency understands, and is likely to apply, its binding statutes and legislative rules.” *Kisor v. Wilkie*, 139 S. Ct. 2400, 2420 (2019) (plurality opinion) (quoting *Perez*, 575 U.S. at 97). Guidance may also help explain an agency’s programs and policies or communicate other important information to regulated entities and the public. Guidance can collect related statutes, regulations, and other requirements in a single place. And guidance materials often convey important information to the public in language that is clearer and more accessible than the underlying statutes and regulations. Guidance documents can thus serve as an important tool to promote transparency, fairness, and efficiency.

Going forward, including in all currently pending litigation, the following principles should govern the Department’s issuance of guidance documents and, as appropriate, the Department’s use of guidance documents issued by both the Department and other agencies:

- The Department’s guidance documents should be drafted with the recognition that they do not bind the public (except where binding by operation of a grant award or contract) or have the force and effect of law. Guidance documents may, however, set forth the Department’s interpretation of binding regulations, statutes, and constitutional provisions. To reflect this distinction, Department components shall, to the greatest extent practicable: (i) label a document as guidance when it is intended as such; and (ii) cite the source of any binding legal requirement the guidance is describing.
- In the enforcement context, an agency guidance document by itself “never forms ‘the basis for an enforcement action’” because such documents cannot “impose any ‘legally binding requirements’ on private parties.” *Kisor*, 139 S. Ct. at 2420 (plurality opinion) (citation omitted). Instead, enforcement actions must be based on the

DAG Required For
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Organization And
Functions Manual

Appeals Resource
Manual

Civil Resource Manual

ENRD Resource
Manual

Civil Rights Resource
Manual

failure to comply with a binding obligation, such as one imposed by the Constitution, a statute, a legislative rule, or a contract. *See, e.g., id.* But Department attorneys handling an enforcement action (or any other litigation) may rely on relevant guidance documents in any appropriate and lawful circumstances, including when a guidance document may be entitled to deference or otherwise carry persuasive weight with respect to the meaning of the applicable legal requirements. *See id.; see also id.* at 2424–25 (Roberts, C.J., concurring in part). To the extent guidance documents are relevant to claims or defenses in litigation, Department attorneys are free to cite or rely on such documents as appropriate.

- The Department’s guidance documents should be clear, transparent, and readily accessible to the public. Department components are free to post guidance and other public-facing materials on their own websites. In addition, whenever practicable, Department components should continue posting materials to the Department’s Online Guidance Portal, <https://www.justice.gov/guidance>; guidance documents posted there should contain unique numbers and include issuance and revision dates. While the Guidance Portal is intended for guidance documents, Department components may submit to the portal other public-facing materials that are published elsewhere when the publication of those materials on the Guidance Portal would benefit the public.
- The Department’s guidance documents should reflect the breadth of expertise within the Department and should be drafted in a way that does not create inconsistencies among different components.

[updated April 2022]

◀ 1-18.000 – General Civil Settlement Principles

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