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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 (Slides 4-6)

ICON KEY	
Example	
Reminder	
Resource	

This training is organized into nine modules:

1. **Risk Adjustment Methodology**
   Provides an understanding of the CMS-Hierarchical Condition Category (CMS-HCC) model and payment methodology.

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. **Diagnosis Codes & Risk Adjustment**
   Provides important medical record documentation and coding guidelines related to risk adjustment.

6. **Edits**
   Identifies data integrity logic and error codes, error resolution, and suggestions for avoiding errors.

7. **Reports**
   Describes risk adjustment reports, and defines their uses in monitoring data collection and submission processes.

8. **Data Validation**
   Identifies the data validation approach under the CMS-HCC model, including responding to CMS medical record requests.

9. **Verifying Risk Scores**
   Describes the process for calculating the risk score and its impact on risk adjusted payment.

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.csscoperations.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.csscoperations.com to receive notification for these revisions.

Audience (Slide 7)

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

- Staff of new Medicare Advantage (MA) organizations, demonstration projects, Program of All-Inclusive Care of the Elderly (PACE) organizations, 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 organizations.

Throughout this training, the term MA organization includes all organizations listed in Table B.

TABLE B – ORGANIZATION DESCRIPTION

NAME	DESCRIPTIONS
MA Organizations	Organizations (formerly called Medicare+Choice organizations), including Medicare Advantage (MA) 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 in 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.
EverCare	The EverCare demonstration uses nurse practitioners as care providers and coordinators for the chronically ill and frail elderly living in nursing facilities. EverCare's model was developed to study the effect of providing enhanced primary and preventive care to Medicare beneficiaries who are long-stay nursing home residents.
Capitated Demonstration Projects	Capitated demonstration projects use alternative capitated financing to allow the provider to offer comprehensive medical service.

Learning Objectives (Slide 9-10)

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

- Identify the CMS-HCC model and payment methodology.
- Identify the components of the risk adjustment process.
- Describe the requirements for data collection.
- Determine the process for submitting data to CMS.
- Interpret the editing rules and steps in the error resolution process.
- Identify and interpret the reports available for risk adjustment monitoring.
- Understand the data validation approach under the CMS-HCC model.
- Understand 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 MA program. Monitors plans to improve the quality of data.	Jeff Grant jeffrey.grant@cms.hhs.gov Sean Creighton sean.creighton@cms.hhs.gov Henri Thomas henry.thomas@cms.hhs.gov Jan Keys janice.keys@cms.hhs.gov
CMS Regional Offices	Provide assistance to MA 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.csscoperations.com csscoperations@palmettogba.com
Aspen Systems Corporation	Training Contractor responsible for risk adjustment training initiatives, including regional training programs and User Group meetings.	cmstraining@aspensys.com Kristel Harms kharms@aspensys.com

MODULE 1 – RISK ADJUSTMENT METHODOLOGY

Purpose (Slide 2)

To provide information on risk adjusted payment under the Centers for Medicare & Medicaid Services – Hierarchical Condition Category (CMS-HCC) payment model. The goal of risk adjustment is to pay Medicare Advantage (MA) and Prescription Drug Plans (PDPs) 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 (Slides 3-4)

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 how to calculate a risk factor.
- Identify the new enrollee factors.
- Describe the long-term institutional model.
- Describe how to calculate the frailty adjuster.
- Recognize the components of the End-Stage Renal Disease (ESRD) model.
- Describe the new Prescription Drug Risk Adjustment model.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 Risk Adjustment History (Slides 5-11)

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.

- 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.
  - Created Medicare drug benefit to begin in 2006.
  - Established bidding methodology for MA organizations and drug plans in 2006.

- January 16, 2004-New ratebook for 2004 published.

- Revised ratebook took into account changes from MMA—adding 4th prong to the "highest of" methodology for 2004 and modifying the minimum percentage increase rate for 2004 and beyond.

📖 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.
  - Proposed revised MA payment methodology—based on MMA, 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 2005 (i.e., 45-Day notice) published.
  - Proposed changes in the MA capitation rate methodology and 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.

📖 April 7, 2005-Final diagnoses in the RxHCC model posted at http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp Crosswalks for RxHCCs are included.

1.2 CMS-HCC Risk Adjustment Payment Model (Slides 14, 17-19)

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.

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.

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

Table 1A describes the characteristics of the CMS-HCC model.

TABLE 1A – CHARACTERISTICS OF THE CMS-HCC MODEL

CHARACTERISTIC	DESCRIPTION
Selected Significant Disease (SSD) Model	• Serious manifestations of a condition are considered rather than all levels of severity of a condition. • Model is additive. • Includes most body systems and conditions with a high prevalence among the frail elderly.
Prospective Model	• Uses diagnostic information from a base year to predict total costs for the following year.
Site Neutral	• Model does not distinguish payment based on a site of care.
Diagnostic Sources	• Model recognizes diagnoses from inpatient hospital, 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	• This model includes five demographic factors: age, sex, Medicaid eligibility, disabled status, and original reason for entitlement. • These factors are typically measured as of the data collection period.
Frailty Adjuster	• Frailty add-on is used for PACE and certain demonstration plans with a frail elderly population in the community.
Community-Based and Long-Term Institutionalized Enrollees Distinguished	• Long-term institutionalized is defined as enrollees with greater than 90 days residence in an institution. • 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.

1.3 Calculating Payments

1.3.1 Payments Prior to 2003 – Demographic Adjustment Only

Prior to 2000, managed care capitation payments were adjusted based on demographic characteristics. The demographic factors were age, sex, Medicaid, and institutional status. The demographic factors were then multiplied separately by the Part A and Part B county rates (separately for aged versus disabled beneficiaries) and then added. MA organizations were paid 100 percent of this rate.

Before 1997, managed care county rates were based on average cost experience found in a county for fee-for-service Medicare, using a five year moving average of the county's share of the national average costs. From 1997 to 2000, the M+C rates for each county were defined as the maximum of three possible categories: the blended capitation rate, minimum "floor" amount, or minimum two percent increase. The blended rate was a combination of national average rates and local rates.

1.3.2 Payments from 2000 to 2003 – PIP-DCG model

Per statutory mandate, CMS was required to begin using a risk adjustment payment methodology as a part of its calculation of payment to MA plans beginning in January 2000. Under the PIP-DCG model, MA payment calculations involved two steps. The first step was to calculate the demographic portion of the adjustment. The second was to calculate a risk adjustment factor for an individual, composed of demographic characteristics within the risk model (i.e., age, gender, Medicaid status, original reason for Medicare entitlement) as well as the PIP-DCG category (if applicable) for an individual.

The M+C rates for each county were defined as the maximum of three possible categories: the blended capitation rate, minimum "floor" amount, or minimum two percent increase.

Because plans were paid based on the health status of their enrollees, CMS needed to adjust county rates for health status. CMS derived county rates for Part A and Part B by multiplying the unadjusted Part A and Part B county rates (used for demographic payments) by a rescaling factor, based on the PIP-DCG risk factor of the FFS enrollees in that county. This adjusted county amount was then multiplied by the individual's PIP-DCG risk factor to determine the appropriate payment amount. For 2000-2003, MA organizations were paid using 90 percent of the demographic payments and 10 percent of the PIP-DCG payments.

1.3.3 Payments from 2004 to 2005 – CMS-HCC model

For 2004 and 2005, MA payment calculations involved the same two steps as under the PIP-DCG model: the calculation of a demographic adjustment and a risk adjustment factor. CMS derived county rates for Part A and Part B by multiplying the unadjusted Part A and Part B county rates (used for demographic payments) by a rescaling factor, based on the CMS-HCC risk factor of the FFS enrollees in that county. This adjusted county amount was then multiplied by the individual's CMS-HCC risk factor to determine the appropriate payment amount. 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.

Prior to the passage of the MMA, the 2004 M+C rates for each county were defined as the maximum of three possible categories: the blended capitation rate, minimum "floor" amount, or minimum two percent increase. With the enactment of the MMA in December 2003, the original 2004 payment methodology changed and required a recalculation of the 2004 ratebook. The MMA mandated that a fourth amount, 100 percent of projected fee-for-service Medicare costs (with adjustments to exclude direct medical education and include a VA/DOD adjustment) be added to the payment methodology. With the addition of this 4th prong to the MA payment methodology, the formula reconnects the link between managed care payment rates and fee-for-service spending at the county level.

In addition, for 2004, the MMA modifies the methodology for calculating the minimum update rate (2 percent in 2003) to be the larger of:

- 102 percent of the previous year's rate.

or

- An increase by the Medicare growth percentage over the previous year's rate, with no adjustment to this rate for over-under projection for years before 2004.

1.3.4 MA Payment Rates for 2006

Final estimates of the increase in the National Per Capita Medicare Advantage Growth Percentage for aged beneficiaries are 4.8 percent, which is greater than 2 percent. Therefore, 4.8 percent will be used as the minimum update percentage in calculating the 2006 rates. For 2006, all demographic capitation rates will be 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.

1.3.4.1 Risk Ratebook

Once the demographic rates are determined, a rescaling factor is used to convert the demographic ratebook to get the risk adjusted rate for each county (referred to as 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.

Two adjustments are included in the 2006 rescaling factor. The first is an adjustment to make risk adjustment budget neutral (distinct from the budget neutrality for rate-setting discussed above) and the second is the fee-for-service normalization factor.

1.3.4.2 Adjustment for Budget Neutrality

While risk adjustment (without the implementation of budget neutrality) would reduce aggregate payments to the MA organizations, 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 budget neutrality, savings that would have accrued to the Medicare Trust Fund would instead be redistributed among MA organizations. The budget neutrality proportion 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.

In 2006, risk adjustment continues to be implemented in a budget neutral manner. CMS estimates the amount of adjustment to be incorporated into the rescaling factor, which for 2006 redistributed estimated payment reductions that result if risk adjustment were implemented without budget neutrality.

There are three changes in budget neutrality for 2006, and the details on each change are discussed in the three sections below.

1.3.4.3 Change in the Budget Neutrality Calculation to Account for Different Payment Methodologies for Local MA Plans Verses 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 for 2006 will be 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.

1.3.4.4 Phase Out of Budget Neutrality

Consistent with the President's FY2006 Budget, CMS is proposing to implement a phase out of risk adjustment budget neutrality, with a transition through 2010. In order for competition to work in the long run, bidding and payment must take into account risk selection. Moreover, beginning in 2006, organizations will be paid separately for the Part D drug benefit, so organizations will receive direct payments for benefits (i.e., drugs) that they were previously providing as supplemental benefits. 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 will be 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. In 2007, CMS will reduce the amount added back into the risk adjusted rates to 60 percent of the difference between payment under the demographic method and payment under risk adjustment. It will continue to reduce the percentage in accordance with Table 1B until it reaches zero percent in 2011.

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.

The MA organizations will see payments that reflect this budget neutral approach in the beneficiary-level amounts that are shown on the Monthly Membership Reports (MMR), beginning in January 2006. The reports for January 2006 are available for downloading.

1.3.4.5 Fee-for-Service Normalization Adjustment

The purpose of fee-for-service normalization is to adjust the restandardized ratebook to the appropriate denominator for the payment year. The number represents 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 has not yet stabilized the way hospital coding has. Therefore, a change to the ratebook to adjust for coding patterns is necessary.

For a complete explanation of the derivation of the demographic and risk adjusted ratebook, see the following: http://www.cms.hhs.gov/manuals/Downloads/mc86c07.pdf

1.3.5 Payments for 2006 and Beyond (Slides 12-13)

1.3.5.1 Bidding Background

Beginning in 2006, CMS' payments for plan enrollees will be 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 (or 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.

1.3.5.2 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.

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.

1.3.5.3 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 × 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 × 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 × 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

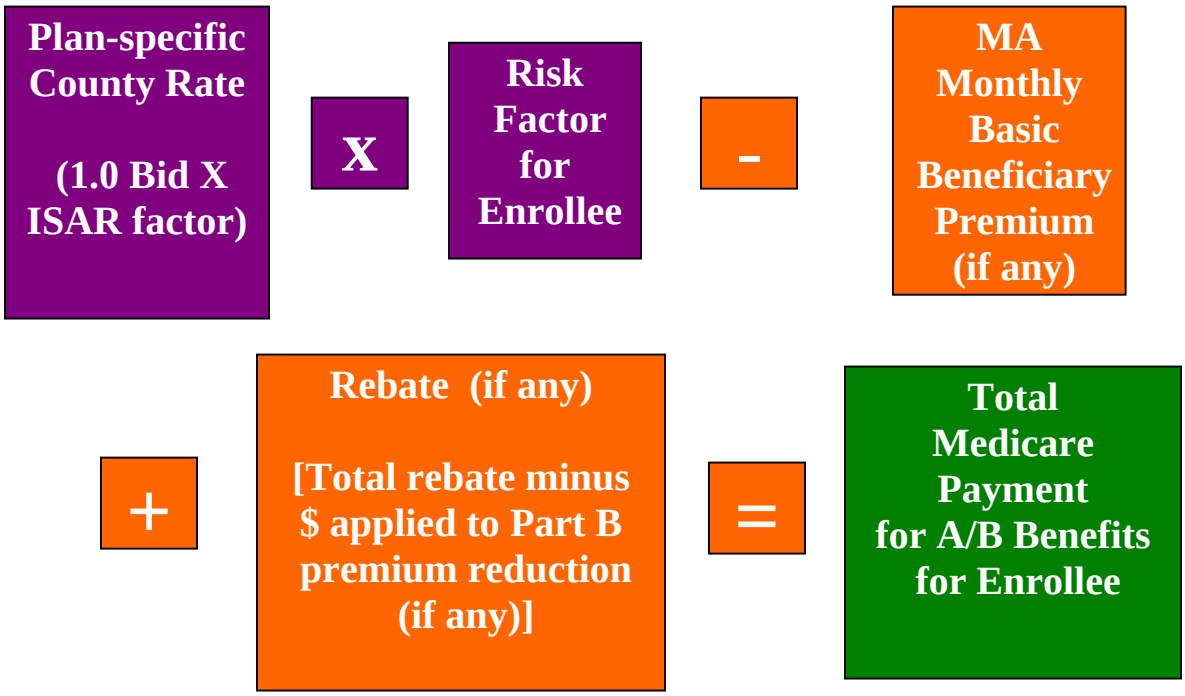
adjusted. It is a fixed amount determined through comparison of the plan A/B bid to the plan A/B benchmark based on the plan's projected enrollment.

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 X .98) = $588
- Monthly Part C payment for Mr. Jones for his plan:
  ($588 X 1.2) + 54 = $759.60

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

Figure 1A – Calculation of Risk Adjusted Payment for Plans



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

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.

1.4.1 Demographic Factors (Slides 20-21)

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). Each of these characteristics was part of the PIP-DCG calculation as well.

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 demographic payment methodology, an enrollee's age is determined by his or her age group at the end of the payment month. 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: Under the CMS-HCC model, additional payments are made for Medicaid eligible disabled individuals residing in the community. The disabled factors for enrollees under 65 years old are labeled as "disabled" and those over 65 years old are labeled as "aged."

Original Reason for Medicare Entitlement: The factors labeled "originally disabled" apply to enrollees that are 65 years old or over who were originally entitled for Medicare due to disability.

1.4.2 Disease Groups/HCCs (Slide 22)

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 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

1.4.3 Disease Interactions

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 two 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).

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 2

Two-disease Interaction for Community-Based Enrollee
Factor 1: Diabetes Mellitus (DM), HCC15 = 0.764
Factor 2: Congestive Heart Failure (CHF), HCC80 = 0.417
Factor 3: Interaction: DM*CHF = 0.253

Risk Score = (demographics) + 0.764 + 0.417 + 0.253

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

1.4.4 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 two 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 3

Disabled/Disease Interaction for Community-Based Enrollee
Factor 1: Rheumatoid Arthritis, HCC38 = 0.322
Factor 2: Opportunistic Infection, HCC5 = 0.652
Factor 2: Disabled * Opportunistic Infection = 0.789

Risk Score = (demographics) + 0.322 + 0.652 + 0.789

1.4.5 Disease Hierarchies (Slide 23)

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 4

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

1.4.6 Beneficiary Disease Profile Data

CMS uses diagnoses from either Medicare fee-for-service or from RAPS for determining the HCCs for an enrollee. Medicare fee-for-service data is utilized for risk adjusted payment when an enrollee joins a MA organization (or PACE/demonstration) after opting-out of traditional Medicare fee-for-service coverage. That is, if an enrollee new to a 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.

1.5 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 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 1C, 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.

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 8/31/2006 to elect this option.

TABLE 1C – 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.

New enrollee factors for 2006 are available at:
http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp

1.6 Long-Term Institutional Model

In 2004, the CMS risk adjustment approach began including separate models for enrollees that are considered to be long-term institutional residents. Separate models were necessary because there are significant cost differences between the traditional community-based MA beneficiary population and a long-term institutionalized beneficiary 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 1D lists the considerations for community and long-term institutionalized populations.

TABLE 1D – 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 (more flexible). • 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 1E, 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.

Note: MA organizations must continue to track the institutional status of their enrollees to ensure that CMS correctly identifies institutional status for demographic payments via the Monthly Membership Reports.

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	0.685	1.344
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.464	0.540

Table 1E reflects the distribution of Medicare beneficiaries in the January 2005 cohort institutionalized longer than 90 days as of April 2004.

TABLE 1E – DISTRIBUTION OF LONG-TERM INSTITUTIONALIZED BENEFICIARIES ACROSS PLAN TYPES - 2005

Plan Type	Total Number Beneficiaries	Number Beneficiaries Institutional	Percent of Beneficiaries Institutional	Number of Plans	Number Of Plans >5% of Beneficiaries Institutional
1876 Cost	337,869	5,435	1.61%	32	3
Dual Eligible and Other Demonstrations	7,427	2,387	32.14%	12	5
HCPP	97,210	2,512	2.58%	15	0
PACE	10,150	531	5.23%	32	19
Medicare Advantage	4,848,817	50,158	1.03%	199	12
S/HMO	133,763	840	0.63%	4	0
Total	**5,435,236**	**61,863**	**1.14%**	**294**	**39**

Key
Dual Eligible and Other Demonstrations: include Wisconsin Partnership Program (WPP), Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO), Massachusetts Senior Options (SCO)
S/HMO: Social Health Maintenance Organizations

1.7 Frailty Adjuster (Slides 24-25)

The frailty adjuster is included as part of risk adjusted payments for PACE and certain demonstrations. The purpose of the frailty adjuster is to predict Medicare expenditures that are unexplained by the risk adjustment methodology alone. 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.

1.7.1 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.

- Risk adjustment does not explain all of the variation in expenditures for the frail, community-based population. The frailty adjuster is used to explain the Medicare expenditures of community populations age 55 and over that are unexplained by risk adjustment.

1.7.2 Which Organizations Are Currently Being Paid Under Frailty Adjustment?

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

TABLE 1F – 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

1.7.3 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 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.

1.7.4 How is ADL Information Collected?

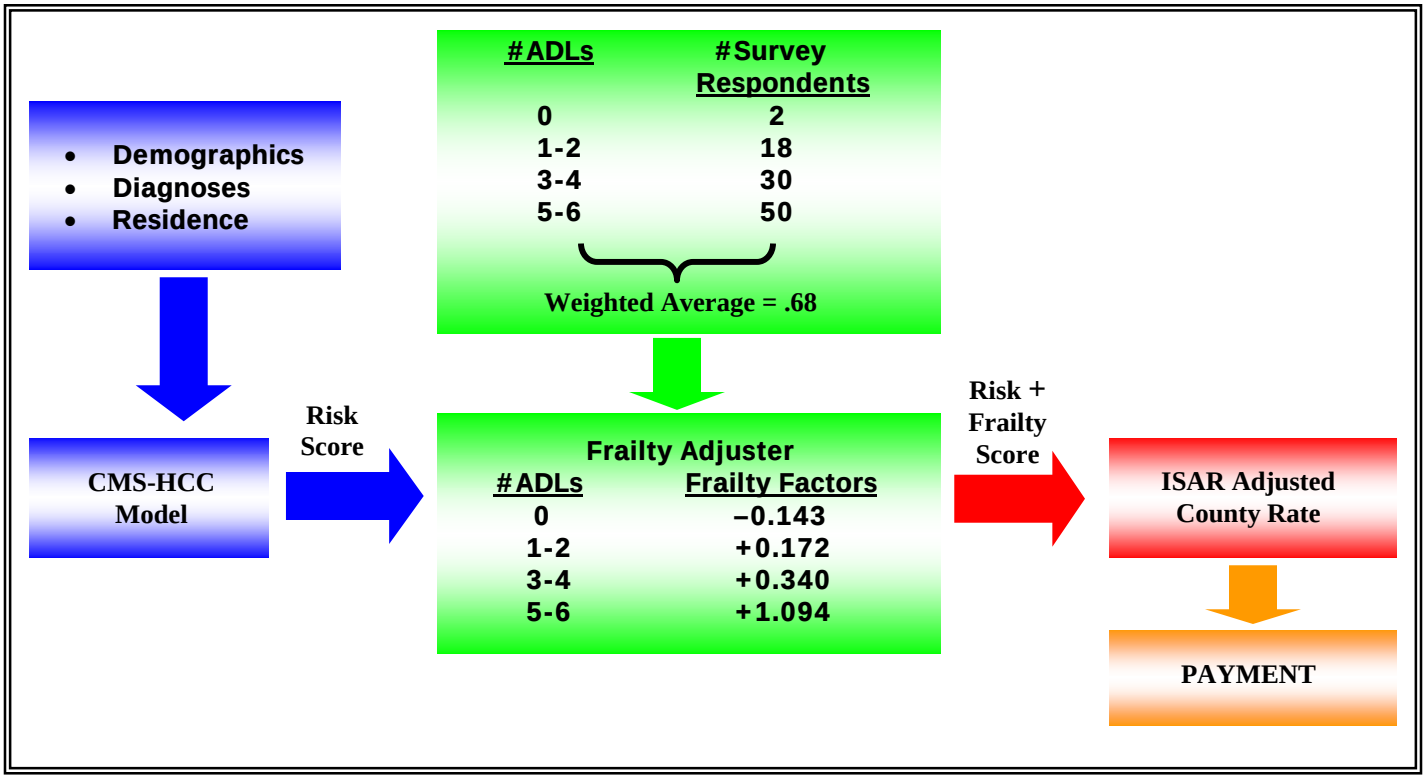
CMS collects the ADL data from organizations using the Health Outcomes Survey-Modified (HOS-M). CMS will use the annual HOS-M data to support frailty adjustments for the following payment year.

1.7.5 Calculating the Frailty Score

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



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.

1.7.6 Range of Frailty Scores and Implications For Payment (Slide 26)

The range of frailty scores varies considerably among the organizations to which frailty adjustment applies (i.e., "frailty" plans). Note that there is considerable variation in the frailty scores among PACE organizations. Moreover, there is variation in the health status of PACE enrollees for which risk and frailty adjustment accounts.

The CMS-HCC model uses diagnoses to adjust the payment 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. Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises risk scores for all of the categories of ADLs. CMS is investigating whether the addition of a frailty factor would improve payment accuracy for MA organizations.

1.7.7 Frailty Adjuster Development (Slide 28)

CMS has conducted a survey of fee-for-service beneficiaries regarding the level of frailty in the Medicare fee-for-service population. These data will help us to better determine the relationship between frailty and Medicare costs in the general Medicare population. CMS is considering using this information to develop a more accurate frailty adjuster for the Medicare Advantage program. Specifically, CMS must assess technical improvements in the adjuster by reviewing its impact on the county level ratebook and on payments for various biased sub-groups. CMS also needs to consider the impact of the interaction between applying a program wide frailty adjuster and the implementation of the new bidding methodology concurrently.

Once the technical analyses are complete, CMS must consider many policy factors in deciding whether to implement a frailty adjuster across all MA organizations. First, CMS wants to understand the payment impact of a frailty adjuster for different types of plans with various enrollee mixes. CMS also must evaluate the impact of the frailty adjuster on plans that serve special populations, including the new specialized needs plans. Based on technical merit and policy justifications, CMS will determine whether to implement a frailty adjuster across the MA program.

1.8 Updating Diagnosis Codes in the CMS-HCC Model (Slide 29)

CMS updates the CMS-HCC risk adjustment model 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. Organizations were informed of the new diagnostic codes to be collected and submitted following the October 2004 update via an announcement in the Health Plan Management System (HPMS). These updates are for data collection beginning October 1, 2004.

1.9 Payment Methodology for ESRD Enrollees (Slides 30-33)

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. 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:

1. **Dialysis Status–**A risk adjustment model that is calibrated for people on dialysis, so the payment weights are unique to these beneficiaries. A rescaled state-level ratebook was created to reflect this population's program costs.

2. **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. The former have a higher intensity of care. CMS is working to implement these differential amounts during the 2005 reconciliation.

3. **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.

1.9.1 Risk Adjustment Model for Dialysis Patients

The dialysis model has the same HCC categories used for the CMS-HCC model. One exception is that the HCCs representing kidney disease diagnoses are excluded (HCC128 to HCC132). This means that the ESRD model has only 67 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 1999 (diagnostic) and 2000 (program payment) data on fee-for-service ESRD beneficiaries. For example, expenditures for a fee-for-service beneficiary on dialysis from January through August 2000 who received a transplant in September 2000 are included in the dialysis group for eight months, but then are excluded. From September through November 2000, this beneficiary's costs are included in the transplant data to determine estimated average transplant costs. As of December 2000, this beneficiary is included in the functioning graft model.

1.9.2 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: $33,424 (average transplant costs in month 1) divided by $4,450.36 (mean monthly dialysis costs, i.e., $53,404.31/12). The relative factors for transplant reflect the costs in each month; therefore, the 1st month has a substantially higher factor (7.51) than months 2 and 3 (1.016). 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.

By examining data from 2002, when a new DRG was added that clearly specified payment for a kidney/pancreas simultaneous transplant, CMS has been able to determine a differential payment for the two transplant types. Each type will have a different factor. CMS will make additional payments for the small number of simultaneous kidney/pancreas transplants that occur in a reconciliation process after the end of the payment year.

1.9.3 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 2005 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 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.

1.9.4 Model Comparison of Coefficients

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.

1.9.5 New Enrollee Factor (Slide 34)

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.

1.9.6 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.

The ESRD information system will also remain the standard for identifying enrollees who receive a transplant. However, MA organizations will be given the opportunity to notify CMS directly of a transplant in order to receive more timely payments for a transplant. Ultimately, MA organization-reported ESRD status will be reconciled against CMS's existing ESRD information reporting system to determine final ESRD status for payment. In Fall 2004,CMS provided additional information to plans regarding direct notification of a transplant.

1.10 Part D Model (Slides 36-38)

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/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.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 the following year's expected costs 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/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp

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.

Low- Income and Long Term Institutionalization Multipliers (Slides 39-40)

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 1G for the definition of LI multipliers for the Part D benefit.

TABLE 1G – 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 2006 but was determined to be a Group 1 beneficiary for February 2006, the plan would receive the LI multiplier for February (and beyond) but not for January.)

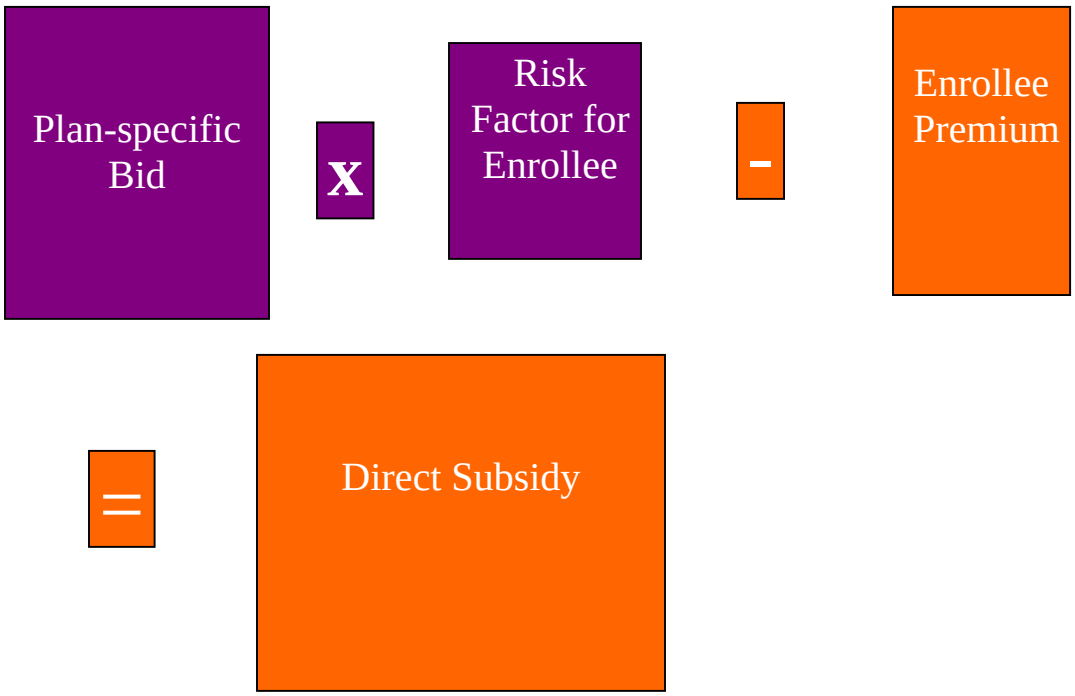
An enhancement was also computed for the predicted spending by persons institutionalized in nursing facilities for more than 90 days. Spending for this group is expected to be higher because prices for the specific packages of drugs they receive are somewhat higher than the same drugs in the community. (An analysis of drug data done by IMS Health shows 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 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



1.11 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 12-13 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.

1.12 Payment Blends

A schedule for implementing risk adjusted payments based on the CMS-HCC model and a blended transitional approach is provided 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 portion of risk adjusted payment will increase to 50 percent in 2005, to 75 percent in 2006, and finally to 100 percent in 2007. The CMS-HCC implementation schedule is shown in Table 1H.

TABLE 1H – 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 1I illustrates the risk adjustment implementation schedules for certain specialty plans.

TABLE 1I – PAYMENT BLENDS FOR SPECIALTY PLANS

TYPE OF HEALTH PLAN	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 is implementing by 100 percent rate.

1.13 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.

Example: 6

Data Collection Period: July 1, 2003 through June 30, 2004
Data Collection End Date: June 30, 2004
CY2000: First payment made based on this collection period = January 1, 2005
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.

- Beginning with risk-adjusted payments in July 2004, the 6-month lag was eliminated.
- For all subsequent years, CMS will calculate a preliminary risk factor based on lagged data. For 2005, it was based on data from July 2003 through June 2004. Payments from January 2005 through June 2005 were based on this factor.
- In July 2005 CMS used a risk factor based on non-lagged data (i.e., from calendar year 2004) 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).

Note: Organizations that desired to opt-out of the standard implementation approach for elimination of the payment lag must have notified CMS in writing by March 31, 2004.

1.14 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 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.

1.15 Special Needs Plans

The MMA establishes a new type of plan as a permanent part of the program called "specialized MA plans for special needs individuals". These are plans that exclusively serve the special needs individuals such as those who are institutionalized, Medicaid eligible or who CMS determines would benefit from enrollment in such a specialized plan and who are suffering from severe or disabling chronic conditions. Note that there is no special payment provision that applies to these types of plans.

MODULE 2 – RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

Purpose (Slide 2)

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 (Slide 3)

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

- Identify 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 4)

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 is 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.
MBD	The **Medicare Beneficiary Database** maintains Medicare beneficiary eligibility data.
HPMS	The **Health Plan Management System** is a CMS MA information system that contains health plan-level data.
Relevant Diagnosis	ICD-9-CM diagnosis code in the CMS-Hierarchical Condition Category (HCC) model.

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 5)

- The data required under the risk adjustment process include:
  - Health Insurance Claim (HIC) number.
  - Diagnosis code.
  - Service from/through dates.
  - Provider type (hospital inpatient, hospital outpatient, physician).
  - Patient control number (optional).
  - Date of birth (optional).
- 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 relevant 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 6)

- MA organizations may choose to collect data from providers in a variety of formats:
  - Standard fee-for-service claim or encounter formats
    - Full or abbreviated Uniform Billing Form 92 (UB-92) v6.0
    - 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

2.2.3 Risk Adjustment Data Submission (Slide 7)

- MA organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing any of the following formats:

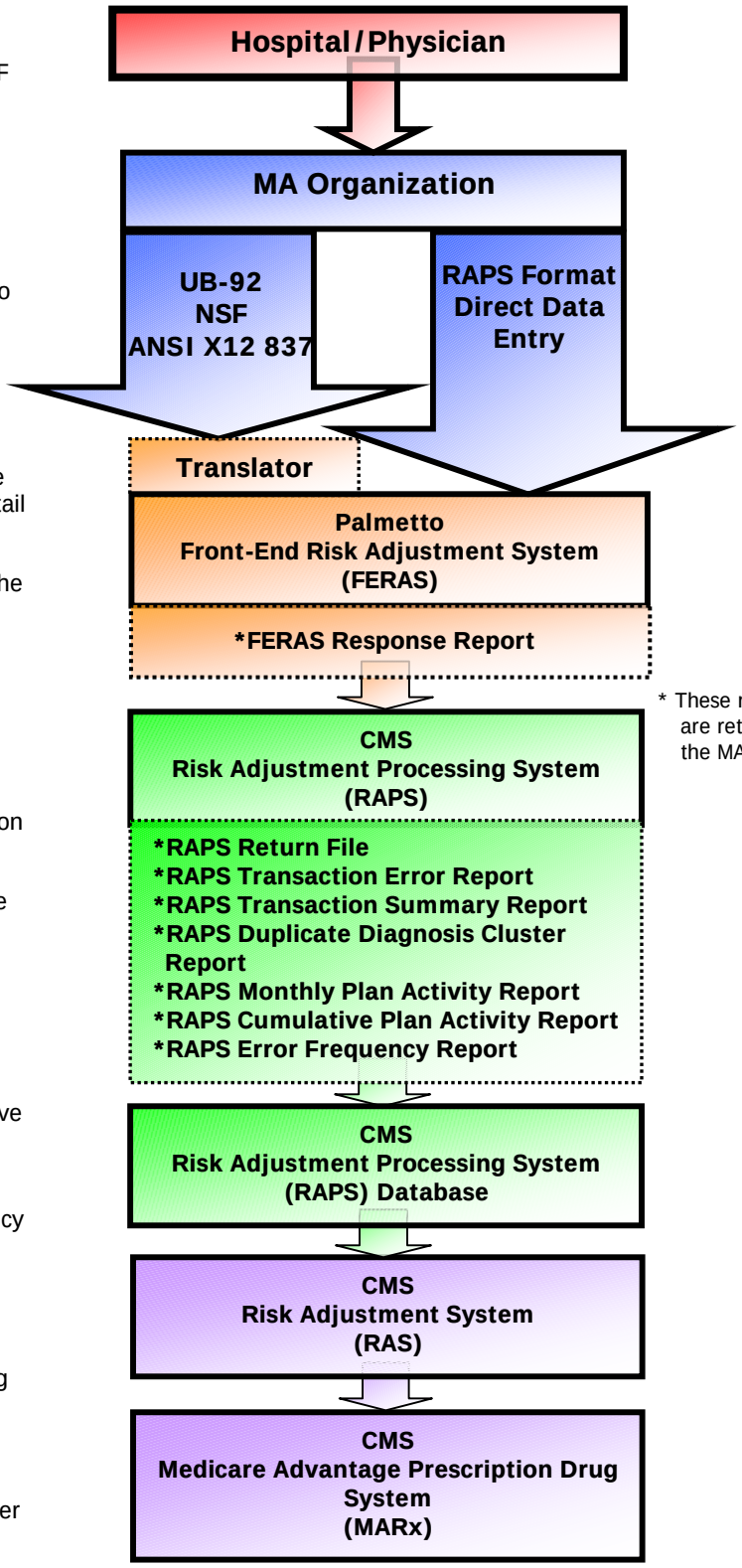
  - Full or abbreviated UB-92 v6.0 (hospital inpatient and hospital outpatient)
  - NSF v3.01 (physician)
  - ANSI X12 837 v30.51 or v40.10 (all types of data) (HIPAA uses v40.10)
  - RAPS format (all types of data)
  - Direct Data Entry Screen (all types of data)

Figure 2A illustrates the risk adjustment dataflow.

2.2.4 Risk Adjustment Dataflow (Slide 8)

- Hospital/physician submits data to MA organization via:
  - Full or abbreviated UB-92 v 6.0, 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.
- If the MA organization submits data via the UB-92, NSF, or ANSI formats, Palmetto translates the data to the RAPS format.
- If the MA organization submits the data via Direct Data Entry or in the RAPS format, data do not need translation.
- 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



2.2.5 Important Information About Risk Adjustment Processing

- MA organizations transmit data to FERAS at Palmetto GBA. If the data are submitted to FERAS via the UB-92, NSF, or ANSI X12 837 formats, the file is automatically translated to the RAPS format.
- 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 hospital inpatient bills (112, 113, and 114 bill types) must not be submitted. If a MA organization receives interim bills, the organization should submit the hospital inpatient diagnoses on receipt of the final bill (114). This means the appropriate *discharge* diagnoses will be submitted for risk adjustment, rather than the *admitting* diagnoses.

2.3 Submission Schedule (Slide 9)

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 May 15, 2006. Beginning in 2007 (CY 2006 data), the reconciliation deadline changes to January 31. The schedule and these changes are illustrated in Table 2B.

TABLE 2B – SUBMISSION TIMETABLE

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2005	July 1, 2003 through June 30, 2004	September 3, 2004	January 1, 2005	NA*
2005	January 1, 2004 through December 31, 2004	March 4, 2005	July 1, 2005	May 15, 2006
2006	July 1, 2004 through June 30, 2005	September 2, 2005	January 1, 2006	NA*
2006	January 1, 2005 through December 31, 2005	March 3, 2006	July 1, 2006	January 31, 2007
2007	July 1, 2005 through June 30, 2006	September 1, 2006	January 1, 2007	NA*
2007	January 1, 2006 through December 31, 2006	March 2, 2007	July 1, 2007	January 31, 2008
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

*With elimination of the payment lag, the final submission deadline (reconciliation) is May 15 in 2006 and then becomes January 31 from 2007 forward. There is no longer a September 30 deadline for reconciliation.

2.4 Training and Support (Slide 10)

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 midnight Saturday through noon Sunday when systems and equipment are routinely maintained.
www.csscoperations.com	The CSSC website, www.csscoperations.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 is 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.csscoperations.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.
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.
Getting Started Training Program	The program presents the basics about the risk adjustment process for MA organizations and staff new to risk adjustment. It includes a self-paced video, workbook, and resource guide.
Regional Training Program	The program provides practical training for new and current users.
Regional Training Video	This is a video version of the 2005 Regional training.
Physician Training CD	This interactive CD provides important risk adjustment medical record documentation and coding guidelines in accordance with the CMS risk adjustment data collection requirements.

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 for your organization. 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.
- Identify the three sources of risk adjustment data.
- Identify data collection formats available to MA organizations.
- Discuss factors to consider when determining the method for collection of diagnostic data.
- Discuss 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 numeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers followed with 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.

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. They 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.

3.1.3 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, reflecting 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 an 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. A network hospital should have a Medicare provider billing number as a hospital inpatient facility. Table 3B identifies covered and non-covered facilities with regard to risk adjustment data collection.

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. This will be covered in the Data Submission module.

Table 3D illustrates the steps MA organizations may use to identify the provider numbers of facilities.

3.2.2 Hospital Outpatient (Slide 12)

Hospital outpatient services are therapeutic and rehabilitative 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 facilities are Medicare certified, network, or non-network. Table 3C identifies covered and non-covered hospital outpatient facilities.

TABLE 3C – HOSPITAL OUTPATIENT

PROVIDER TYPE	COVERED FACILITIES		NON-COVERED SERVICES	NON-COVERED FACILITIES*
Hospital Outpatient	• 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 (formerly Christian Science Sanatoria)**	• Long-term Hospitals • Rehabilitation Hospitals • Children's Hospitals • Psychiatric Hospitals • Rural Health Clinic (Free-standing and Provider-Based)**	• Laboratory Services • Ambulance • Durable Medical Equipment • Prosthetics • Orthotics • Supplies • Radiology Services	• Free-standing Ambulatory Surgical Centers (ASCs) • Home Health Care • Free-standing Renal Dialysis Facilities

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

- **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.

- **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.

- **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.

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

MA organizations are responsible for ensuring that data collected and then submitted are acceptable for the risk adjustment process. The Medicare provider number is the most appropriate indicator 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 of facilities.

TABLE 3D – DETERMINING COVERED HOSPITAL ENTITY PROVIDER NUMBERS

SITUATION	ISSUE	ACTION
Situation 1	The provider number has been idenitifed.	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.	Obtain the provider number 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; therefore, do not submit risk adjustment data for this provider until the provider number can be obtained.
Situation 3	An out-of-network provider submits a claim without a provider number.	Try to obtain a provider number, if possible. If no provider number is available, check the list of Veterans Administration and Department of Defense (VA/DoD) listings published on csscoperations.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.

3.2.2.2 Medicare Provider Numbers (Slide 14)

There are several sources that may be used to verify that the data are acceptable for risk adjustment. Hospital inpatient (and hospital outpatient) data have associated Medicare provider numbers.

- MA organizations should verify that diagnoses are provided by Medicare certified hospitals/facilities.
- All network hospital/facilities must be Medicare certified and will have a Medicare provider number.

The provider number 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	20	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, with the exception of **U, W, Y, Z, 5** or **6**. These exceptions indicate that the service was provided in a swing bed component of a hospital or a skilled nursing facility. The last three characters are numerals unique to the 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 and home health care are not covered entities for risk adjustment data.

MA organizations may wish to create a system for checking the Medicare provider number against a list of provider number ranges that identify what type of service has been rendered. The following two tables (3F and 3G) provide the range of potential characters for inpatient and outpatient facility services.

TABLE 3F – HOSPITAL INPATIENT COVERED ENTITIES

TYPE OF HOSPITAL INPATIENT FACILITY	NUMBER RANGE
Short-term (general and specialty) Hospitals	XX0001 – XX0899 XXS001 – XXS899 XXT001 – XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225 – XX1399
Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1990 – XX1999
Long-term Hospitals	XX2000 – XX2299
Rehabilitation Hospitals	XX3025 – XX3099
Children's Hospitals	XX3300 – XX3399
Psychiatric Hospitals	XX4000 – XX4499

TABLE 3G – HOSPITAL OUTPATIENT COVERED ENTITIES

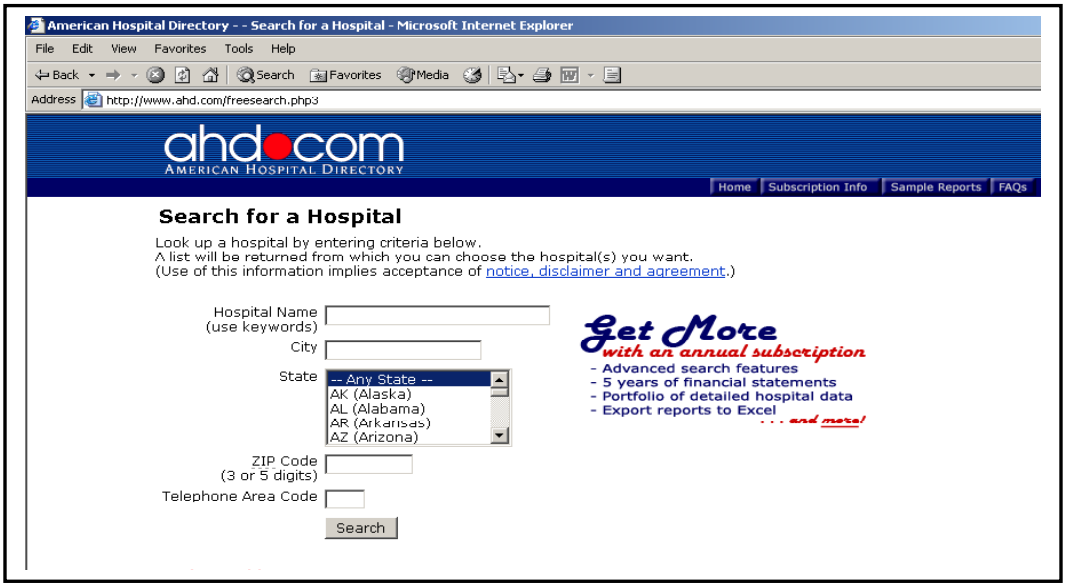
TYPE OF HOSPITAL OUTPATIENT FACILITY	NUMBER RANGE
Short-term (general and specialty) Hospitals	XX0001 – XX0899 XXS001 – XXS899 XXT001 – XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225 – XX1399
Community Mental Health Centers	XX1400 – XX1499 XX4600 – XX4799 XX4900 – XX4999
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1800 – XX1999
Long-term Hospitals	XX2000 – XX2299
Rehabilitation Hospitals	XX3025 – XX3099
Children's Hospitals	XX3300 – XX3399
Rural Health Clinics, Freestanding and Provider-Based	XX3400 – XX3499 XX3800 – XX3999 XX8500 – XX8999
Psychiatric Hospitals	XX4000 – XX4499

MA organizations may access the **American Hospital Directory** www.ahd.com/freesearch.php3 for assistance in determining hospital provider numbers. 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 should 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 might be different then what is included in the database.
- Avoid entering abbreviations.

Figure 3A is a picture of the search page on the American Hospital Directory website.

Figure 3A – American Hospital Directory



See Resource Guide for more information about Medicare provider numbers.

3.2.3 Physician Data (Slide 15)

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

Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment. The Medicare provider number does not apply to the collection of physician data.

TABLE 3H – ACCEPTABLE PHYSICIAN DATA SOURCES

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).

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 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 visit during the data collection period.

For example, a prescription for an ACE inhibitor, alone, would not be considered sufficient for the sole data source of "clinical evidence" of congestive heart failure (CHF); instead, the medical record would need 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 would also not be considered to be sufficient "clinical evidence" of diabetes–the medical record would need 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

These are several formats that MA organizations can accept when collecting data from medical providers. The formats are listed by provider type in Table 3I.

3.3.1 Data Collection Formats (Slide 17)

For facility services, the standard billing format is UB-92 (Uniform Billing Form –1992 version). The HCFA 1500 form is the standard format for physician services.

TABLE 3I – DATA COLLECTION FORMATS

HOSPITAL INPATIENT/HOSPITAL OUTPATIENT	• Full UB-92 • Abbreviated UB-92 • ANSI X12 837 4010 • RAPS Format
PHYSICIAN	• HCFA 1500 • NSF 3.01 • ANSI X12 837 4010 • RAPS Format • Superbill

3.3.2 Collection Format Features

The decision regarding the data collection tool should be considered carefully, as it 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-92*		•		•		•
Abbreviated UB-92*		•		•		•
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 their providers. A variety of collection formats may be used for different providers. If you are planning to use multiple collection formats, you may need to consider 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.

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 3B and 3C. 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 relevant risk adjustment diagnoses have been bolded.

The second example illustrates what the same superbill might look like if it were 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.

FIGURE 3B – SAMPLE FEE-FOR-SERVICE SUPERBILL

JOHN E. DOE, M.D.
Internal Medicine
Board Certified

123 Main Street
Anytown, UL 99999
Office (555) 555-5555
Billing (555) 555-5550
TAX I.D. #12345678

PATIENT NAME | INSURANCE

OFFICE PATIENT NUMBER	ADMIT DATE	DIAGNOSIS
847		

DR#	ACCIDENT TYPE	1)	2)	3)	4)
	☐ Work Comp DATE OF ACCIDENT ☐ Auto ☐ Other _____/_____/_____				

OFFICE SERVICE

	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	___

PHYSICALS

	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	___

INITIAL HOSPITAL CARE

Level 1	99221	___	95 ___
Level 2	99222	___	156 ___
Level 3	99223	___	213 ___

DAILY HOSPITAL CARE

Level 1	98231	___ ___ ___	
From _____ To _____ @ $55			
Level 2	99232	___ ___ ___	
From _____ To _____ @ $87			
Level 3	99	___ ___ ___	
From _____ To _____ @$145			
Discharge	98238	___	
Discharge-over 30	99239	___	

NEW/ESTABLISHED HOME CARE

Partial Detailed	99302	___	3 ___
Partial Comprehensive	99303	___	___
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	___ ___	___

PROCEDURES

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 ___

IMMUNIZATIONS & INJECTIONS

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 _____	_____	___	___

NOT INTENDED FOR REPRODUCTION

☐ MCR PAP SMEAR
992__-25 E&M
Q0091 Pap $50
G0101 P&B Exam $60
V15.80 High Risk Dx
V76.2 Routine Dx

☐ FLU SHOT
90659 Flu Shot
90471 Admin
V04.8 Flu Vaccine Dx

☐ MCR FLU SHOT
90859 Flu Shot
G0008 Admin
V04.8 Flu Vaccine Dx

☐ PNEUMOVAX
80732 Shot
90471 Admin
V03.82 Vaccine Dx

☐ MCR PNEUMOVAX
90732 Shot
G0008 Admin
V0[illegible] Vac[illegible]

☐ HEPATITIS
9074[illegible]lt Sh
9074[illegible]ld Sh
90[illegible]in
V0[illegible]ne Dx

☐ HEPATITIS A
90632 Shot
90471 Admin
V08.3 Vaccine Dx

☐ TETANUS
90707 Shot
90471 Admin
906.5 Vaccine Dx

☐ B-12 INJECTION
J3420 Shot
80782 Admin
266.2 B-12 Dx

Next Visit

Total: $ _____
Amt Pd $ _____
11 ☐ Check # _____
43 ☐ Co-Pay Not Collected

Physician Signature Date

DIAGNOSIS CODES: ICD-9-CM

__789.00 Abdominal Pain, NEC
__796.4 Abnor Unexpl Tst
__762.3 Adema
__427.31 A. Fib.
__285.9 Anemia NOS
__413.9 Angina
__V58.61 Anticoag Med
__300.00 Anxiety
__427.9 Arythmia NOS
__719.40 Arthralgia
__716.00 Arthritis Acu Chron
__714.0 Arthritis, Rheum
__429.2 ASCVD
__493.90 Asthma
__724.2 Back Pain
__578.1 Blood in Stool
__726.91 Bone Spur
__174.9 Breast CA, Female
__611.72 Breast Lump
__490 Bronchitis
__727.3 Bursitis
__ 682.9 Cellulitis, NOS
__767.99 Chg/Bowel/Habits
__780.9 Chg
__786.50 Chest Pain
__428.0 CHF
__574.20 Cholellthlasis, NOS
__153.9 Colon C[illegible]
__564.0 Constipatio[illegible]
__496 COPD
__436 CVA
__799.4 Deconditior[illegible]
__276.5 Dehydratior[illegible]
__294.8 Dementia
__311 Depression
__692.9 De[illegible]atitis
__250.92 [illegible]abetes[illegible]tle
__[illegible]ab[illegible]
__250.62 Diab Neuropathy
__250.00 Diabetes, NIDDM
__250.50 Diabs, Retinopathy
__250.00 Diabetes, Type I I
__250.32 Diabetic Coma
__787.91 Diarrhea
__562.11 Diverticulitis
__780.4 Dizziness/Vertigo
__453.8 DVT
__787.2 Dysphagia
__780.7 Fatigue
__610.1 Fibrocystic Breast Dis
__729.1 Fibromyalgia
__558.9 Gastroenteritis
__530.81 GERD
__578.9 GI Bleeding
__240.9 Goiter
__274.9 Gout
__242.0 Graves Disease
__245.2 Hashimotos
__307.81 Headache, Tension
__784.0 Headache
__V70.0 Health Maint
__V43.2 Heart Valve Repl
__455.6 Hemorrhoids
__573.3 Hepatitis, NOS
__070.1 Hepatitis A
__070.30 Hepatitis B
__070.61 Hepatitis C, Acute
__070.54 Hepatitis, C, Chron
__V05.3 Hepatitis Viral, Vac
__704.1 Hirsutism
__276.7 Hyperka
__272.4 Hyper
__276.0 Hyper
__252.0 Hyperparathyroid
__401.9 Hypertension
__242.90 Hyperthyroid
__276.8 Hypokalemia
__276.1 Hyponatremus
__244.9 Hypothyroid
__788.30 Incon Urinary
__487.1 Influenza
__V04.8 Influenza Vac
__780.52 Insomnia
__564.1 Irrit Bowel Syn
__386.30 Labyrinthitis
__710.0 Lupus
__263.9 Malnutrition
__995.2 Med Side Effect
__410.9 MI, Acu, Unspec
__412 MI, Old 8+ wks
__424.0 Vive Pro
__728.85 Muscle Spasm
__355.9 Neuropathy
__278.00 Obesity
__110.0 Onychomycosis
__733.00 Osteopotasin
__388.70 Otalgia
__362.9 Otitis Media
__V15.89 Pap High Risk
__V76.2 Pap Rout MCR
__625.9 Pelvic Pain, Fem
__281.0 Perrouout Anem
__462. Pharyngitis
__486 Pneumonia
__V03.82 Pneumonia Vac
__627.2 Post Meno Synd
__V72.84 Preop Exam
__185 Prostate Cancer
__600.0 Prostate Hyper
__601.9 Prostatis
__896.1 Psoriasis
__415.19 Pulmon Embol
__569.3 Rectal Bleeding
__592.9 Renal Lithisis
__477.9 Rhinitis, Allergic
__473.9 Sinusitis
__709.9 Skin Lesion
__305.10 Smoker
__848.9 Strain/Spasm, NOS
__780.2 Syncope/Collapse
__079.89 System Vrt Infect
__451.9 Thrombophlebitia
__193 Thyroid CA
__241.0 Thyroid Nodule
__245 Thyroiditis
__533.9 Ulcer, Peptic
__411.1 Unstable Angina
__465.9 URI
__599.0 UTI
__616.10 Vaginitis
__286.2 Vit B-12 Deficiency
__380.4 Wax in Ears
__783.2 Weight Loss
__V72.3 Well Woman

FIGURE 3C – SAMPLE RISK ADJUSTMENT SUPERBILL

JOHN E. DOE, M.D.
Internal Medicine
Board Certified

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	Arrythmia
__285.9	Anemia,NOS
__284	Aplastic Anemia
__413	Angina
__300.00	Anxiety
__716.90	Arthritis, NOS
__714	Arthritis, Rheumatoid
__427.9	Arrythmia,NOS
__429.2	ASCVD
__493.00	Asthma
__493.2	thma COP
__174	east C male
__511.72	east
__490	NOS
__466.0	nchitis, acute
__491	nchitis, chroni
__[illegible]	litis, 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	Fibromyalagia
__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
__386.30	Labyrinthitis
__710	Lupus
__263	Malnutrition
__995.2	Medicine Side Effect
__410	MI
__424.0	Mitral Valve
__355.9	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

Other:

Next Visit

Total: $ _____
Amt Pd $ _____

12 ☐ Check # _____
44 ☐ Co-Pay Not Collected

Physician Signature Date

3.3.4 Factors Affecting Data Collection Method (Slide 18)

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 that is 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 19)

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 will affect how data are collected 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.

3.4 Health Information Portability and Accountability Act (HIPAA) (Slide 20)

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.

- **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 that has been 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).

Your organization 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.

- **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:

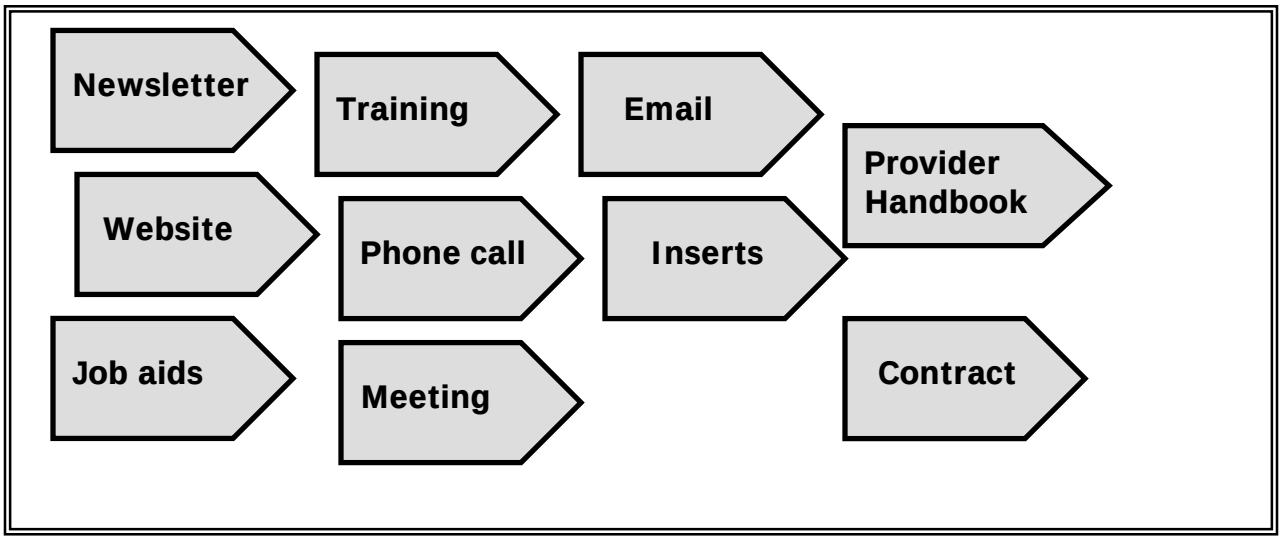
- **Identify the methods that tend to work best for your organization.** Many MA organizations indicate that the organization's provider Web page and newsletters reach a large audience, but small and large group training sessions are most successful for causing a change in action.

- **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 3D. 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.

Figure 3D – Communication Methods



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.

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 the MA organization must complete the EDI Agreement. MA organizations 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.

MA organizations must submit during each quarter, at a minimum, approximately one-fourth of their total risk adjustment data submission for the collection period. More frequent submissions are recommended and 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. It is used to submit risk adjustment to CMS and receive information in return. The three connectivity options are described in Table 4A.

TABLE 4A – CONNECTIVITY OPTIONS

Connect:Direct	Formerly Network Data Mover (NDM). Mainframe-to-mainframe connection. Next day receipt of FERAS response.
FTP **File Transfer Protocol**	Modem-to-modem connection. Requires password and phone line. Same day receipt of FERAS response.
Secure Website	Extranet site hosted by Palmetto. Point and click features. Same day receipt of FERAS response. Allows for Direct Data Entry.

4.3 Relevant Diagnosis (Slide 8)

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

For payments beginning on January 1, 2006, the initial submission deadline is September 2, 2005 for the reporting period July 1, 2004 through June 30, 2005. For payments beginning on July 1, 2006, March 3, 2006 is the initial submission deadline for reporting data with dates of service January 1, 2005 through December 31, 2005. **Refer to the Risk Adjustment Process Overview module, Table 2B.**

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

- The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model.
- 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 diagnosis was recorded based on 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 that were not collected from one of the three provider types shall not be submitted as risk adjustment data.

4.4 Submission Formats (Slide 9)

MA organizations must submit data electronically using one of five formats:

- RAPS format (for all provider types)
- National Standard Format (NSF) (physician only)
- Universal Bill - 92 (UB-92) (hospital inpatient and hospital outpatient)
- American National Standards Institute (ANSI) (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

A summary of the RAPS file structure may be seen in Figure 4A.

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

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.

4.7 Provider Type

MA organizations must submit risk adjustment data for hospital inpatient, hospital outpatient, and physician services. All provider types may be submitted 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.

TABLE 4B – PROVIDER TYPES

PROVIDER TYPE	CODE
Principal Hospital Inpatient (principal diagnosis)	01
Hospital Inpatient Other (other diagnosis)	02
Hospital Outpatient	10
Physician	20

All records submitted in the NSF format are considered to be physician records and will automatically be translated to provider type code "20." Therefore, MA organizations must submit only data that qualify as physician data when using the NSF.

All records submitted on the UB-92 must include a type of bill so that the correct provider type can be translated. Table 4C shows the bill types.

TABLE 4C – BILL TYPES

PROVIDER TYPE	BILL TYPE
01 or 02	111 or 11Z
10	131, 13Z, 141, or 14Z

4.8 From and Through Dates

- Format should always be CCYYMMDD.
- "Through Date" determines the date of service for risk adjustment purposes.

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

TABLE 4D – 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		

June 30, 2006 should be submitted as 20060630.

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

Interim bills (112, 113, & 114 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). If the MA organization uses the UB-92, submit the final interim bill as bill type 111 or 11Z. This allows the appropriate discharge diagnoses to be submitted for risk adjustment, rather than the admission diagnoses.

4.9 Diagnosis Code

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

4.10 RAPS Format

- Each field of the RAPS file layout is described below in Table 4E.
- The shaded fields in the table represent where new information will be provided on the RAPS Return File after data are processed through RAPS.
- There are two diagnosis cluster error fields because MA organizations can receive up to two errors on any diagnosis cluster.

TABLE 4E – 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 should be formatted as CCYYMMDD.
5	28-31	Required	Production Test Indicator	Must be populated with "PROD" or "TEST." Submission test data will proceed 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. This field should always be 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 H# assigned by CMS.
4	16-512	Spaces	Filler	Must be populated with 497 spaces. The "Filler" field allows for additional fields in the future.

TABLE 4E – 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.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return, this field will be 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 will be populated with an error code if RAPS finds an error in the HIC number, or remain 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 will edit 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 will be populated with an error code if RAPS finds an error with DOB, or remain blank if no errors were detected in the DOB.

TABLE 4E – 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 will be populated with one error code if RAPS finds an error in the diagnosis cluster, or remain 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 will be populated with one error code if RAPS finds an error in the diagnosis cluster, or remain blank if no errors were detected in the diagnosis cluster.
19	413-437	RAPS RETURN	Corrected HIC number	This must be submitted with spaces. If the MA organization has submitted an outdated HIC, upon return, this field will be populated with the most current HIC number and the "HIC Error" field will contain 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.

TABLE 4E – 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).
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.

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, Table 3B** 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, Table 3H** 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, Table 3C** for examples of covered facilities and non-covered services/facilities.

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

a) 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).

b) 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).

c) 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.

4.12 Modifying Risk Adjustment Data (Slide 15)

RAPS allows for the correction of risk adjustment data that have been 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 information is added. For this reason, data correction is at least a two-step process.

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 is submitted erroneously (e.g., data from an interim bill was submitted for hospital inpatient).
- Incorrect HIC number was 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").

Deletions may be submitted 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 Risk Adjustment System (RAS) 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.csscoperations.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.

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 RAS.
- 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 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 National Standard Format (NSF) (Slide 22)

- NSF format is used to submit physician data.
- Table 4F below describes the minimum data set required for NSF submission. This format is translated into the necessary RAPS data set in FERAS prior to the editing process. To protect the integrity of the file, the data must be located in the correct position in the flat file format.
- Files processed by FERAS must be submitted with Payer ID C80883 (NSF RT AA0 17.0).

TABLE 4F – NSF MINIMUM REQUIRED FIELDS

RECORD TYPE/ FIELD NO	NSF POSITION	NSF FIELD NAME	NSF EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
AA0 1.0	1-3	RECORD ID	The first record in the file. Must be "AA0."	AAA 1	The first record in the file. Will be translated to "AAA."
AA0 2.0	4-19	SUBMITTER ID (SHnnnn)	The 6 alphanumeric characters assigned by CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled	AAA 2	The 6 alphanumeric characters assigned by CSSC that identify the submitter.
AA0 5.0	35-40	SUBMISSION NUMBER	The inventory file number assigned by the submitter's system. Must be unique for every new file submitted. This number may not be reused in a 12-month period.	AAA 3, ZZZ 3	This field allows for 6 alphanumeric characters. This file identification number is assigned by the submitter for tracking submissions. This number may not be duplicated within a 12-month period.
AA0 15.0	213-220	CREATION DATE	The date the file was created.	AAA 4	This is the date the file was submitted to FERAS in the CCYYMMDD format.
AA0 21.0	254-257	TEST/ PRODUCTION INDICATOR	This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission.	AAA 5	This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission.
BA0 1.0	1-3	RECORD ID	The first record in the batch. Must be "BA0."	BBB 1	This is the first record in the batch. Will be translated to "BBB."
BA0 4.0	22-25	BATCH NUMBER	Sequential number assigned by the submitter to each batch of claims. Must be numeric 0001 through 9999. Increment by 1 for each BA0 record.	BBB 2	This is a sequential number assigned by the submitter to each batch of detail records. Contains 7 digits beginning with 0000001. FERAS will right justify and zero fill the first 3 positions.

TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)

RECORD TYPE/ FIELD NO	NSF POSITION	NSF FIELD NAME	NSF EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
BA0 9.0	48-62	PLAN NUMBER	In encounter data, MA organizations enter the H number of the MA organization assigned by CMS, left justified and space filled.	BBB 3, YYY 3	The plan number indicates the unique H number of the MA organization assigned by CMS. Field is 5 characters with no spaces.
CA0 1.0	1-3	RECORD ID	The first record in the claim. Must be "CA0."	CCC 1	This is the first record in the detail record. Will be translated to "CCC."
CA0 3.0	6-22	PATIENT CONTROL NUMBER	This field contains up to 17 characters that identify the encounter data transaction of the beneficiary. The patient control number is assigned by the MA organization.	CCC 4	This field allows up to 40 characters that identify the beneficiary. Upon translation, the 17-character NSF PCN will be left justified and space filled. The patient control number is assigned by the MA organization. This field is optional.
CA0 8.0	59-66	PATIENT DATE OF BIRTH	This field must indicate the date of birth for the beneficiary in CCYYMMDD format. This date must be prior to or equal to the From Date.	CCC 7	This optional field indicates the date of birth for the beneficiary in CCYYMMDD format. This date must be prior or equal to the From Date.
DA0 18.0	157-181	MEDICARE NUMBER (HIC)	The HIC number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first 9 characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces.	CCC 5	The HIC Number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first 9 characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces.

TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)

RECORD TYPE/ FIELD NO	NSF POSITION	NSF FIELD NAME	NSF EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
EA0 32.0	179-183	DIAGNOSIS CODE 1	ICD-9-CM format – DO NOT use a decimal point.	CCC 9.4	This is the valid ICD-9-CM code for this submission. Do not use a decimal point.
EA0-33	184-188	DIAGNOSIS CODE 2	ICD-9-CM format – DO NOT use a decimal point.	CCC 10.4	
EA0-34	189-193	DIAGNOSIS CODE 3	ICD-9-CM format – DO NOT use a decimal point.	CCC 11.4	
EA0-35	194-198	DIAGNOSIS CODE 4	ICD-9-CM format – DO NOT use a decimal point.	CCC 12.4	
FA0 5.0	40-47	SERVICE FROM DATE	Date service was initiated. This date indicates the date of the encounter. Must be present, must be a valid date, and cannot be greater than the current date.	CCC 9.1 CCC 10.1 CCC 11.1 CCC 12.1	This same date will be used for each diagnosis cluster in this record.
FA0 6.0	48-55	SERVICE TO DATE	Must be equal to or greater than Service From Date. This date indicates the date of the encounter. Must be present, must be a valid date, and cannot be greater than the current date.	CCC 9.3 CCC 10.3 CCC 11.3 CCC 12.3	If left blank, RAPS will insert the same date as the From Date. These same dates will be used for each diagnosis cluster in this record.
YA0 1.0	1-3	RECORD ID	Must be "YA0." This is the last record of any electronically submitted batch. It contains information pertinent to the balancing of each batch (i.e., batch record count, batch charges) within a file.	YYY 1	This is the batch level trailer record. It is translated to "YYY."

TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)

RECORD TYPE/ FIELD NO	NSF POSITION	NSF FIELD NAME	NSF EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
YA0 4.0	22-25	BATCH NUMBER	Sequential number assigned by the submitter to each batch of claims. Must be numeric 0001 through 9999. Increment by 1 for each BA0 record.	YYY 2	This 4-digit number must agree with the BBB 2 record.
YA0 10.0	61-67	BATCH CLAIM COUNT	May not be blank. Must be numeric. Must be computed sum of all Record Types CA0 included between this Batch Trailer Record (YA0) and preceding Batch Header Record (BA0). Right justify, zero fill.	YYY 4	This 7-digit number must agree with the total number of records in the "CCC" file.
ZA0 1.0	1-3	RECORD ID	Must be "ZA0." This is the last record of any file submitted. It contains information pertinent to the balancing of the file (i.e., File Record Counts File Charges) within a file.	ZZZ 1	The file level trailer record. Will be translated to "ZZZ."
ZA0 2.0	4-19	SUBMITTER ID (SHnnnn)	The 6 alphanumeric characters assigned by CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled.	ZZZ 2	The 6 alphanumeric characters assigned by CSSC that identify the submitter. Field is 6 characters with no spaces.
ZA0 8.0	66-69	BATCH COUNT	May not be blank. Must be numeric. Must be computed sum of all Record Types YA0 within this file. Right justify. Zero fill.	ZZZ 4	This number indicates the total number of batches contained in the file.

- All NSF submissions will be translated to Provider Type 20 in CCC 9.0. Only physician data will be accepted via the NSF format.
- A CCC record is created in the RAPS format each time a new beneficiary claim is identified in the NSF format.
- Palmetto plugs the CCC 2 in the order in which the detail records appear in the batch.
- Record Identifiers DA0 1.0, EA0 1.0, and FA0 1.0 must be populated. These are not optional fields when submitting via NSF.

4.18 UB-92 (Slide 23)

- UB-92 format is used to submit hospital outpatient and hospital inpatient data.
- Table 4G describes the format as translated into the necessary RAPS data set in FERAS prior to applying the checks. In order to protect the integrity of the file, all of the other fields must be populated with zeros or spaces.
- Files processed in FERAS must be submitted with Payer ID C80884 (UB-92 RT 01, Field 6).

TABLE 4G – UB-92 REQUIRED FIELDS

RECORD TYPE/ FIELD NO	UB-92 POSITION	UB-92 FIELD NAME	UB-92 EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
01 1.0	1-2	RECORD TYPE	The first record in the file. Must be "01."	AAA 1	The first record in the file. Will be translated to "AAA."
01 2.0	3-12	SUBMITTER ID (SHnnnn)	The 6 alphanumeric characters assigned by CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled.	AAA 2	The 6 alphanumeric characters assigned by CSSC that identify the submitter.
01 17.2	137-142	FILE SERIAL NUMBER	File Serial Number. When submitting risk adjustment data, use 6 characters only, right justify the field and fill first position with space.	AAA 3	This field allows for 6 alphanumeric characters. This file identification number is assigned by the submitter for tracking submissions.
01 18.0	143-146	TEST/PROD INDICATOR	Test/Prod Indicator.	AAA 5	This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission.
01 20.0	155-162	PROCESSING DATE	Date Bill Submitted on the UB-92 (CCYYMMDD).	AAA 4	This indicates the date on which the file is transmitted to FERAS.
10 1.0	1-2	RECORD TYPE	The first record in the batch. Must be "10."	BBB 1	The first record in the file. Will be translated to "BBB."
10 3.0	6-7	BATCH NUMBER	Batch Number. Must start with 01 and increment by one for every new batch.	BBB 2	Will be zero filled for first 5 spaces, then will have batch number submitted by MA organization in last two spaces.

TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)

RECORD TYPE/ FIELD NO	UB-92 POSITION	UB-92 FIELD NAME	UB-92 EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
20 1.0	1-2	RECORD TYPE	The first record in the claim. Must be "20."	CCC 1	The first record in the file. Will be translated to "CCC."
20 3.0	5-24	PATIENT CONTROL NUMBER	Patient Control Number. This field is limited to 20 characters that identify the encounter data transaction or the beneficiary. The patient control number is assigned by the MA organization.	CCC 4	This optional field allows 40 characters for PCN. When translated, the PCN will be left justified with all remaining positions of this field filled with spaces.
20 8.0	56-63	PATIENT DATE OF BIRTH	Birth Date (CCYYMMDD). This date must be prior to or equal to the From Date. This field must be space filled.	CCC 7	This optional field indicates the date of birth for the beneficiary in CCYYMMDD format.
20 19.0	133-140	STATEMENT COVERS PERIOD FROM	Statement Covers Period From Date (CCYYMMDD.) For inpatient, must be the admission date. For outpatient, should be the date of service or the first date of a series of services.	CCC 9.1	This date is required for inpatient and outpatient submissions.
20 20.0	141-148	STATEMENT COVERS PERIOD TO	Statement Covers Period Through Date (CCYYMMDD.) For inpatient, must be the discharge date. For outpatient, must be the date of service or the last date of service for a series of services (with the date span between from and through dates not to exceed 31 days). Do not submit interim bills.	CCC 9.2	This date is required for all hospital inpatient submissions. If left blank, CMS will insert same date as the From Date for physician and hospital outpatient submissions.

TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)

RECORD TYPE/ FIELD NO	UB-92 POSITION	UB-92 FIELD NAME	UB-92 EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
30 7.0	35-53	HICN	HIC Number.	CCC 5	The HIC number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first nine characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces.
31 15.0	178-182	PLAN NUMBER	Plan Number	BBB 3 YYY 3	The plan number indicates the unique H number of the MA organization assigned by CMS.
40 4.0	25-27	TYPE OF BILL	Type of Bill. Must be 11Z or 111 for inpatient, 131, 13Z, 141, or 14Z for outpatient.	CCC 9.0	If 111 or 11Z, this field indicates that the provider type for all diagnoses on this encounter will be inpatient. The principal diagnosis on this UB-92 will translate to provider type 01, all other diagnoses to 02. If 131, 13Z, 141, 14Z, this field indicates that all diagnoses will be outpatient.

TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)

RECORD TYPE/FIELD NO	UB-92 POSITION	UB-92 FIELD NAME	UB-92 EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
70 4.0	25-78	PRINCIPAL	Principal Diagnosis Code (ICD-9-CM).	CCC 9.4	The valid ICD-9-CM code for this submission. When bill type is 111 or 11Z, the principal diagnosis will be associated with provider type 01.
70 5.0 – 12.0		OTHER DIAGNOSIS CODES	Other Diagnosis Code (occurs 8x).	CCC 10.4, 11.4, 12.4, 13.4, 14.4, 15.4, 16.4, 17.4	When bill type is 111 or 11Z, these diagnosis codes will be associated with Provider Type 02.
95 1.0	1-2	RECORD TYPE	The first record in the batch trailer. Must be “95.”	YYY 1	The first record in the batch trailer. Will be translated to “YYY.”
95 6.0	25-30	NUMBER OF CLAIMS	The number of claims in the batch. Zero fill and right justify.	YYY 4	This field indicates the total number of CCC records contained within the batch.
99 1.0	1-2	RECORD TYPE	The first record in the file trailer. Must be “99.”	ZZZ 1	The first record in the file trailer. Will be translated to “ZZZ.”
99 2.0	3-12	SUBMITTER ID (SHnnnn)	The 6 alphanumeric characters assigned by CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled.	ZZZ 2	The 6 alphanumeric characters assigned by CSSC that identify the submitter.
99 5.0	22-25	NUMBER OF BATCHES BILLED THIS FILE	Number of batches billed this file. Zero fill and right justify.	ZZZ 4	This number indicates the total number of batches contained in the file.

- A CCC record is created in the RAPS format each time a new beneficiary claim is identified in the UB-92 format.
- Palmetto plugs the CCC 2 in the order in which the detail records appear in the batch.
- Record Identifiers 30.1, 40.1, and 70.1 must be populated. These are not optional fields when submitting via UB-92.

4.19 ANSI 837

- ANSI 837 is the HIPAA compliant electronic format that can be used for data collection.
- This is an optional transmission format for submitting to RAPS.
- ANSI 837 Institutional format is used for hospital inpatient and outpatient data, and ANSI 837 Professional is used for physician data.
- HIPAA does not require an MA organization to use the ANSI 837 to submit risk adjustment data to CMS.

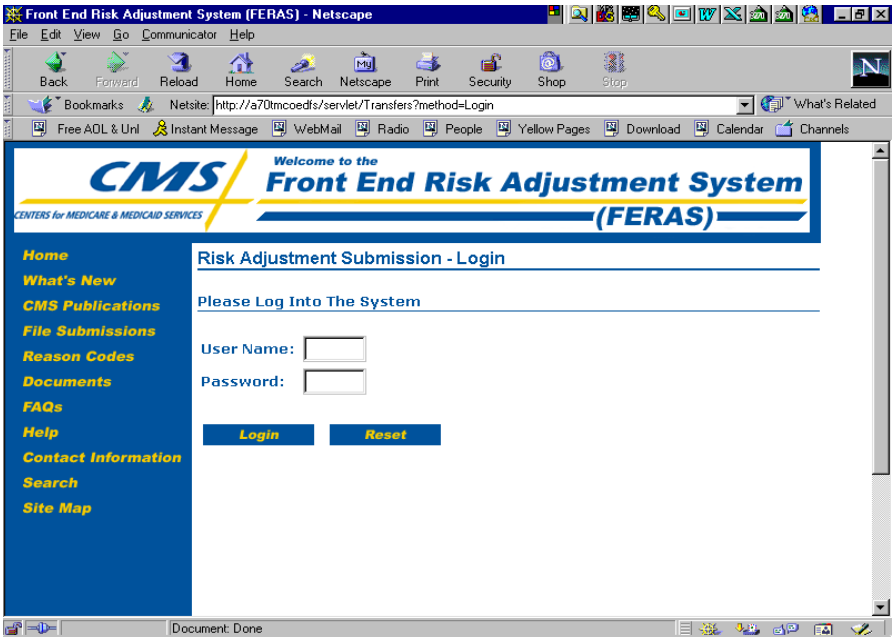
See Resource Guide for ANSI crosswalk.

4.20 Direct Data Entry (Slide 24)

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).

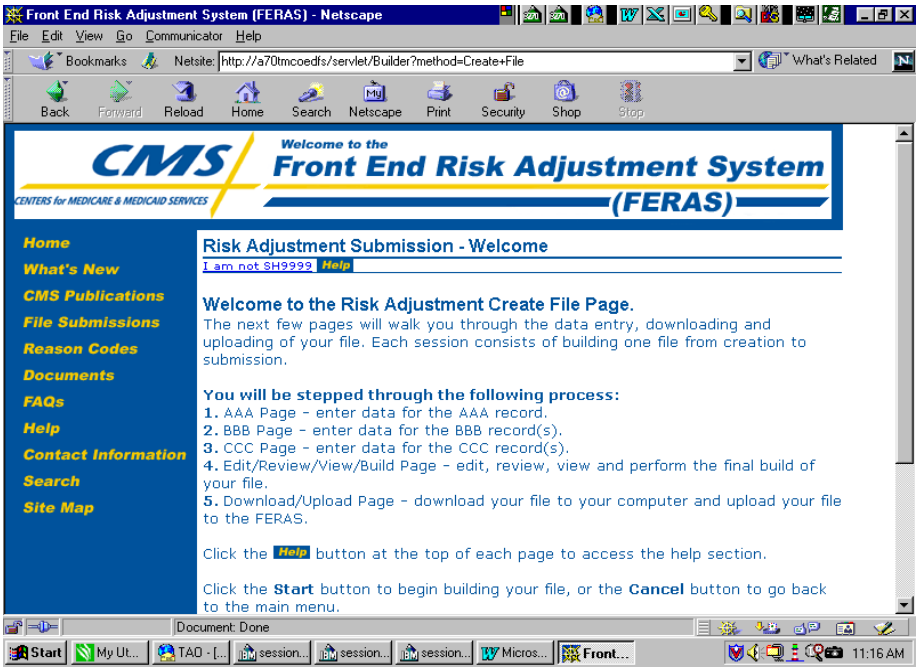
- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 4B through 4G, automatically prevent the placement of incorrect data characters (e.g., alpha characters will not be accepted in the “From” or “Through Date” fields).
- 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.

Figure 4B – DDE 1



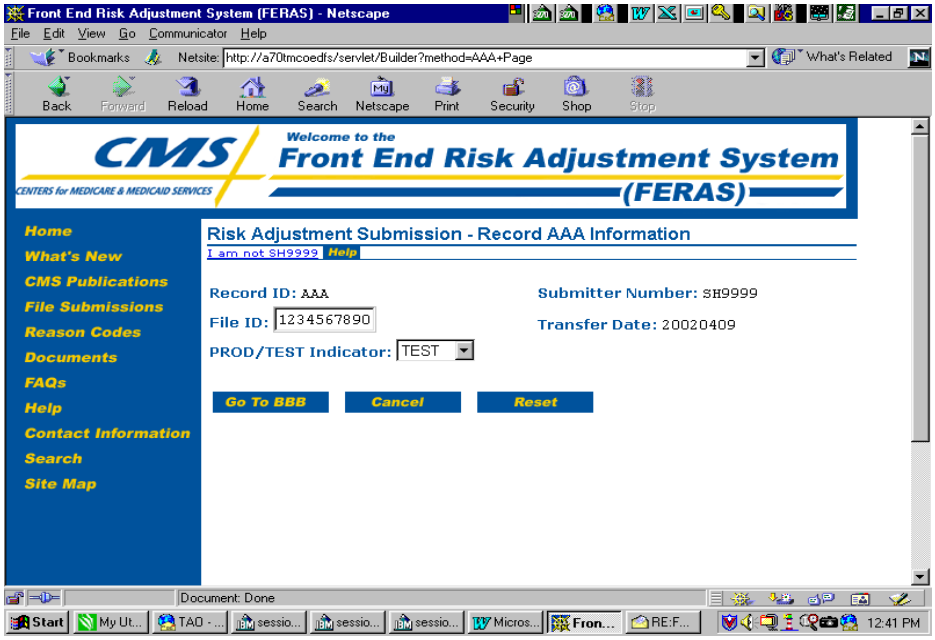
LOGIN PAGE – Submitters are assigned a User Name and Password to access the DDE application.

Figure 4C – DDE 2



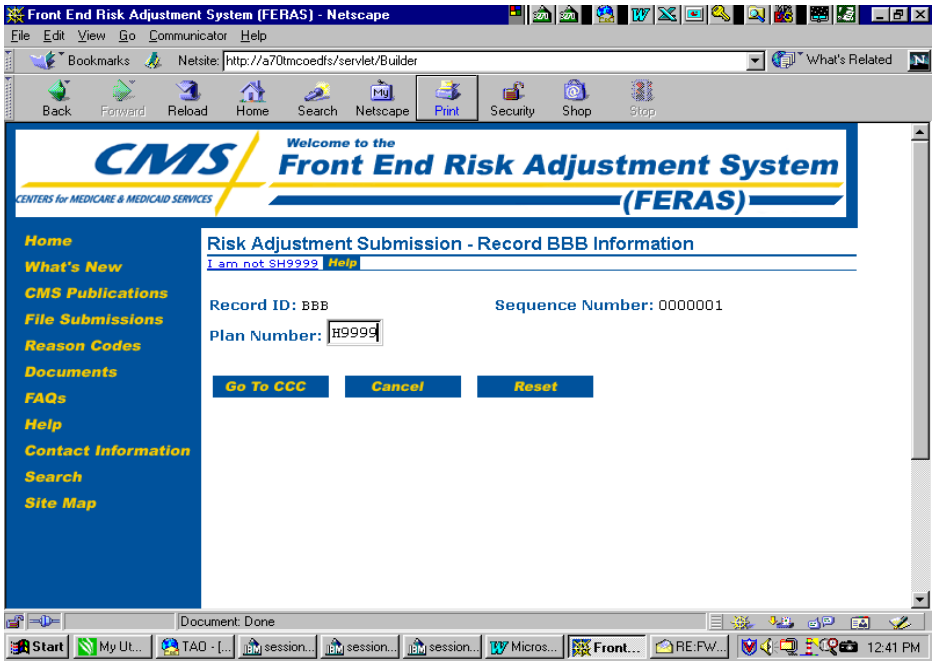
WELCOME PAGE – Submitters are provided instructions on the use of the DDE.

Figure 4D – DDE 3



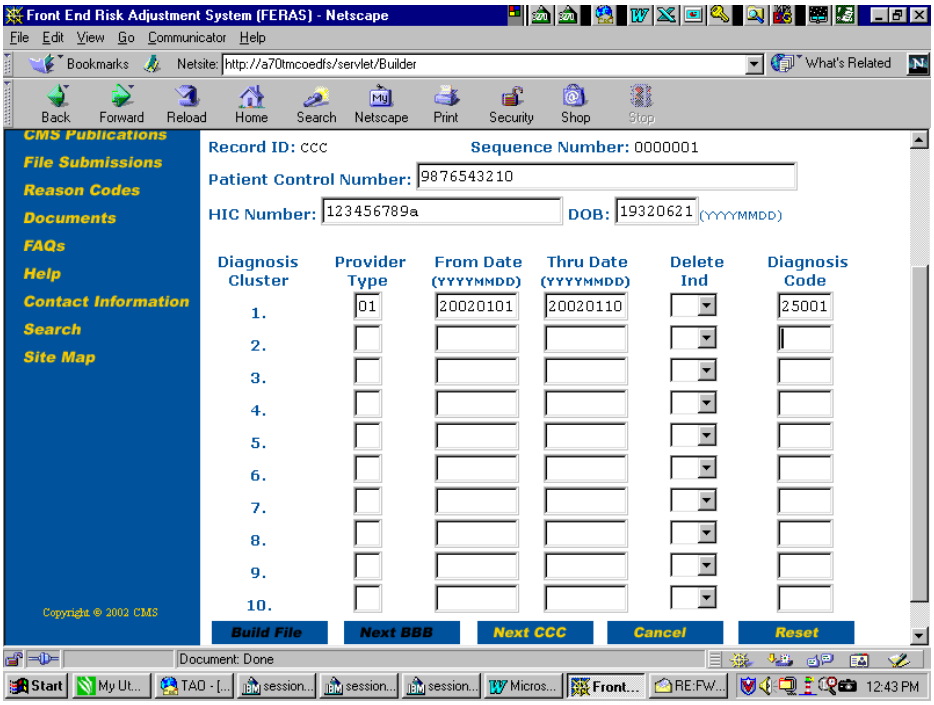
The file-level information is entered and must begin with RT AAA.

Figure 4E – DDE 4



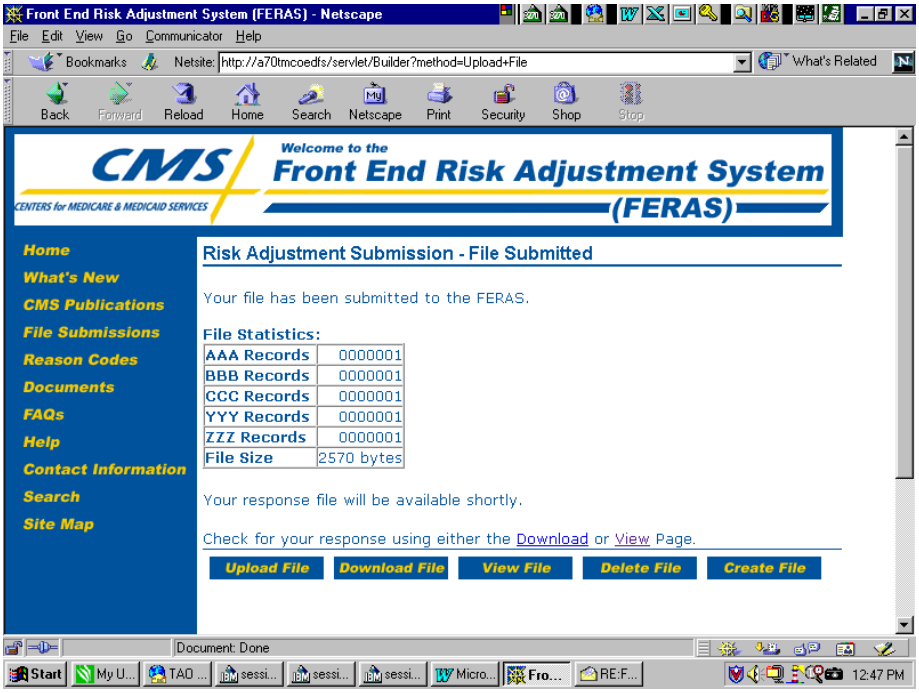
The batch-level information is entered and must begin with RT BBB.

Figure 4F – DDE 5



The CCC Record allows up to 10 diagnostic clusters.

Figure 4G – DDE 6



The file has been uploaded to FERAS.

MODULE 5 – DIAGNOSIS CODES & RISK ADJUSTMENT

Purpose

This module provides Medicare Advantage (MA) organizations 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. 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

5.1 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 relevant ICD-9-CM diagnosis codes for each beneficiary.
- Submit unique diagnoses at least once during the risk adjustment data reporting period.

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

Relevant diagnoses are defined as those diagnoses collected from one of the three provider types that are used in the CMS-HCC model.

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 CMS-HCC model depends upon accurate diagnosis coding, which means that physicians must fully understand and comply with documentation and coding guidelines for reporting diagnoses.

5.1.1 Benefit to the MA Organization and Physician

Benefits to the MA organization and physician are illustrated in Table 5A.

TABLE 5A – 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 CMS-HCC model. – 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.

5.2 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 classification system to be reliable, the application of the codes must be consistent across users. Therefore, CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. These guidelines are available on:

www.cdc.gov/nchs/data/icd9/icdguide.pdf. The diagnosis portion of ICD-9-CM consists of two volumes: the Disease Tabular and the Disease Index.

- **The Disease Tabular (Numeric)** is also known as Volume I of ICD-9-CM. It is a numeric listing of codes organized primarily by body system. The Disease Tabular provides much more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.

- **The Disease Index (Alphabetic)** is also known as Volume II of ICD-9-CM. It is an index of all diseases and injuries categorized in ICD-9-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and subterms that further describe or specify the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

5.2.1 Special Notes and Abbreviations

Throughout ICD-9-CM, there are notes and cross references to assist the coder in arriving at the most accurate code according to official coding guidelines. Examples include:

Excludes notes: Informs the coder which diagnosis codes are not included in the code selected.

Use Additional Code note: Informs the coder that more than one code is needed to fully describe the condition and gives examples of common associated conditions.

Not otherwise specified (NOS) is an abbreviation frequently used in ICD-9-CM. Basically it means "unspecified." The documentation does not provide additional information to assign a more specific code in the particular category. In many (but not all) code categories, the fourth digit "9" signifies an unspecified code.

Not elsewhere classified (NEC) also is present in ICD-9-CM. It is used when the medical record documents a condition to a level of specificity not identified by a specific ICD-9-CM code. In some cases the fifth digit "8" represents an NEC code.

5.2.2 Supplemental Classifications and Tables

Included in Volumes I and II are supplemental classifications and special tables that provide additional guidance in determining the most accurate code.

- **V codes** are a section of ICD-9-CM diagnosis codes that represent factors that influence health status or describe contact with health services. They are used to describe those circumstances or reasons for encounter other than for disease or injury. Selected V codes are included in the HCC model and are described later in this module.

- **E codes** are a supplemental classification included in ICD-9-CM and are used for reporting external causes of injuries and poisonings. The HCC model includes 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.

5.3 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.

Note: There will be no new ICD-9 codes implemented in April 2006. The next update to ICD-9-CM will be in October 2006.

The annual ICD-9-CM diagnosis codes update may result in updates to the list of diagnosis codes used in the CMS-HCC model. CMS posts a list of new codes in the CMS-HCC model annually, prior to the codes taking effect on October 1 and April 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 in *Coding Clinic for ICD-9-CM*, December 2005.

5.3.1 October 2005 Update

The ICD-9-CM Coordination and Maintenance Committee made changes for October 1, 2005. The proposed rule was published in the Federal Register in May 2005, and the final rule in August 2005. Code changes related to codes in the CMS-HCC model are listed below:

- New codes for alcohol induced sleep disorder 291.82 (HCC 51) and drug induced sleep disorder 292.85 (HCC 51).
- New codes 362.03-362.07 for specific types of diabetic retinopathy. Note that only diabetic retinopathy clinically documented as “proliferative” is coded 362.02 (HCC 119). Non-proliferative or unspecified diabetic retinopathy should not be coded 362.02.
- Non-ST elevated Myocardial Infarction (NSTEMI) is coded 410.7X.
- New code has been added for erythromelalgia 443.82 (HCC 105).

- New fifth digits have been added to specify types of suppurative/bacterial peritonitis 567.2 (HCC 31).
- New fourth digits have been added and code titles revised to specify stages of chronic kidney disease. These replace the term "chronic renal failure" code 585 (HCC 131).
- New fifth digits have been added for code 799.0 (HCC 79) to distinguish between asphyxia and hypoxemia.
- New fifth digits added for code 996.4 (HCC 164) to specify type of mechanical complications.
- New fifth digits added for V46.1. V46.13 weaning from respirator (HCC 77) and V46.14 mechanical complication of respirator (HCC 77).

5.3.2 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 Federal government must publish a notice of proposed rule-making, requesting public comment on the new policy.

5.4 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.

5.4.1 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 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 relevant 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.

5.4.1.1 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).

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 CMS-HCC model.

- 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.

5.4.2 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, 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.

5.4.3 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 key to 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 CMS-HCC model, 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 model 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 CMS-HCC model 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 model. 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.

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 CMS-HCC model. 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 CMS-HCC model. Even if the type of cancer included in HCC 7 is of a different site or origin, any other cancer the patient has that is included in HCCs 8, 9, and 10 are dropped by the CMS-HCC model.

Complete Neoplasm guidelines are included in the Resource Guide.

5.4.4 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 model, 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.

5.4.5 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.

5.4.6 E Codes

The HCC model includes codes E950-E959 describing suicide or self inflicted injuries (HCC 55, Major Depressive Disorders). The injury or poisoning diagnosis codes that would be reported with these E codes are not included as relevant diagnoses. 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 relevant diagnoses.

The complete list of V codes and E codes in the model is provided in the Resource Guide.

5.5 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 5B lists documentation considerations.

The *2003 Physicians and Medicare+Choice Risk Adjustment* CD provides examples and documentation tips. It is available through cmstraining@aspensys.com.

TABLE 5B – DOCUMENTATION CONSIDERATIONS

Documentation Guidelines
• Reported diagnoses must be supported by medical record documentation. • Medical records and codes are subject to validation by CMS. • 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: – **S**ubjective: How the patients describe their problem or illness. – **O**bjective: Data obtained by the exam, lab results, vital signs, etc. – **A**ssessment: Listing of the patient's current condition and status of all chronic conditions. How the objective data relate to the patient's acute problem. – **P**lan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for followup.

5.6 Provider and Staff Training

Remaining current on medical record documentation and coding guidelines is important to ensure accurate risk adjustment payment. Table 5C provides examples of resources available for medical record documentation and coding guidelines.

TABLE 5C – DOCUMENATION AND CODING RESOURCES

TRAINING SOURCES	DESCRIPTION
***2003 Physicians and Medicare+Choice Risk Adjustment* CD** Available through cmstraining@aspensys.com.	The *2003 Physicians and Medicare+Choice Risk Adjustment* CD provides the physician and physician office staff with risk adjustment information and useful resources.
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.

MODULE 6 – EDITS

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. When Medicare Advantage (MA) organizations understand common errors and steps to prevent such errors, the efficiency of the risk adjustment process is increased. 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. It provides information to assist MA organizations in minimizing data errors and taking appropriate steps in correcting errors that occur.

Learning Objectives (Slide 3)

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

- Understand the FERAS and the RAPS data integrity logic and error codes.
- Describe how the Medicare Beneficiary Database (MBD) supports the editing process.
- Describe the FERAS and RAPS editing processes.
- Recognize common FERAS and RAPS errors and determine action required to avoid or correct them.

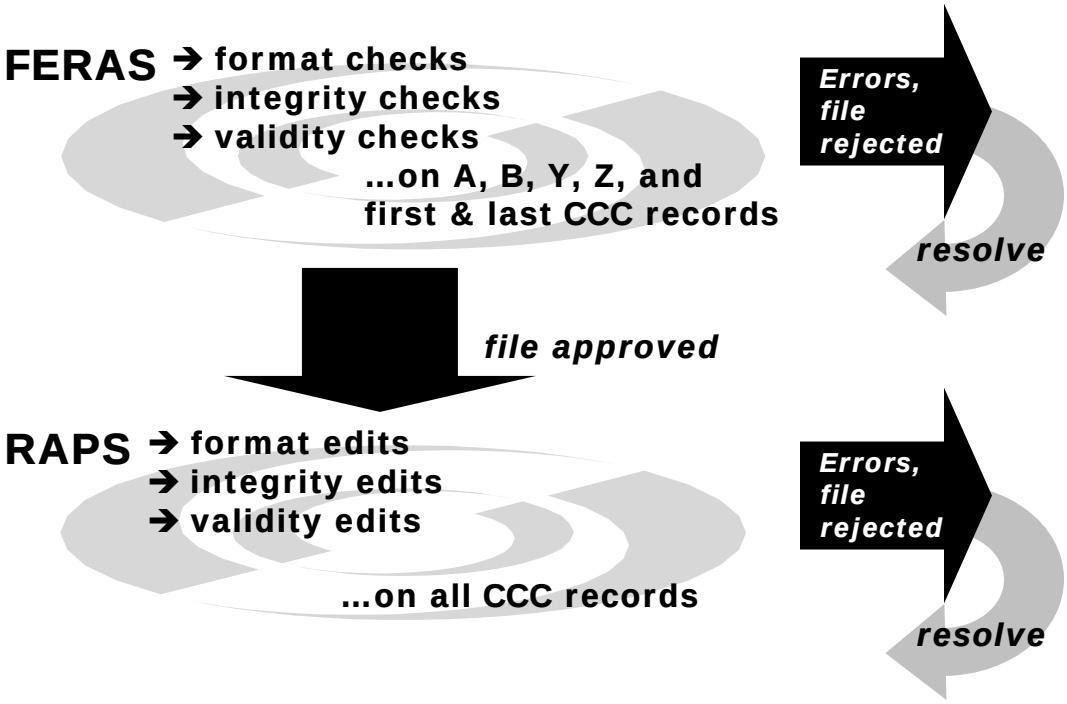
ICON KEY	
Example	
Reminder	
Resource	

6.1 Data Flow (Slide 4)

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. The flow of data for edit processing is illustrated in Figure 6A.

Figure 6A – Data Flow



All data submitted via Universal Billing form – version 1992 (UB-92), National Standard Format (NSF), and American National Standards Institute (ANSI) formats are translated by Palmetto to the RAPS format prior to applying any FERAS checks or RAPS edits.

6.1.1 FERAS System (Slide 5)

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, the complete file is rejected.

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.

6.1.2 FERAS Error Code Logic (Slide 7)

When a FERAS check fails, an associated error code is created. Table 6A 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.

TABLE 6A – 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.

6.1.3 FERAS Error Code Ranges (Slide 8)

Error code ranges are explained in Table 6B.

TABLE 6B - 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 101-error code refers to an error found in field 1 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 112-error code indicates that the submitter ID in field 2 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 151-error code refers to an error found in field 1 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 162-error code indicates that the submitter ID, field 2 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 201-error code refers to an error found in field 1 on the BBB record.
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. FERAS file-level, batch-level, and detail-level error codes are described in Table 6C.

TABLE 6C – 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

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

TABLE 6C – FERAS ERROR CODES (CONTINUED)

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
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

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; it must be populated with spaces. FERAS would identify this error, since it occurred in the first CCC record.

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

6.1.4 RAPS Edits (Slide 10)

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 primarily 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.

6.1.5 RAPS Editing Rules

The RAPS editing process takes place in four logical stages.

Stage 1- Field Validity and Integrity Edits (Slide 11)

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 (Slide 12)

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.

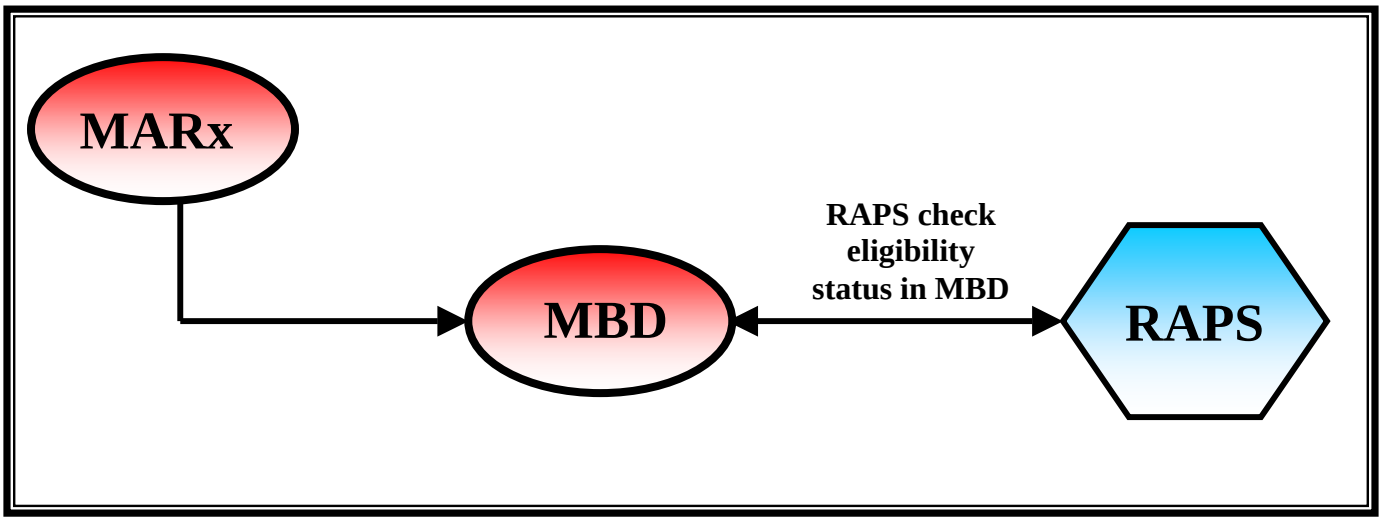
Stage 3 - Medicare Beneficiary Database Edits (Slides 13-16)

The next stage of editing cross-checks the appropriate fields against the MBD. The MBD serves as a centralized database that communicates with other systems. The MBD can be used to view and manage beneficiary information. For risk adjustment purposes, MBD is the authoritative source of beneficiary information, and supports managed care enrollments and payments 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 MBD.

The information contained in MBD is updated nightly with the Medicare Advantage Prescription Drug System (MARx) files. RAPS bases MA eligibility verification on data from the MBD. Since MARx is the source system for the plan enrollment data in MBD, both databases should reflect the same data. Figure 6B illustrates the flow of data between MARx and MBD.

Figure 6B – MBD Flow of Data



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

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

Stage 4 – Diagnosis Code Edits (Slide 17)

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 Risk Adjustment System (RAS). 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, and informational edits are presented in Tables 6D, 6E, and 6F, respectively.

TABLE 6D – 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 6E – 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

TABLE 6E – 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 12/31/2003
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 6F – 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 A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE

Example: 3

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 in the MBD 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 RAS.

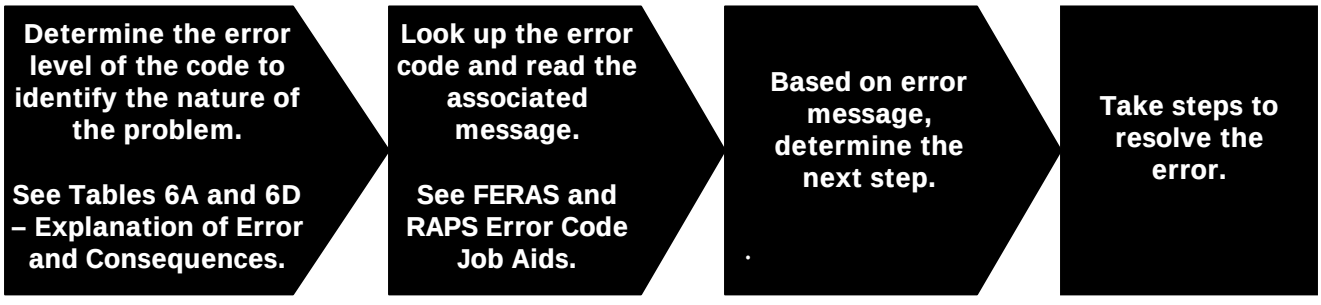
6.2 Resolving Error Codes

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.

6.2.1 Resolution Steps (Slide 20)

It is the MA organization's responsibility to resolve errors that CMS identifies. Described below in Figure 6C 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 6C – Resolution Steps



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

Example: 4

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, new error code 455 was added 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", the following steps should be taken:

- 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.

Note: A 455 error will not occur with error codes 302 through 315. These error codes indicate the CCC record is not valid.

Example: 5

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.

6.2.2 Common Errors (Slide 23)

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

6.2.2.1 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 ten-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.

In addition, if a file ID was accepted in encounter data processing prior to October 2003, the file ID should not be used for Risk Adjustment processing within 12 months. The NSF and UB-92 formats support a 10-digit file number while the RAPS format requires a 10-digit format. FERAS performs an edit of the entire 10 digit file number, so submitters should make certain that those digits are unique.

Example: 6

SenCare Health Plan submitted an encounter data hospital inpatient production file in August 2002 and an encounter data physician test file in August 2002. The plan cannot submit both files with the same file ID, regardless if the data is test or production, 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 11**3**, 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 resubmited following correction.

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

6.2.2.2 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 is already deleted.

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.

6.2.2.3 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 on 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.

6.2.2.4 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 MBD to determine eligibility and other demographic information. 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 MBD before submitting data to FERAS.

The most common uses for MBD to support the MA risk adjustment requirements can be found under the Beneficiary Profile tab of MBD using the Inquiry mode. The information includes:

- Date of birth.
- Date of death.
- Medicare effective date.
- Medicare termination date.

Note: MA organizations can manually research each beneficiary or electronically research by batch load through MBD.

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 in the MBD. RAPS cross-references MBD 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.
- 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 MARx and MBD.
- If MARx shows that the beneficiary was enrolled in the plan on the from/through dates of service and MBD has different data, contact CSSC.
- If the CSSC determines that the MBD requires updated plan enrollment data, resubmit the data after CSSC corrects the MBD data.

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.

6.2.2.5 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 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 this plan on or after the from date.
- If MARx shows that the beneficiary was enrolled in the plan on the from/through dates of service and MBD has different data, contact CSSC.
- If CSSC determines that the MBD needs to have the plan enrollment data updated, resubmit after CSSC corrects the MBD data.

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.

6.2.3 Informational Error Messages

The RAPS system generates informational messages that do not stop processing of data, i.e., no immediate action is necessary. However, these messages, illustrated in Table 6G, provide MA organizations with information to improve future submissions.

TABLE 6G – 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 A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD.	DETERMINE IF FILTERING SHOULD BE INCORPORATED INTO SUBMISSION PROCESS TO REDUCE NUMBER OF 501 MESSAGES.
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE.	CREATE INTERNAL EDITING SYSTEMS THAT ALERT SUBMITTER WHEN FEATURES OF A UNIQUE DIAGNOSIS CLUSTER (PROVIDER TYPE, FROM/THROUGH DATE, DIAGNOSIS CODE) FOR EACH HIC NUMBER ARE SUBMITTED.

MODULE 7 – REPORTS

Purpose (Slide 2)

The Centers for Medicare & Medicaid Services (CMS) provides reports to each Medicare Advantage (MA) organization regarding the status of submitted diagnosis clusters via reports. Some reports present summary-level data, others present details about individual diagnosis clusters, including whether or not a cluster generated an error in the Risk Adjustment Processing System (RAPS). It is essential that the appropriate staff at MA organizations understand how to read the reports and resolve any issues identified. This module 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:

- Identify the purpose of each of the risk adjustment reports.
- Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- Accurately read the risk adjustment reports to identify and submit corrections.
- Understand the relationship between values in the RAPS Transaction Summary and the Monthly and Cumulative Plan Activity Reports.

ICON KEY

Example	
Reminder	
Resource	

7.1 Accessing Risk Adjustment Processing Reports (Slide 4)

MA organizations can access the reports designed to support the risk adjustment process through three methods:

- Secure Website
- File Transfer Protocol (FTP)
- Connect:Direct

Secure Website and FTP users receive reports generated by the Front-End Risk Adjustment System (FERAS) typically within 15 minutes of submission. Connect:Direct users receive reports the following business day if the file transfer is complete by 5 p.m. Eastern Time (ET). If the submission is received after 5:00 p.m. ET, the Connect:Direct user will receive the report 2 business days after submission.

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 7 years. Reports are sent to the mailbox identified on the submitter application. Since the reports are generated out of the processing systems at CMS and sent to Palmetto for distribution, the reports cannot be duplicated and sent 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.

7.2 Printing Reports

All risk adjustment reports are delivered as text reports, with the exception of the RAPS Return File. Organizations may download the reports in Note Pad and should change the print orientation to landscape to ensure that all information on the report prints on one page. When users open the reports in Note Pad, the report prints with the automatic page breaks incorporated. Users should avoid opening the report in Microsoft Word to prevent the default programming that occurs.

7.3 Report Overview (Slides 5 – 7)

Table 7A summarizes the content and general information about each of the reports.

TABLE 7A – REPORTS OVERVIEW

FERAS Report	
FERAS Response Report	• Indicates file is accepted or rejected • Identifies reasons for rejection • Report layout • Secure Website and FTP users receive reports the same business day • Connect:Direct 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

7.4 FERAS Response Report (Slides 8-9)

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 7A 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 and Secure Website users typically receive their reports within 15 minutes of submission. Connect:Direct users receive their reports the next business day.

Figure 7A – 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       DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS
AAA                  113
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-digit file identification number.
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).

Example: 1

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 7B illustrates this example.

Figure 7B – 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.

7.5 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.

7.5.1 RAPS Return File (Slides 10-13)

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 7B 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.

Table 7B – 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

TABLE 7B – RAPS RECORD LAYOUT (CONTINUED)

RECORD YYY – 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: 2

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 Beneficiary Database (MBD). The submitter received a RAPS Return File. Figure 7C 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 7C – RAPS Return File

AAASH77770000000001200304 11PROD
BBB0000001H9999
CCC0000001 7321430 123456789A **19350305354**01200303142003031 8 4359
YYY0000001H99990000003
ZZZSH777700000000010000003

DOB and Error Code

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

7.5.2 RAPS Transaction Error Report (Slides 14 - 15)

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 7D illustrates the RAPS Transaction Error Report and describes the report's fields.

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

Figure 7D – 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] SEQ NUM	[11] SEQ ERR	[12] PATIENT CONTROL NUM	[13] HIC	[14] HIC ERR	[15] DOB	[16] DOB ERR	[17] PVDR TYPE	[18] FROM DATE	[19] THRU DATE	[20] DEL IND	[21] DGNS CODE	[22] DGNS ERR1	[23] DGNS ERR2	[24] CORRECTED 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 file identification number.
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.

RAPS performs edits on all CCC records. Table 7C describes the steps.

TABLE 7C – STEPS IN RAPS EDIT PROCESS

Step 1	Check all CCC records.
Step 2	Crosscheck fields in CCC records against other fields.
Step 3	Apply MBD edits.
Step 4	Edit diagnosis code against the Diagnosis Lookup Table.

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

- 300 – 349 error codes indicate a record-level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
- 350 – 399 error codes indicate a record-level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
- 400 – 489 error codes indicate a diagnosis cluster error. All possible diagnosis edits were performed, but the specific diagnosis cluster was not stored.
- 490 – 499 error codes indicate a diagnosis delete error. The diagnosis was not deleted.
- 500 – 599 error codes are informational messages. All edits were performed, and diagnosis cluster(s) were stored unless another error is listed.

Example: 3

The MA organization submitted a batch that included eight records (Figure 7E). Since errors occurred in records three, five, and seven, only those sequence numbers are reflected on the report. In record three, the plan submitted a HIC that does not appear in MBD. The plan received a 353-error for this record, and the diagnosis was not stored. The fifth record included three clusters for a hospital inpatient stay, two of which received errors due to the beneficiary not being enrolled in a health plan on the date that the beneficiary was admitted to the hospital. The hospital inpatient clusters received the 408-error message, but no 409-error message. Hospital inpatient rules hold the MA organization responsible for reporting patient admissions for all enrollees. The submission rules also require that the entire stay be reported, even if the patient was not enrolled in the health plan on the discharge date.

On the seventh record, the health plan attempted to delete one diagnosis cluster and replace that cluster with one containing the same diagnosis and different service dates. This record had errors for both actions. The original cluster had previously been deleted and received a 491-error code. The new cluster received 408- and 409-errors because the beneficiary was not enrolled in the plan on or after the dates of service.

Figure 7E – RAPS Transaction Error Report

REPORT: RAPS002 **RISK ADJUSTMENT PROCESSING SYSTEM**
RUN DATE: 20040523 **TRANSACTION ERROR REPORT** PAGE: 22
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			
		00000000000000000012345678901234567890												
0000005			888888888A		19260217		01	20040212	20040225		486	408		
		00000000000000000012345675675675675675												
							02	20040212	20040225		2508	408		
							02	20040312	20040325		496			
0000007			666666666D		19301206		20	20040101	20040105	D	25004	491		
							20	20040411	20040422		25004	408	409	

END OF FILE

7.5.3 RAPS Transaction Summary Report (Slide 17)

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. Figure 7F illustrates the RAPS Transaction Summary Report and describes its fields.

Submitters receive a RAPS Transaction Summary Report the next business day after submitting files.

Figure 7F – RAPS Transaction Summary Report

[1]REPORT : RAPS001 **RISK ADJUSTMENT PROCESSING SYSTEM**
[2]RUN DATE : 20030412 **TRANSACTION SUMMARY REPORT** **[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 file identification number.
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 by the system.
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 relevant clusters stored (clusters associated with diagnoses that are 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.

7.5.3.1 Relationships Between Values in Report (Slide 18)

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. Line 10 + Line 11 + Line 14 + Line 15 = Line 9.

- The total stored (Line 12) is less than or equal to the total accepted (Line 11). The Risk Adjustment Database stores all unique, valid diagnosis clusters, including diagnoses that are not used in the 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: 4

Based on the information displayed in Figure 7F, 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: 5

In Figure 7G, 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 had never been stored. The RAPS Return File or the RAPS Transaction Error Report will communicate the specific reason for each rejection.

Figure 7G – Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM
Transaction Summary Report

REPORT ID: RAPS001
RUN DATE: 20040503 TRANS-DATE: 20040430

SUBMITTER ID: SH7777 FILE ID: 0000000005 PLAN NO: H9999

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 DELE ACPTD	2	2	0	2	0	6
TOTAL DELE RJCTD	0	7	5	0	0	12

The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected will equal 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.

7.5.4 RAPS Duplicate Diagnosis Cluster Report (Slide 19)

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 7H illustrates the file layout and provides a key to the fields.

Organizations are notified through a www.csscoperations.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.

Figure 7H – Duplicate Diagnosis Cluster Report

(1) REPORT: RAPS002 **(2) RISK ADJUSTMENT PROCESSING SYSTEM**
(4) RUN DATE: 20030523 **DUPLICATE DIAGNOSIS CLUSTER REPORT** (3) PAGE: 22
(5) TRANS DATE: 20030521

(6) SUBMITTER ID:SH9999 (7) FILE ID: 0000000001 (8) PLAN: H9999 (9) BATCH NUMBER: 0000001

(10) SEQ NO	(11) SEQ ERR	(12) PATIENT CONTROL NUMBER	(13) HIC NUMBER	(14) HIC ERR	(15) DOB	(16) DOB ERR	(17) PVDR TYPE	(18) FROM DATE	(19) THRU DATE	(20) DEL IND	(21) DGNS CODE	(22) DGNS ERR1	(23) DGNS ERR2	(24) CORRECTED HIC
0000003			999999999A		19301206		01	20030101	20030105		4823	502		
		00000000000000000012345678901234567890												

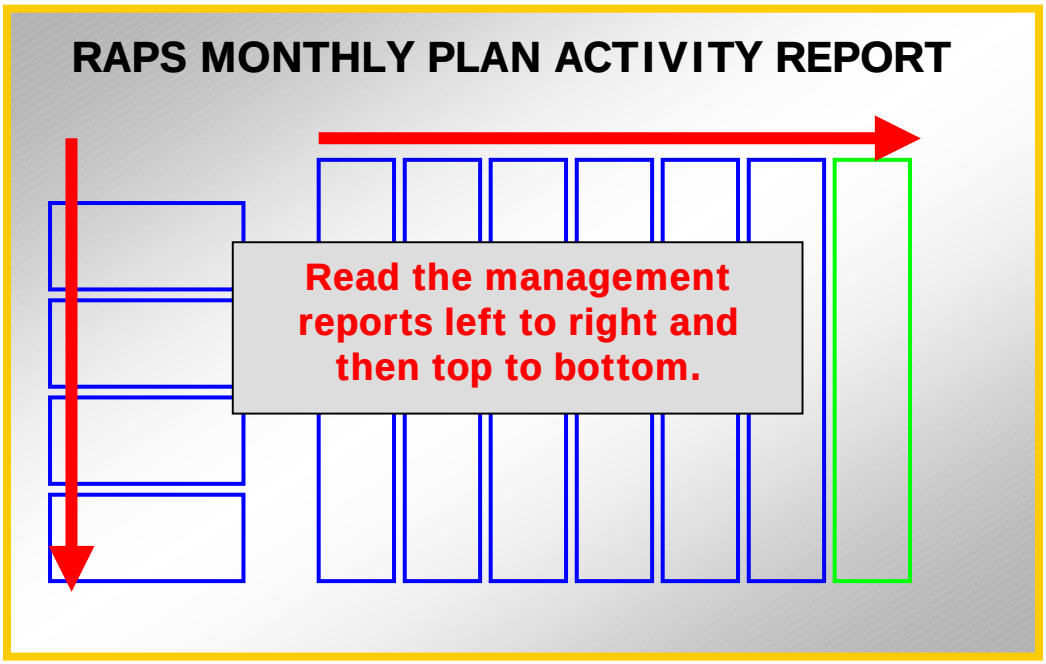
Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Page Number	Page number of the report.
4	Report Run Date	Date CMS generated the report (CCYYMMDD).
5	MCO Transmit Date	Date the submitter created the transaction.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization (H-number).
7	File ID	The 10-character file identification number.
8	Plan Number	H-number assigned by CMS; a different report is printed for each MA 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-digit (alpha-numeric) 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 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.

7.6 RAPS Management Reports (Slide 20)

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 7I.

Figure 7I – Analysis of Management Reports



7.6.1 RAPS Monthly Plan Activity Report (Slide 21)

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 7J 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 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 7J – 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 NO: 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	1278	1674
[13]TOTAL STORED	9	18	17	54	298	1278	1674
[14]TOTAL MODEL STORED	5	8	12	27	158	646	856
[15]TOTAL DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
[10]TOTAL SUBMITTED	103	113	143	407	2447	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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
[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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE 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	4284	11492	29533	124538	175088
[14]TOTAL MODEL STORED	608	721	1116	2797	7462	29413	42117
[15]TOTAL DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE RJCTD	0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE

Figure 7J – 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 ***relevant*** 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: 6

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 7K 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 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.

Figure 7K – RAPS Monthly Plan Activity Report

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 2
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2003

SUBMITTER ID: SH7777 — FOR THE MONTH OF MARCH, 2004
PLAN NO: H7777

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

Figure 7K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — 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

Figure 7K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 2
RUN DATE: 20040503 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2003

SUBMITTER ID: SH7777 — FOR THE MONTH OF APRIL, 2004
PLAN NO: H7777

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

Figure 7K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040503 — RAPS MONTHLY PLAN ACTIVITY REPORT — 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

7.6.2 RAPS Cumulative Plan Activity Report (Slide 22)

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 7L illustrates the report and its fields.

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

Figure 7L – RAPS Cumulative Plan Activity Report Layout

[1]RAPS0020 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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE 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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE 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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE 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 DELE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELE RJCTD	0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE

Figure 7L – 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 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 ***relevant*** 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.

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: 7

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 7K to this Cumulative Plan Activity Report (Figure 7M), we can see that the April transaction accounted for very few of the January, February, and March numbers, which would indicate that there were 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 that there were diagnosis clusters submitted where the service dates could not be identified. These are reported on the service year 9999.

Figure 7M – 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

Figure 7M – 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
PLAN NO: H7777

FOR PERIOD ENDING APRIL 30, 2004

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 INPATIEN							
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

Figure 7M – RAPS Cumulative Plan Activity Report (continued)

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

7.6.3 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: 8

The April RAPS Cumulative Plan Activity Report (Figure 7M) displays a high reject rate in the data submitted for dates of service July – September (page 2 of the report). The report shows that 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.

7.6.4 RAPS Error Frequency Reports (Slide 23)

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 7N, 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.

Figure 7N - RAPS Monthly Error Frequency Report Layout

[1] REPORT: RAPS04M PALMETO GBA [2]PAGE: 1

[3]RUN TIME: 10.06.09 [4]RISK ADJUSTMENT PROCESSING ERROR FREQUENCY SUMMARY [5]RUN DATE:20050502

[6]SUBMITTER ID: SH9999 [7] FOR THE MONTH OF APRIL, 2005

[8] PLAN NO: H9999

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

[13] ERROR CODE	[14] <==PROVIDER TYPE XX==> <=UNKNOWN PROV TYPE=>	[15] <==PROVIDER TYPE 01==> <PRINCIPAL INPATIENT>	[16] <==PROVIDER TYPE 02==> <==OTHER INPATIENT==>	[17] <==PROVIDER TYPE 10==> <=====OUTPATIENT=====>	[18] <==PROVIDER TYPE 20==> <=====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

Figure 7N – 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: 9

The sample RAPS Monthly Error Frequency Report (Figure 7O) 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 MBD.

Figure 7O – RAPS Monthly Error Frequency Report

REPORT: RAPS004M PALMETO GBA]PAGE: 1
RUN TIME: 13.31.06 RISK ADJUSTMENT PROCESSING RUN DATE:20050219
ERROR FREQUENCY SUMMARY

SUBMITTER ID: SH9999 FOR THE MONTH OF APRIL, 2005
PLAN NO: H9999

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

7.7 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.

7.7.1 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 7M) for every month in the data collection period.

Example: 10

Figure 7P 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 could 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.

Figure 7P – 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

Data collection "lag" is 90 days.

SUBMITTER ID: SH8 FOR THE MONTH OF APRIL, 2004
PLAN NO: H88

High rate of rejected data.

PROVIDER TYPE/TOTALS	JANUARY	FEBUARY	MARCH	APRIL	MAY	JUNE	AL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1940	1944	643	50	0	0	4577
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 could 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.

7.7.2 External Issues Affecting Data Collection

When reviewing the management reports, MA organizations should consider external issues that may 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.

7.7.3 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 that 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 they submit 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: 11

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 overfiltering 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 is being performed 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.

7.8 Report Naming Conventions (Slide 26)

Table 7D provides the naming conventions for reports placed in the submitter's mailbox.

TABLE 7D – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
FERAS Response Report	RSP####.RSP.FERAS_RESP
RAPS Return File	RPT#####.RPT.RAPS_RETURN_FLAT
RAPS Transaction Error Report	RPT#####.RPT.RAPS_ERROR_RPT
RAPS Transaction Summary Report	RPT#####.RPT.RAPS_SUMMARY
RAPS Duplicate Diagnosis Cluster Report	RPT####.RPT.RAPS_DUPDX_RPT
RAPS Monthly Plan Activity Report	RPT#####.RPT.RAPS_MONTHLY
RAPS Cumulative Plan Activity Report	RPT#####.RPT.RAPS_CUMULATIVE
RAPS Monthly Error Frequency Report	RPT#####.RAPS_ERRFREQ_MNTH
RAPS Quarterly Error Frequency Report	RPT#####.RAPS_ERRFREQ_QTR

7.9 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 them 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.

MODULE 8 – RISK ADJUSTMENT DATA VALIDATION

Purpose (Slide 2)

To provide participants with an understanding of the risk adjustment data validation process to ensure risk adjusted payment integrity and accuracy.

Objectives (Slides 3-4)

- Identify the purpose and goals of risk adjustment data validation.
- Identify and describe the stages of risk adjustment data validation.
- Learn about the components of a medical record request.
- Describe the requirements for acceptable medical record documentation.
- Identify risk adjustment data discrepancies.
- Describe payment adjustments and appeals.
- Provide recommendations and lessons learned.

ICON KEY

Example 

Reminder 

Resource 

8.1 Risk Adjustment Data Validation

8.1.1 What Is Risk Adjustment Data Validation? (Slide 5)

Data validation occurs after risk adjustment data are collected and submitted, and payments are made to the Medicare Advantage (MA) organizations. Data validation is currently conducted using medical record review but could also include other data monitoring activities. Centers for Medicare & Medicaid Services (CMS) uses two independent review contractors to confirm payment discrepancies. The initial validation contractor (IVC) conducts the initial review of medical records, and a second validation contractor (SVC) confirms risk adjustment discrepancies that are identified by the IVC.

Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the MA organization are supported by medical record documentation for an enrollee.

Purpose: To ensure risk adjusted payment integrity and accuracy

8.1.2 Goals of Risk Adjustment Data Validation (Slide 6)

The primary goals of risk adjustment data validation are to:

- Identify:
  - Confirmed risk adjustment discrepancies.
  - Plans in need of technical assistance to improve risk adjustment data quality.
- Measure:
  - Accuracy of risk adjustment data.
  - Impact of discrepancies on payment.
- Improve:
  - Quality of risk adjustment data.
  - The CMS-Hierarchical Condition Category (HCC) model.

8.1.3 Guidelines for Risk Adjustment Data Validation (Slides 7-8)

The guidelines for risk adjustment data validation reflect the purpose and goals described above. From CY2000 through CY2003, data validation activities involved only hospital inpatient medical records. Beginning in CY2004, risk adjustment data validation includes hospital inpatient, hospital outpatient, and physician medical records. This change reflects the implementation of the CMS-HCC model that began with CY2004 payment. To make the data validation more flexible for MA organizations, CMS developed the following Guiding Principle.

Guiding Principle: The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM) Guidelines for Coding and Reporting*. MA organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.

In addition to the Guiding Principle, risk adjustment data validation guidelines include the following:

- The medical record documentation must support an assigned HCC.

- Beneficiary records are selected based on risk adjustment diagnosis clusters [provider type, Health Insurance Claim (HIC) number, service date(s), and ICD-9 code] submitted to the Risk Adjustment Processing System (RAPS).

- Given the flexibility of the Guiding Principle, plans must select **"one best medical record"** to support each HCC identified for validation. This means the plan decides whether to submit a hospital inpatient, hospital outpatient, or physician medical record when more than one option is available.

- Since CMS does not collect provider identifiers for risk adjustment, MA organizations must be able to track and locate supporting medical record documentation.

- Coders who review medical records will not search beyond the date of service identified for the review. Once an MA organization selects their "one best medical record," a date of service must be identified to facilitate the medical record review process.

- "In lieu of" medical records may be submitted for data validation. An "in lieu of" medical record is based on data that was not submitted to RAPS but complies with the Guiding Principle. [See Section 8.2.3.2 *Medical Record Submission - "In Lieu of" Medical Records,* for more detail.]

- Payment adjustments are based on confirmed risk adjustment discrepancies.

- An appeals process is in place to address disagreement with a confirmed risk adjustment discrepancy.

8.1.4 Risk Adjustment Data Validation Process (Slide 9)

Risk adjustment data validation occurs every year. Figure 8A illustrates the overall data validation process. This process involves the coordination of multiple entities such as CMS, MA organizations, and CMS contractors. The data validation process begins with selecting MA organizations, then beneficiaries and their HCCs. This occurs after the risk adjustment data submission deadline for calendar year payment. The stages of the risk adjustment data validation process are briefly described below:

🗝 **STAGE 1** **Plan Selection:** CMS designs a sampling plan to select MA organizations to participate in risk adjustment data validation. Once the MA organizations are selected, individual beneficiaries and their HCCs are selected on the basis of the sample framework. The sample is based on payment year risk adjustment data. Every MA organization has a chance of being selected for validation.

🗝 **STAGE 2** **Medical Record Request Process:** This stage is defined by three distinct segments: 1) medical record request; 2) medical record submission (plan response); and 3) medical record receipt. After the sample has been drawn, medical records are requested from the selected MA organizations. All correspondence with MA organizations related to Stage 1 is facilitated by the IVC.

🗝 **STAGE 3** **Medical Record Review:** After medical records are received by the IVC, certified ICD-9 coders review the medical records to validate the selected beneficiary HCC(s). During this stage, data discrepancies are identified. Data discrepancies occur when beneficiary medical record documentation does not match the risk adjustment data submitted for payment. A data discrepancy that results in an HCC assignment change is known as a risk adjustment discrepancy. All identified risk adjustment discrepancies undergo a second, independent medical record review to confirm the discrepancy. The second medical record review is conducted by the SVC. This activity is transparent to MA organizations. There is no correspondence between the SVC and plans during this stage.

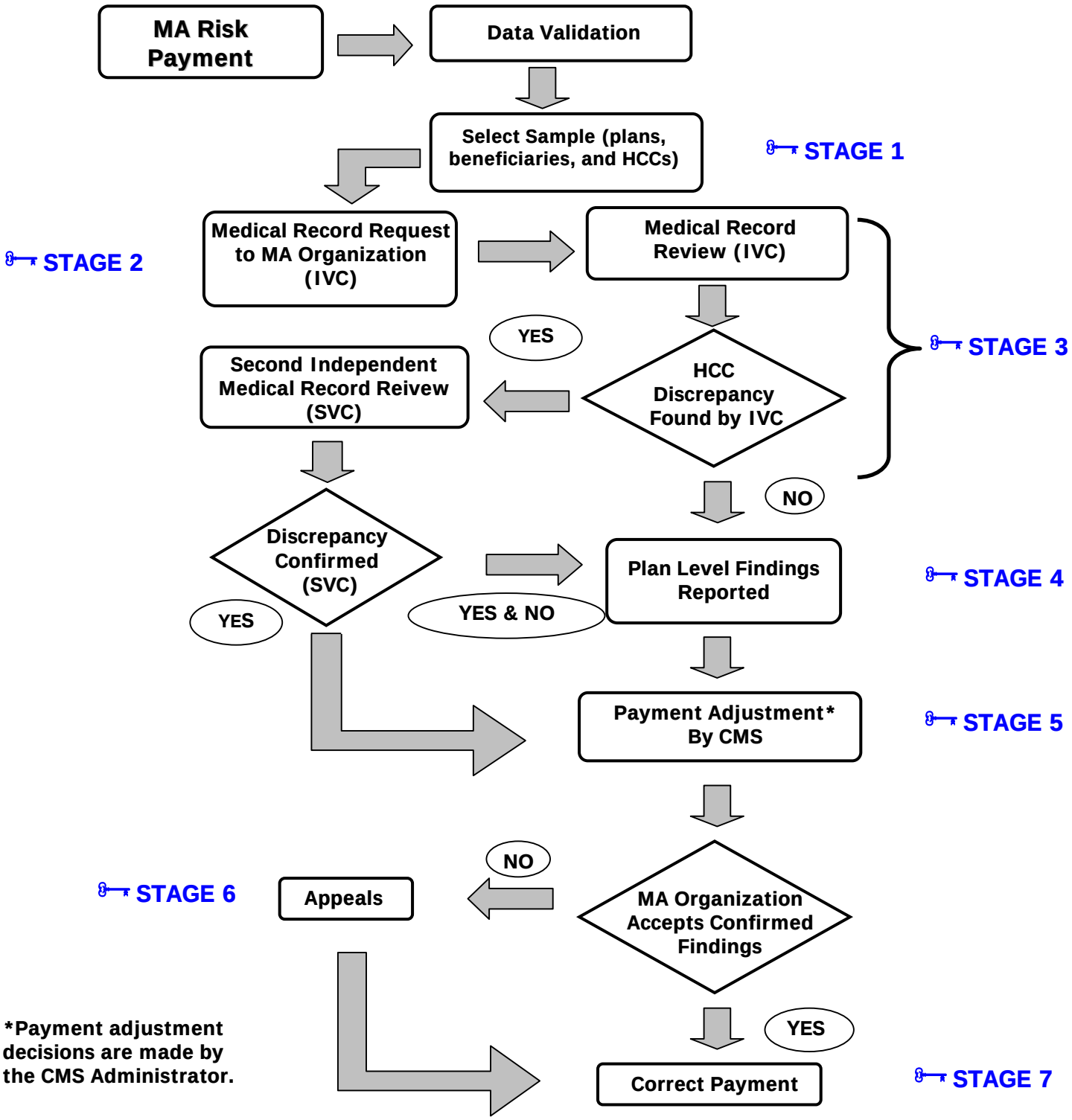
🗝 **STAGE 4** **Plan-Level Findings:** At this point in the data validation process, CMS communicates plan-level findings from Stage 3 to participating MA organizations. Data discrepancies determined by medical record review are described. Additional feedback such as national and plan-level response rates and discrepancy rates are provided. Plan patterns, systemic problems, and plans in need of additional technical assistance may also be identified during this stage.

🗝 **STAGE 5** **Payment Adjustment:** After Stage 4 is completed, CMS analyzes plan-level findings and makes recommendations to the CMS Administrator on payment adjustment. A payment adjustment is based on a confirmed risk adjustment discrepancy. If the CMS Administrator decides to make the adjustment, then the change in risk adjustment payment is made. Payment adjustments are reflected in the Monthly Membership Report (MMR).

🗝 **STAGE 6** **Appeals:** After a payment adjustment is made, MA organizations have the option of appealing the change. In the event that a plan chooses to appeal, then the organization has 60 days from the date of the payment adjustment to respond. This process is fully described in the *Appeals* section of this module.

🗝 **STAGE 7** **Correct Payment:** Once Stage 6 has been completed, the risk adjusted payment is now correct and final.

Figure 8A – Data Validation Process



8.2 Components of the Risk Adjustment Data Validation Process (Slides 10-35)

Several key components of the data validation process are important for MA organizations to understand. These components will be thoroughly discussed and include the basis for sampling the medical record request process and the receipt of medical record documentation by the IVC.

8.2.1 Plan Selection STAGE 1 (Slide 10)

Sampling

Data validation sampling is conducted on an annual basis. Sampling involves the selection of plans, beneficiaries, and beneficiary HCCs for data validation. The sample is drawn from risk adjustment data submitted for the payment year (data collection period, January 1 through December 31). The data sampling approach includes both random and targeted components. Some plans may be selected randomly, while others may be targeted.

Under the CMS-HCC model, CMS expects to draw a national random sample for each payment year. The purpose of the national sample is to derive national net payment error and risk adjustment discrepancy estimates for the payment year. It is important to note that all MA organizations have a chance of being selected as part of the national sample.

In addition to the national random sample, some targeted sampling will be employed. The targeting criteria may include:

- Patterns in the risk adjustment data that are suggestive of potential problems.
  - A plan may be targeted for data validation because the risk adjustment data for that plan showed a disproportionately high number of HCCs.

- Past performance from previous data validation years.
  - A plan may be reselected for medical record review as a result of a high risk adjustment data discrepancy rate based on prior validation activities.

- Specific HCCs may be targeted due to known ICD-9 coding problems or other issues related to a condition.

The medical records reviewed for a beneficiary may reflect the entire HCC profile (all HCCs) or a subset of one or more HCCs.

8.2.2 Medical Record Request Process STAGE 2 (Slides 11)

During Stage 2 of the data validation process, CMS works with the IVC to devise a communication plan to implement the process of requesting and receiving medical records from MA organizations. Stage 2 is defined by three distinct segments: 1) medical record request; 2) medical record submission (plan response); and 3) medical record receipt.

8.2.2.1 Medical Record Request - Initial Contact Letter (Slide 12)

The IVC sends an initial contact letter to the Medicare compliance officer for each selected MA organization. The purpose of the initial contact letter is to: 1) inform the compliance officer that the organization was selected for data validation; and 2) establish a primary point of contact (either the compliance officer or a designee) to be responsible for facilitating the medical record request process for the organization.

8.2.2.2 Medical Record Request - Beneficiary List (Slide 12)

A list of selected beneficiaries for each organization is sent to the confirmed primary contact person for the MA organization. The beneficiary list is generated from the sample that is derived from the risk adjustment data submitted to CMS. The list is provided to MA organizations before the IVC distributes comprehensive instructions; this affords the MA organizations the opportunity to track enrollees and establish contact with the specific providers of services. As previously mentioned, CMS does not require or store provider identification numbers as part of risk adjustment data. Therefore, the MA organization must use data systems that can:

- Track and locate the requested medical records.
- Link a specific diagnosis to a specific provider.

The beneficiary list is provided in an electronic spreadsheet format [with beneficiary name, HIC number, diagnosis clusters, HCC assignments, and date(s) of service] and is also provided with the medical record comprehensive request package. It is recommended that MA organizations review available medical records to identify the most appropriate documentation for submission.

Example 1

For beneficiary Joe K. Smith, HCC 16, HCC 38, and HCC 80 will be validated as illustrated in Table 8A. To validate HCC 16, the MA organization may rely on one of the two diagnosis clusters (ICD-9 code, service date, and physician provider type) associated with HCC 16 as the source of data to select the "one best medical record" to support HCC 16. HCC 38 and HCC 80 are based on one entry each; therefore, there is only one source (provider type) of the medical record for each of these HCCs, unless an "in lieu of medical record" is selected. (See Section 8.2.3.2 *Medical Record Submission - "In Lieu of" Medical Records*.)

TABLE 8A – BENEFICIARY LIST

LAST NAME	FIRST NAME	MI	DOB	HIC	HCC	ICD-9 CODE	DATE OF SERVICE	PROVIDER TYPE	CASE ID*
Smith	Joe	K	09/02/1925	183838279A	HCC 38	7101	01/15/2003	Physician	H1234-101-HCC 38
					HCC 80	40201	12/03/2003	Outpatient	H1234-101-HCC 80
					HCC 16	2506	04/15/2003	Inpatient	H1234-101-HCC 16-1
					HCC 16	2506	04/30/2003	Physician	H1234-101-HCC 16-2
Mumford	Anne	A	03/15/1933	986023456A	HCC 2	0382	08/27/2003	Inpatient	H2351-102-HCC 2
					HCC 79	42741	05/13/2003	Physician	H2351-102-HCC 79

*Case IDs are assigned by the IVC and used when communicating with MA organizations. All Case IDs are specific to the data validation year.

8.2.2.3 Medical Record Request - Comprehensive Instructions and Coversheets (Slide 12)

A comprehensive instructions package is sent to MA organizations to facilitate the request for submitting medical records. This package generally includes detailed instructions, a list of beneficiaries and HCCs selected, CMS letters addressed to providers for use in requesting records, a HIPAA fact sheet, a sample request letter to providers, and coversheets for each enrollee HCC. If an MA organization plans to use the CMS instructions package to request records from particular providers, the organization should be sure that all pertinent information is included to provide a complete understanding about the process.

8.2.3 Medical Record Submission (Slide 13)

Medical records and all corresponding coversheets for each enrollee HCC are submitted to the IVC by the MA organizations. In responding to the medical record request, MA organizations must select the "one best medical record" to support the enrollee HCC.

8.2.3.1 Medical Record Submission - Coversheets (Slide 14)

Once a sample of beneficiaries has been selected for a plan, a coversheet will be generated for every HCC being validated for each beneficiary. Each coversheet shows every diagnosis cluster that was submitted to RAPS and generated the same HCC. The coversheet is where the concept of the "one best medical record" is applied. The MA organization has the option of selecting the best medical record from the submitted RAPS data (diagnosis clusters) by indicating on the coversheet which diagnosis cluster matches the submitted medical record for the HCC being validated. In addition, MA organizations have the option of selecting an "in lieu of" medical record that is from the data collection year and an acceptable risk adjustment provider type to validate an HCC. (See Section 8.2.3.2, *Medical Record Submission - "In Lieu of" Medical Records*.)

Under the CMS-HCC model, beneficiaries may have more than one HCC. This means that more than one medical record may be used to validate beneficiary HCCs. In addition, one medical record could be used to support multiple HCCs.

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. If an MA organization is unable to submit the required medical record(s) to support the enrollee HCC(s), Sections 1, 4, and 5 of the coversheet must be completed prior to submission to the IVC. This information informs the IVC that no medical record could be obtained to support the HCC. Complete medical record coversheets are essential to timely medical record review.

8.2.3.2 Medical Record Submission - "In Lieu of" Medical Records (Slide 14)

In addition to using a beneficiary's diagnosis clusters to choose the "one best medical record," MA organizations may submit an "in lieu of" medical record. An "in lieu of" medical record is related to a service for which the data was not submitted to RAPS or there is no exact match for the ICD-9 code and date of service provided on the coversheet (diagnosis cluster). For example, your plan may have chosen to submit CMS-HCC model diagnoses only once per beneficiary during the data collection period. Consequently, the "one best medical record" to validate a beneficiary HCC is not based on the submitted RAPS data. In this case, you may submit an "in lieu of" medical record as long as the service occurred

during the data collection period from an acceptable risk adjustment provider type. The ICD-9 code and service date must be provided on the beneficiary HCC coversheet for the "in lieu of" medical record to be acceptable for data validation (Coversheet Section 3B).

If you are submitting an "in lieu of" medical record, do not check a RAPS date of service from Section 3A. Instead, complete Section 3B by furnishing the appropriate information for the date of service for the "in lieu of" medical record. If these data are not provided for the "in lieu of" medical record, then the record will not be reviewed.

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 plan will receive reimbursement for one record. Reimbursement checks are sent by the IVC after completion of data validation activities.

8.2.4 Medical Record Receipt by the IVC (Slide 15)

Once medical records are selected by the MA organization, they must be sent to the IVC for data validation. Upon receipt, all medical records are logged into a chart-tracking database on the basis of the barcode on each medical record coversheet. This method identifies the date the medical record was received for a given HCC. To protect patient confidentiality, all records are stored in a secure, designated area accessible only to those having direct responsibility for risk adjustment data validation activities.

When the coversheet and medical record are received by the IVC, 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.

Based on the administrative and clinical checks, the IVC may elect to contact (telephone call or email message) the MA organization to request clarification or additional information. This step is provided as a service to the organization and normally is performed only if the records are received in a timely manner.

After intake, the medical record (with coversheet) is assigned to a category. The possible categories include:

- Unit of analysis received and identified as "okay" for review;
- Problem; or
- Missing medical record.

Throughout the data validation process, CMS and its contractors make a reasonable effort to alert MA organizations of medical record documentation issues and allow plans the opportunity to correct problems**.**

8.2.4.1 Medical Record Documentation (Slides 16-18)

Proper medical record documentation is the key to correct payment and successful data validation. The accurate assignment of ICD-9 diagnosis codes is based on thorough medical record documentation. Therefore, risk adjusted payment accuracy also relies on medical record documentation. Remember, a beneficiary HCC is assigned based on a diagnosis cluster that has been submitted to RAPS.

The CMS-HCC model, when compared to the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model, includes many more diagnoses from additional settings. Data from physician settings will comprise a large portion of the diagnoses submitted. Depending on the beneficiaries selected for data validation, your MA organization may select a hospital inpatient, hospital outpatient, or physician medical record to support the validation of a beneficiary HCC.

Below are some general guidelines for medical record documentation, based on the sources of the documentation.

8.2.4.2 General Guidelines for Hospital Inpatient Medical Record Documentation (Slide 19)

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

8.2.4.3 General Guidelines for Hospital Outpatient and Physician Medical Record Documentation (Slide 19)

Hospital outpatient and physician office medical records should include, but are not limited to, the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Diagnostic reports (to support documentation)
- Consultation reports

Submit all relevant medical record components needed to validate the beneficiary, the HCC, ICD-9 code, and date of service selected. When you submit medical record documentation to support only the physician face-to-face 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 code can be assigned on the basis of the evaluation and clinical findings/treatment.
- Physician signature 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.)

8.2.4.4 Physician Signatures and Dates (Slides 20-23)

All dates of service that are identified for review must be signed 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 (including credentials) and 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.

A medical record that lacks a date or physician signature is invalid and will not be reviewed.

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.

Guidance for Radiology Reports

Medical record documentation from radiologists presents an interesting challenge for data validation. The radiologist generally provides two types of radiology services—diagnostic (e.g., chest x-ray) and therapeutic (e.g., radiation therapy). Based on experience with radiology documentation from an ambulatory setting we have found:

1. In the case of diagnostic radiology services, MA organizations are relying on the referral diagnosis for the radiology service as the actual diagnosis code. ***This diagnosis code is not acceptable as risk adjustment data because the diagnosis has not been confirmed.***

2. While most diagnostic radiology reports do indicate findings or an impression, ***these reports do not indicate a diagnosis***. The radiologist typically sends a report to the referring physician, who then reviews the findings and documents a diagnosis based on those findings.

3. Therapeutic radiology services are delivered after a confirmed diagnosis is assigned; thus, a report for this type of service would normally reflect a confirmed diagnosis.

Given these findings, CMS suggests the following guidelines:

1. Do not send diagnostic radiology medical records for validation if other medical record documentation is available.

2. If a diagnostic radiology medical record is the only documentation of a diagnosis, then the MA organization should review the medical record to ensure that the documentation is sufficient to support an HCC diagnosis.

3. If an insufficiently documented radiologist medical record is submitted, then the HCC diagnosis will be discrepant.

CMS has eliminated diagnostic radiology as an appropriate risk adjustment physician specialty. Diagnoses submitted from this specialty are only acceptable for dates of service occurring between 2003 and 2005. Diagnoses from this specialty will not be accepted beginning with 2006 dates of service. When submitting diagnoses for dates of services between 2003 and 2005, please consider the above guidance with regard to radiology reports.

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. **Since independently billing physicians (not employed by the nursing home) visit patients in nursing homes, the medical record documentation for a beneficiary HCC may come from a nursing home only if the beneficiary is identified in the MDS (Minimum Data Set) as a long-term institutional resident and the physician visit is face-to-face.**

8.2.4.5 Unacceptable Medical Record Documentation (Slides 24-27)

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)
- 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

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)

8.2.5 Medical Record Review STAGE 3 (Slide 28)

The medical record review is the technique used to validate risk adjustment payments. The process involves review of submitted medical record documentation by a certified coder. The reviewer validates the date of service and the diagnosis code identified by the MA organization on the medical record coversheet. Medical record review includes abstracting a diagnosis code when it is based on the accompanying medical record documentation.

During medical record review, the certified coder also checks for the following:

- Diagnosis code(s) supported by medical record documentation per *ICD-9 Coding Clinic Guidelines.*
- A provider signature for each note.
- Coversheet diagnosis against the medical record diagnosis.
- Date of service on coversheet and in medical record that are within data collection period.

8.2.5.1 Data Discrepancies (Slide 29)

During medical record review, medical record data discrepancies may be identified. Data discrepancies occur when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation. There are several types of data discrepancies.

To give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided:

- 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.

- Invalid
  - The medical record documentation submitted for review is from an unacceptable provider type 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.

- 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.

Example 2

Example of a Coding Discrepancy

The reported diagnosis was 428.0 for congestive heart failure (CHF) (HCC 80). Upon review of medical record documentation, it was determined that the code 402.91 hypertensive heart disease with CHF (HCC 80) should have been coded.

Example 3

Example of a Coding Discrepancy

The risk adjustment data indicated a code of 250 diabetes mellitus (HCC 19). After medical record review, the correct code assigned was 250.02 diabetes mellitus without complications uncontrolled (HCC 19). This is a level of specificity coding discrepancy.

8.2.5.2 Risk Adjustment Discrepancies (Slide 30)

A risk adjustment discrepancy is identified when an HCC originally assigned to an enrollee on the basis of submitted risk adjustment data differs from the HCC assigned after data validation. A risk adjustment discrepancy may affect the final risk score for a beneficiary. Risk adjustment discrepancies that are identified by the IVC are referred to the SVC for confirmation. An example of a risk adjustment data discrepancy is provided below.

Example 4

Example of a Risk Adjustment Discrepancy

Reported Diagnostic Data: 482.4 Staphylococcal Pneumonia (HCC 111)
Data Validation Findings: 482.3 Streptococcal Pneumonia (HCC 112)

The medical record documentation supports the code 482.3 streptococcal pneumonia, not 482.4 staphylococcal pneumonia. The factor associated with HCC 111 is .693. The factor associated with HCC 112 (the final HCC) is .202. If confirmed, this finding results in a risk adjustment discrepancy because the beneficiary HCC changed.

The medical record associated with this risk adjustment discrepancy will go to the SVC for a second medical record review and confirmation. Risk adjustment discrepancies confirmed by the SVC provide the basis for a payment adjustment. (See *Payment Adjustment* and *Appeals* sections of this module.)

8.2.6 Risk Adjustment Data Validation Findings STAGE 4 (Slide 31)

The purpose of risk adjustment data validation is to improve risk adjusted payment integrity and accuracy. This is accomplished by identifying problems and sharing findings. CMS will continue to provide MA organization-specific (H number level) and summary findings from the data validation process to participating MA organizations. MA organization-specific findings may include a response rate, data discrepancy rates, and risk adjustment discrepancy rates. Additionally, summarized information such as risk adjustment data discrepancy rates at the national level and problematic diagnosis codes will be shared with the MA industry. CMS will make every effort to provide timely feedback.

8.2.7 Payment Adjustment STAGE 5 (Slides 32-33)

Again, the purpose of risk adjustment data validation is to ensure risk adjusted payment integrity and accuracy. Once a risk adjustment data discrepancy that affects payment has been identified by the IVC and confirmed by the SVC, CMS makes a correction when the CMS Administrator determines that a

payment adjustment should be made. A payment adjustment may increase or decrease the risk adjusted payment, and it is the basis for appeals.

CMS' general approach to making payment adjustments is to first develop the criteria that will identify an MA organization for payment adjustment. For example, the criteria could include payment adjustment based on a "consistent pattern" of inaccurate data for previous and current payment years being validated. Consistent patterns may include:

- High risk adjustment discrepancy rate—in comparison to the national average discrepancy rate.
- High payment error rate—in comparison to the national average net payment error rate.
- Inaccurate risk adjustment data for 2 consecutive years based on validation findings.

8.2.8 Appeals STAGE 6 (Slide 34)

An appeals process is implemented if an MA organization disputes a payment adjustment. The appeals process is conducted by the SVC. An expert coding panel reviews every appeal. 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.

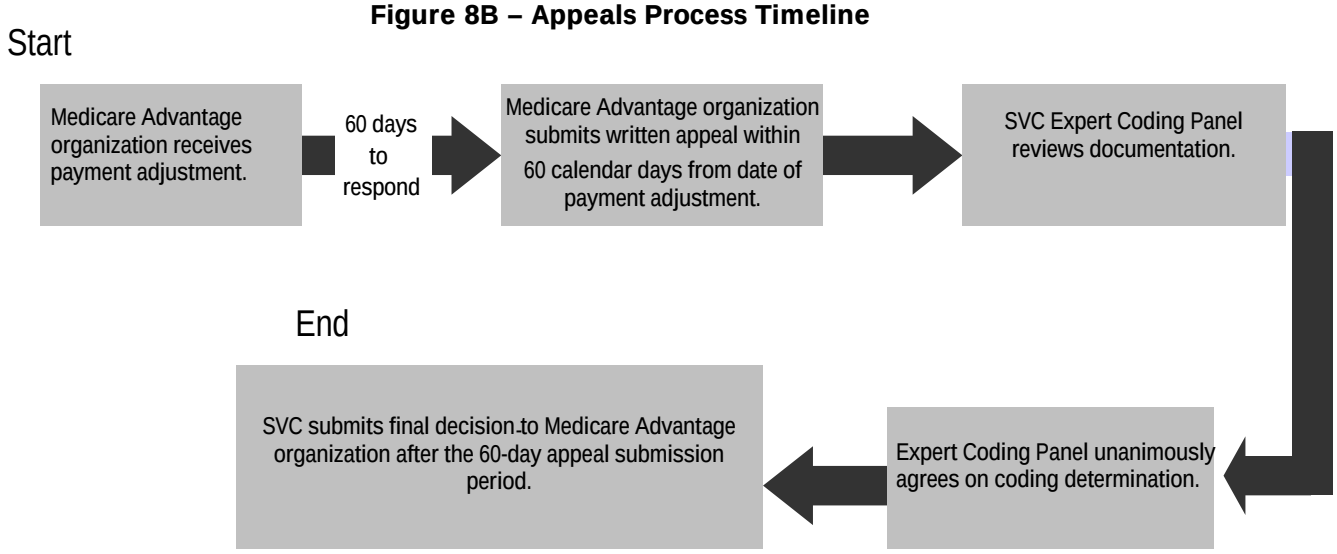
Consistent with Medicare fee-for-service, an MA organization has one opportunity to challenge a payment adjustment. Once a payment adjustment has been made and appears on the Monthly Membership Report (MMR), the MA organization has 60 days to file an appeal.

When submitting an appeal, an MA organization may offer a different interpretation of the ICD-9 code assignment based on *ICD-9 Coding Clinic Guidelines*. MA organizations may also provide additional medical record documentation to support their appeal. Thus, each appeal must include, at a minimum:

- A clearly documented reason for disagreement with the medical record review finding; and/or
- Additional medical record documentation to support the reason for appeal.

Figure 8B illustrates the timing of the appeals process.

Figure 8B – Appeals Process Timeline



8.2.9 Correct Payment STAGE 7 (Slide 35)

The conclusion of the appeals process establishes the correct risk adjusted payment for an MA organization. Based on the outcome of an appeal, the payment adjustment may stand (unchanged) or be reversed.

This concludes the Risk Adjustment Data Validation Process. STAGES 1- 7

8.3 Recommendations & Lessons Learned to Date (Slides 37-38)

Recommendations and lessons learned about the medical record request process that may assist plans in planning and implementing their plan's activities include the following:

- Establish communications with the providers prior to sending the medical record request.
- Use newsletters and CMS training tools to inform physicians about risk adjustment.
- Identify a contact person at the physician's office.
- Send complete information request to providers.
- 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—which may require more effort to obtain medical records from:
  - Specialists.
  - Non-contracted providers.
  - Hospital outpatient or physician settings.
- Consider having the provider indicate the date of service and diagnosis code.
- Involve in-house quality assurance staff/medical record reviewers/medical director to identify the "one best medical record."
- Submit complete medical records as you receive them from providers.

Please note that as of the publication of this module, CY2004 medical record reviews are in process. Upon conclusion of the CY2004 project, additional recommendations and lessons learned will be shared with all MA organizations.

8.4 Technical Assistance (Slide 36)

To improve the quality of risk adjustment data, CMS has technical assistance contractors available for any MA organization that needs help with data completeness, data accuracy, 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.

8.5 Current Validation Activities (Slide 37)

A host of risk adjustment data validation activities have been implemented. Table 8B is a synopsis of risk adjustment data validation activities by payment year and a listing of responsible CMS staff and contractors.

TABLE 8B – CMS STAFF AND CONTRACTORS

PAYMENT YEAR/ CONTRACT TYPE	STATUS	CMS CONTACT	CMS CONTRACTOR(S)
CY2003 RISK ADJUSTMENT DATA VALIDATION	Currently estimating payment adjustment	Mary Guy (mary.guy@cms.hhs.gov)	• IVC—BearingPoint • SVC—AdvanceMed
CY2004 RISK ADJUSTMENT DATA VALIDATION	Currently in the review process	Chanda McNeal (chanda.mcneal@cms.hhs.gov)	• IVC—BearingPoint • SVC—Aspen Systems
CY2005 RISK ADJUSTMENT DATA VALIDATION	Sampling selection expected Fall 2005	Mary Guy (mary.guy@cms.hhs.gov)	• IVC—BearingPoint • SVC—TBA
MONITORING THE QUALITY OF MA RISK ADJUSTMENT DATA	Currently in the development phase; will soon roll out to the plans	Lateefah Hughes (lateefah.hughes@cms.hhs.gov)	• LMI

8.6 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. In addition, with the implementation of the Medicare Modernization Act (MMA), CMS will be developing ways to validate drug data.

MODULE 9– VERIFYING RISK SCORES

Purpose

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

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

- 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	

9.1 Calculating Risk Scores

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 Medicare Beneficiary Database (MBD).

For January payment, CMS typically performs a data sweep after completing the nightly RAPS process on the last business day in September.

CMS calculates the risk scores that are associated with the January risk adjustment payment. 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

Figure 9A illustrates the flow of data used to calculate the risk score.

Figure 9A - Risk Score Calculation Process

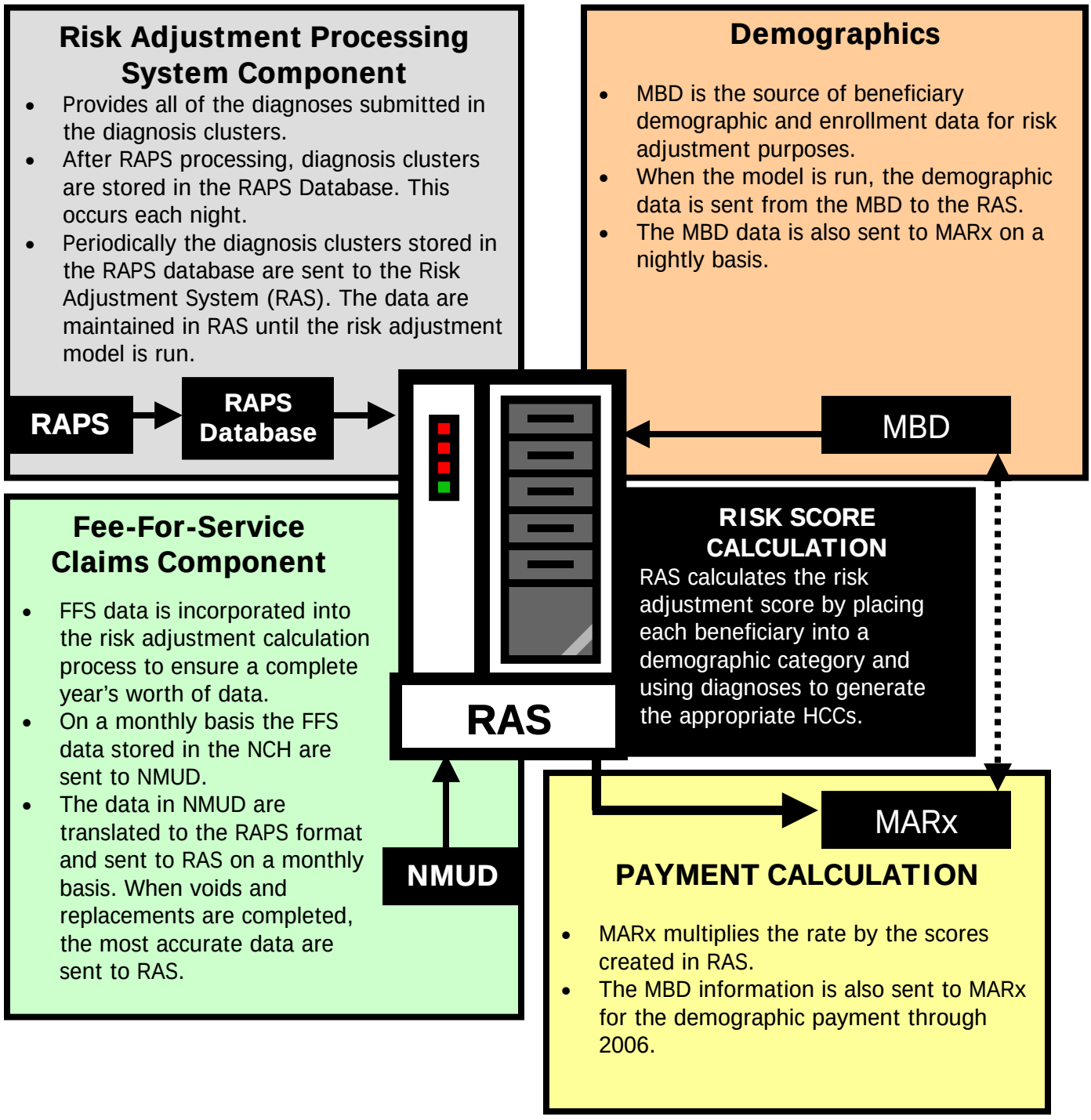


Table 9A describes the eight steps in the risk score calculation.

TABLE 9A - 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 including the MBD. 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. Plan-submitted Medicaid status information is also included. Beneficiaries with an ESRD flag are also 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 the past 90 days or more and classifies these individuals as long-term institutional beneficiaries. CMS passes beneficiary long-term institutional file to the payment 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 for 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. These files are also used in the Prescription Drug HCC (RxHCC) model. The ESRD model is normally run only on those beneficiaries with ESRD flags from MBD. 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.

TABLE 9A – 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 January. 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 also provided to MARx for use to determine which factor, 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 mid-year and reconciliation factor calculations, 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.

9.2 Risk Score Verification Tools

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 9B

TABLE 9B – RISK SCORE VERIFICATION TOOLS

REPORT NAME	ACCESS	AVAILABLE
RAPS Return File/RAPS Transaction Error Report	RAPS Mailbox RPT####.RPT.RAPS_RETURN_FLAT RPT#####.RPT.RAPS_ERROR_RPT	Next business day following data submission
RAPS Monthly and Cumulative Plan Activity Reports	RAPS Mailbox RPT####.RPT.RAPS_MONTHLY RPT####.RPT.RAPS_CUMULATIVE	Second business day of the month
SAS CMS-HCC Model Program	http://cms.hhs.gov/MedicareAdvtgSpecRatesStats *Ratebooks & Supporting Data, 2004 Mar-Dec, Downloads*	June 2003
MMR Non-Drug and Drug Reports	Through MARx	Refer to the 2006 MARx Monthly Schedule
MOR HCC Part C and RAS Rx MOR	Through MARx	Refer to the 2006 MARx Monthly Schedule

See the 2006 MARx Monthly Schedule at:
http://mmahelp.cms.hhs.gov/_assets/PCUG_Appendices_v1.1_11.07.05.pdf

9.2.1 RAPS Return File/RAPS Transaction Error Report

The RAPS Return File contains all transactions submitted by the MA organization. Any errors that were 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. The diagnosis clusters that contain a relevant diagnosis code will be used to calculate risk adjustment factors when CMS runs 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. This file is also utilized in mainframe databases at larger organizations. The Return File is typically used by organizations that employ automated update processes for their databases.

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 can also identify whether the diagnosis was already stored for the enrollee for that payment period.

MA organizations must submit each relevant 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 9B), the plan captured the 70710 (ulcer of the lower limb) and 311 (depression) diagnoses, since both were accepted to RAPS. Figure 9C illustrates the database content based on the results of this RAPS Return File.

Note: although 311 is not a relevant diagnosis for the CMS-HCC model, CMS recommends that plans submitting all diagnoses maintain an accurate record of all data submitted and stored. Therefore, the plan should store a record of this diagnosis. The diagnosis included in the CCC record 3 is a relevant diagnosis cluster, but was returned with an error, so the cluster was not stored in the RAPS database. Therefore, the plan's database will not capture this information.

Note: Figure 9B is an abbreviated version of the RAPS Return File due to space limitations on the page.

Figure 9B – RAPS Return File

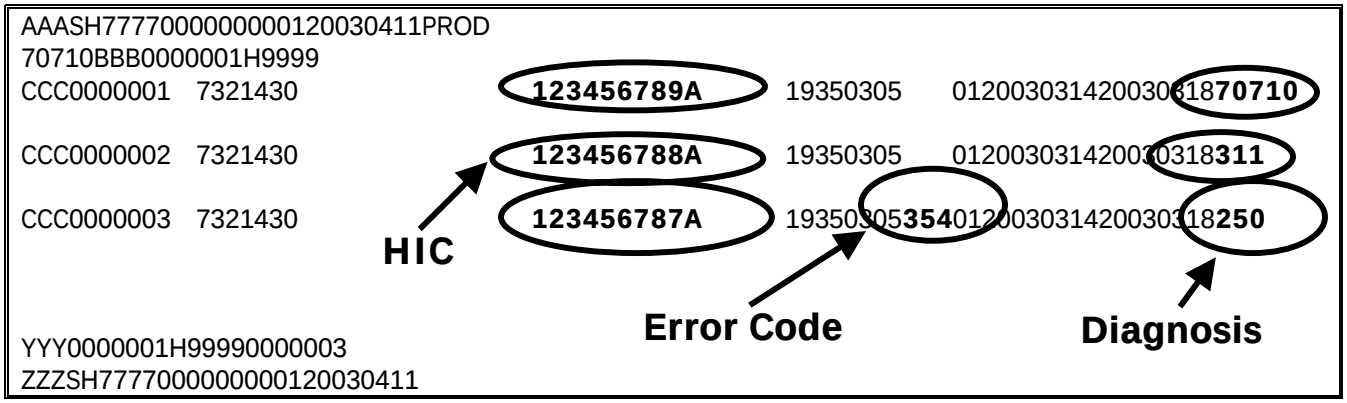


Figure 9C – Internal Diagnosis Cluster Database

HIC	Dx	Date Submitted	Thru Date	Dx	Date Submitted	Thru Date	Dx	Date Submitted	Thru Date
123456789A	70710	20030411	20030318						
123456788A	311	20030411	20030318						

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 store for risk score calculation.

9.2.2 RAPS Management Reports

The RAPS Monthly and Cumulative Plan Reports 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.

Example: 2

If the MA organization stores all unique diagnosis clusters that are not returned on the RAPS Return File for each beneficiary, they would potentially have a database with information such as that included in Figure 9D. The total clusters stored in the organization's July internal database should equal the total clusters stored on the Cumulative Plan Activity Report for July, Figure 9E.

Figure 9D – Internal Diagnosis Cluster Database

HIC	Dx	Date Submitted	Thru Date	Dx	Date Submitted	Thru Date	Dx	Date Submitted	Thru Date
123456789A	70710	20040111	20031210	2910	20031015	20030910	7854	20031101	20031027
123456789B	4254	20031010	20030917	V4321	20031120	20031022			
123467892A	1629	20031123	20031003	481	20031125	20031006	185	20031028	20030926
123456789D	2880	20040130	20031202	71150	20031206	20031103	4280	20031006	20030901
123456788A	4111	20031202	20031114	41091	20031201	20031107	41092	20031110	20031016
123456786A	20198	20031121	20031008						
123456788A	20480	20040117	20031212	2639	20031002	20030904	1500	20031014	20030919
123456789A	25001	20031027	20030912	29590	20031113	20031013			
Subtotal	**8**			**7**			**5**		
Grand Total									**20**

Note: Figure 9D is an abbreviated version of the RAPS Return file for July due to space limitations on the page. The fields included are the minimum required to verify risk scores.

Figure 9E – RAPS Cumulative Plan Activity Report

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN REPORT: DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2003

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	14	24	22	133
TOTAL MODEL STORED	0	0	2	2	2	2	8
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

9.2.3 CMS-HCC Risk Adjustment Model Software

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
  - Ratebooks and Supporting Data
  - 2004 Mar-Dec
  - Downloads
  - HCC software (ZIP 49KB)

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 MACROSFT. 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.

Table 9C lists the software-provided files.

TABLE 9C – SOFTWARE-PROVIDED FILES

FILE NAME	DESCRIPTIONS
HCCSOFT	Main program that supplies user parameters to the main SAS macro program.
MACROSFT	Main macro that creates HCC and Score variables by calling other external macros
MAGESEX	Creates age/sex, originally disabled, disabled variables
EDITICD	Performs edits to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code
MLTCCDG	Assigns ICD-9-CM diagnosis code to multiple CCs where required
HCCLABL	Assigns labels to HCCS
MCMSHIER	Sets HCC=0 according to hierarchies
SCORECAL	Calculates a score variable
FMTCMSCC	Format library that has a crosswalk from ICD-9-CM codes to CC categories that are transformed to HCC categories by the software. SAS transport files, which may be used on any platform running SAS
HCC COEFN	Coefficients for three regression model SAS transport files, which may be used on any platform running SAS

Table 9D provides a list of user supplied files.

TABLE 9D – 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

9.2.4 Monthly Membership Reports (MMR)

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.

9.2.4.1 Monthly Membership Summary Reports

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.

9.2.4.2 Monthly Membership Detail Reports

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.

9.2.4.2.1 Non-Drug Monthly Membership Report

The Non-Drug MMR is based on the CMS-HCC Risk Adjustment Model and 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.

9.2.4.2.2 Drug Monthly Membership Report

The Drug MMR is designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than through the Medicare Part A/B costs. 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 9E describes the MMR field ranges.

TABLE 9E – 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
14-19	Health Status
20-35	Risk Adjustment/Demographic Payment Adjustment Information
36-44	Additional Risk Adjustment Indicators
45-74	Fields added to support the Part D Benefit

Note: In 2006, a Low-Income Subsidy (LIS) Premium Amount field has been added to filler field #35. This field contains the amount of Part D premium that is being paid to MA organizations on behalf of affected members.

 Details of the MMR Record File Layout are located in the Resource Guide**.**

The plans may access the MMR Report format. Figure 9F illustrates an example of the MMR for Non-Drug.

Figure 9F –MMR REPORT FORMAT – NON - DRUG

```
1***GROUP=H0504,CONTRACT=H0504,
1RUN DATE:20051028                          MONTHLY MEMBERSHIP REPORT - NON DRUG                                    PAGE:        1
 PAYMENT MONTH:200601                  PLAN(H0504) PBP(023) SEGMENT(000) CA PHYSICIANS SERV/DBA BLUE SHIELD OF CALIF
0                                    ------------------------------------------- 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     $0.00     *       $0.00              $0.00             $0.00                   $10.25                 $0.00
     PART B     $0.00     *       $0.00              $0.00             $0.00                   $14.75                 $0.00
0             S              -----------  FLAGS  ------------    ------------------------ PAYMENTS/ADJUSTMENTS -----------------------
 CLAIM        E AGE  STATE      P P        M F P A D   S MTHS        DATES          LAG    FTYPE
 NUMBER       X GRP  CNTY       A A H E I   C R R D E E O A B       START   END
 ------------ - ---- -----    O R R O S N N A A D D F G U ---- --- ----------------------------------------------------------------------
    SURNAME F   DMG  BIRTH    O T T S R S H I I I O A H R PIP  ADJ
            I   RA   DATE     A A B P D T C D L B N U P C DCG  REA  FCTR-A  FCTR-B      PART A      PART B      TOTAL PAYMENT
 ------------ - ---- -----    - - - - - - - - - - - - - - ---- ---- ----------------------------------------------------------------------
 000000000T   F 5559 33700                                    1 1    200601 200601     Y       D
    JOHNSON S   5559 19491130 Y Y Y   Y                 B          1.0280  1.0280    $2733.53    $3900.59           $6634.12
 000000000A   F 8084 10050                                    1 1    200601 200601     Y
    JOHNSON M   8084 19240306 Y Y Y                       B          1.1480  1.1480     $209.41     $186.29            $395.70
 000000000A   F 5559 39620                                    1 1    200601 200601     Y       E
    JOHNSON K   5559 19470428 Y Y Y                       B          0.8460  0.8460     $127.82     $116.61            $244.43
 000000000A   F 8084 05200                                    1 1    200601 200601     Y
    JOHNSON T   8084 19220506   Y Y                       B          1.1480  1.1480     $213.77     $190.18            $403.95
 000000000A   F 6064 29010                                    1 1    200601 200601     Y       C
    JOHNSON G   6064 19420801 Y Y Y         Y     Y       B          0.5960  0.5960      $95.27      $86.97            $182.24
 000000000A   F 7074 11370                                    1 1    200601 200601     Y       I
    JOHNSON R   7074 19330503 Y Y Y         Y     Y       B          2.2420  2.2420     $351.87     $323.13            $675.00
 000000000C1  M 3544 03060                                    1 1    200601 200601     Y       C2
```

The plans may access the MMR Report format. Figure 9G illustrates an example of the MMR report for Drug.

Figure 9G –MMR REPORT FORMAT -DRUG

```
1***GROUP=H0504,CONTRACT=H0504,
1RUN DATE:20051028                          MONTHLY MEMBERSHIP REPORT - DRUG                                    PAGE:      1
 PAYMENT MONTH:200601                  PLAN(H0504) PBP(023) SEGMENT(000) CA PHYSICIANS SERV/DBA BLUE SHIELD OF CALIF
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  ADJ RA FCTR     DATES       LOW-INCOME COST     LOW-INCOME COST
 NUMBER        X GRP  CNTY         A A E O O I  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 MTHS DIRECT SUBSIDY        PACE           PACE COST
            I    RA   DATE      A A B P C C T   D    PAYMENT AMT     PREMIUM ADD-ON    SHARING ADD-ON     TOTAL PAYMENT
 ------------ - ---- -----     - - - - - --- ---- ------------------------------------------------------------------------
 000000000T   F 5559 33700                          1.9770  200601 200601        000                  $0.00
    JOHNSO S    5559 19491130         B       1        $129.17          $0.00              $0.00              $129.17
 000000000A   F 8084 10050                          1.0300  200601 200601        000                  $0.00
    JOHNSO M    8084 19240306         B       1         $62.22          $0.00              $0.00               $62.22
 000000000A   F 5559 39620                          1.2870  200601 200601        000                  $0.00
    JOHNSO K    5559 19470428         B       1         $80.39          $0.00              $0.00               $80.39
 000000000A   F 8084 05200                          1.0300  200601 200601        000                  $0.00
    JOHNSO T    8084 19220506         B       1         $62.22          $0.00              $0.00               $62.22
 000000000A   F 6064 29010                          1.0962  200601 200601        000                  $0.00
    JOHNSO G    6064 19420801         B 1     1         $66.90          $0.00              $0.00               $77.50
 000000000A   F 7074 11370                          1.7150  200601 200601        000                  $0.00
    JOHNSO R    7074 19330503         B   A   1        $110.65          $0.00              $0.00              $121.25
 000000000C1  M 3544 03060                          1.0908  200601 200601        000                  $0.00
    JOHNSO M    3544 19620923         B 1     1         $66.52          $0.00              $0.00               $77.12
 000000000A   M 8084 03060                          1.1670  200601 200601        000                  $0.00
    JOHNSO P    8084 19250201         B       1         $71.91          $0.00              $0.00               $71.91
 000000000A   M 8599 39620                          1.4600  200601 200601        000                  $0.00
    JOHNSO J    8589 19200111         B       1         $92.62          $0.00              $0.00               $92.62
 000000000A   M 8084 05200                          0.4449  200601 200601        000                  $0.00
    JOHNSO E    8084 19231201         B 1     1         $20.85          $0.00              $0.00               $31.45
 000000000A   F 5559 05200                          1.2350  200601 200601        000                  $0.00
    JOHNSO J    5559 19480329         B       1         $76.71          $0.00              $0.00               $76.71
 000000000A   F 8084 24260                          1.4914  200601 200601        000                  $0.00
    JOHNSO M    8084 19220322         B   A   1         $94.84          $0.00              $0.00              $105.44
```

9.2.5 Risk Adjustment Model Output Reports (MOR)

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.

9.2.5.1 Part C Risk Adjustment MOR

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 9F provides descriptions of the fields in the Part C MOR.

TABLE 9F – PART C RISK ADJUSTMENT MOR FIELD SUMMARY

REPORT BODY = 162 bytes	
Fields	**Description**
1 – 5	Beneficiary Identifying Information.
6-17	The sex and age group for the female beneficiary.
18-29	The sex and age group for the male beneficiary.
30-31	Medicaid indicators for Female Beneficiary.
32-33	Medicaid indicators for Male Beneficiary.
34	Originally Disabled Female.
35	Originally Disabled Male.
36–106	Disease Coefficients. Field 36 represents HCC 1. Field 106 represents HCC 177.
107-111	Disabled Disease HCC. Field 107 represents HCC 5. Field 111 represents HCC 107.
112-117	Disease Interactions.

9.2.5.2 RAS RxHCC MOR Report

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 9G provides descriptions of the fields in the RxHCC MOR.

TABLE 9G – RXHCC MOR FIELD SUMMARY

REPORT BODY = 164 bytes	
Fields	**Description**
1 – 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.

Figure 9H illustrates an example of a Part C MOR report. Figure 9I illustrates an example of a RAS RxHCC MOR report.

Figure 9H – 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

HIC	LAST NAME	FIRST NAME	I	DATE OF BIRTH	SEX& AGE GROUP
997352032A	NOBLE	ALBERT	A	19421213	MALE60-64
HCC DISEASE GROUPS: HCC019 DIABETES WITHOUT COMPLICATION HCC080 CONGESTIVE HEART FAILURE HCC092 SPECIFIED HEART ARRHYTHMIAS INTERACTIONS: INTI01 DM_CHF					
997361422D	YOUNGMAN	DORIS	C	19260705	FEMALE75-79
HCC DISEASE GROUPS: HCC092 SPECIFIED HEART ARRHYTHMIAS					
997560532B	JAMES	ANNIE	I	19230731	FEMALE80-84
HCC DISEASE GROUPS: HCC105 VASCULAR DISEASE					
998148176A	MANGIONE	GUY		19241230	MALE75-79
ORIGINALLY_DISABLED_FEMALE					
HCC DISEASE GROUPS: HCC010 BREAST, PROSTATE, COLORECTAL AND OTHER CANCERS AND TUMORS					

Figure 9I - RAS RxHCC MOR Report Format

RUN DATE: 20031219 RISK ADJUSTMENT MODEL OUTPUT REPORT
PAYMENT MONTH: 200401 PLAN: S8888 CHAMPION INSURANCE

HIC	LAST NAME	FIRST NAME	I	DATE OF BIRTH	SEX& AGE GROUP
123456789A	JOHNSON	JOHN	J	19300615	MALE70_74

ORGINALLY DISABLED MALE

RXHCC DISEASE GROUPS: RXHCC018 DIABETES WITHOUT COMPLICATION
RXHCC083 SEIZURE DISORDERS AND CONVULSIONS
RXHCC106 VASCULAR DISEASE

RXINTERACTIONS: D_HCC65 DISABLED SCHIZOPHRENIA

987654321B	LEE	BETTY	L	19400205	FEMALE65_69

ORGINALLY DISABLED FEMALE

RXHCC DISEASE GROUPS: RXHCC010 LUNG, UPPER DIGESTIVE TRACT, AND OTHER SERVERE CANCERS
RXHCC017 DIABETES WITH COMPLICATIONS
RXHCC106 VASCULAR DISEASE

RAPS Record Layout

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'
6	FILLER	32 - 512	X(481)	SPACES

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

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	9(8)	'CCYYMMDD'
8	DOB-ERROR-CODE	90 – 92	X(3)	SPACES
9 – 18	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(5)	
9.5	DC-FILLER		X(2)	SPACES
9.6	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.7	DIAG-CLSTR-ERROR-2		X(3)	SPACES
19	CORRECTED-HIC-NO	413 – 437	X(25)	SPACES
20	FILLER	438 - 512	X(75)	SPACES

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

ZZZ RECORD

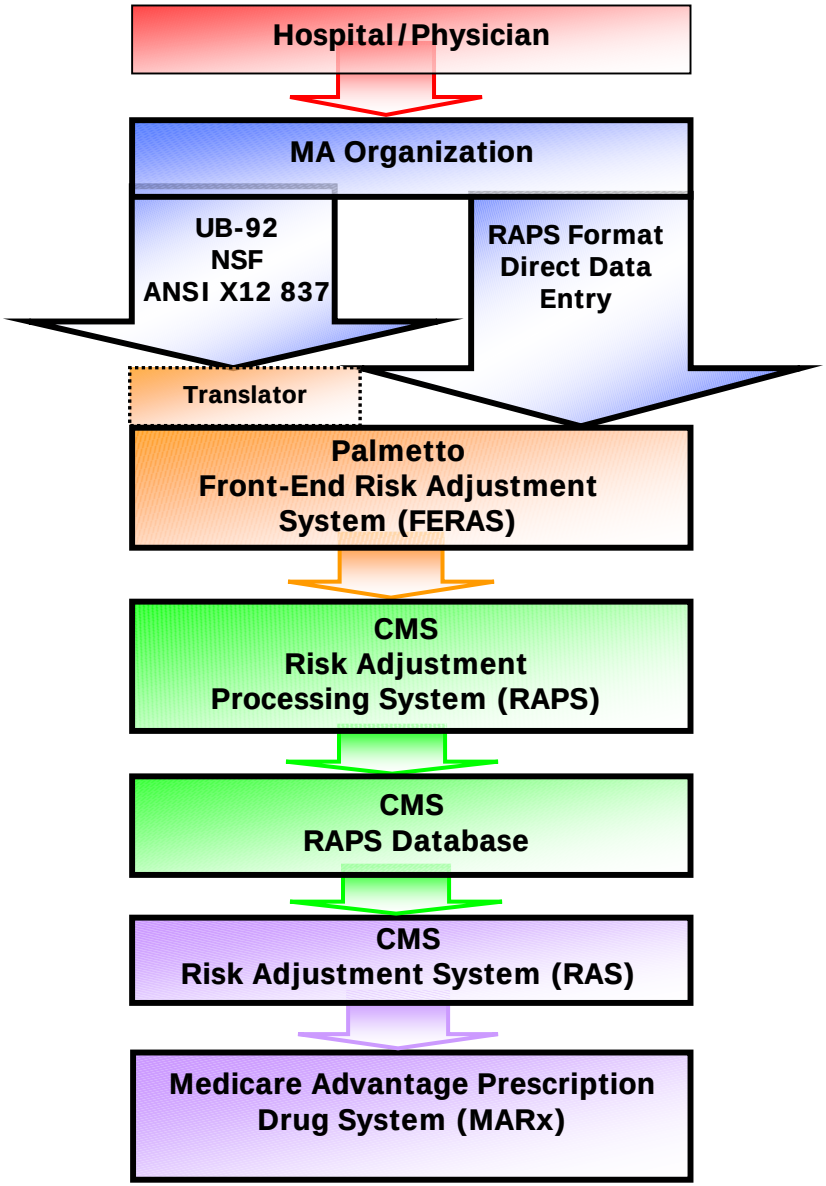
FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'ZZZ'
2	SUBMITTER-ID	4 – 9	X(6)	'SHnnnn'
3	FILE-ID	10 – 19	X(10)	
4	BBB-RECORD-TOTAL	20 – 26	9(7)	
5	FILLER	27 – 512	X(486)	SPACES

Risk Adjustment Submission Timetable

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
2005	7/1/03 – 6/30/04	9/3/04	1/1/05	NA*
2005	1/1/04 – 12/31/04	3/4/05	7/1/05	5/15/06
2006	7/1/04 – 6/30/05	9/2/05	1/1/06	NA*
2006	1/1/05 – 12/31/05	3/3/06	7/1/06	1/31/07
2007	7/1/05 – 6/30/06	9/1/06	1/1/07	NA*
2007	1/1/06 – 12/31/06	3/2/07	7/1/07	1/31/08
2008	7/1/06 – 6/30/07	9/7/07	1/1/08	NA*
2008	1/1/07 – 12/31/07	3/7/08	7/1/08	1/31/09

* With elimination of the payment lag, the final submission deadline (reconciliation) is May 15 in 2006 and then becomes January 31 from 2007 forward. There is no longer a September 30 deadline for reconciliation.

Risk Adjustment Process Overview



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FERAS Error Codes

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

FILE LEVEL

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

If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed.

FERAS Error Codes

BATCH LEVEL

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 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
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

If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed.

RAPS Error Codes

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.

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

RAPS Error Codes

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 12/31/2003
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	DIAGNOSIS CLUSTER WAS NOT SUCCESSFULLY DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE.

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 A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE.

MODULE 3 – DATA COLLECTION

Exercise 1

Yellowstone Health Plan collected data from one of its providers. The information submitted by the physician includes four diagnoses, each with a different date of service. From the information provided, does the health plan have the minimum data required for risk adjustment?

Exercise 2

Using Tables 3E through 3G in your Participant's Guide, determine if the Medicare Provider Numbers are from acceptable sources for risk adjustment. Also identify the location and type of facility.

Medicare Provider #	Covered or Non-covered Facility	Location	Type
27S750	_____	_____	_____
453350	_____	_____	_____
345455	_____	_____	_____
114705	_____	_____	_____
52Y610	_____	_____	_____

Exercise 3

Jane Doe visited her primary care physician complaining of chronic pain and stiffness in her major muscles, accompanied by severe headaches and constant fatigue. Her physician ordered a MRI scan of the brain and a referral to the Pain Management clinic. The radiologist noted no abnormal findings in the MRI scan and the visit to the Pain Management clinic resulted in the diagnosis of fibromyalgia syndrome.

1. List the physician and specialty sources involved in Jane Doe's treatment.
2. Is the source acceptable for risk adjustment?

MODULE 4 – DATA SUBMISSION

Exercise 1

Bill Doe received health care on several occasions during the second quarter of 2006. The Winfield Health Care Plan submitted the following diagnoses in one CCC record. The plan submits all diagnoses whether they are in the model or not, and filters by provider type.

1. Mr. Doe visited his primary physician on 4/5/06 for increased weakness and tremor. The physician diagnosed Parkinson's Disease **332.0**, ordered a CAT scan and MRI of the brain to rule out any tumors or stroke, and referred him to a neurologist for further evaluation.

2. A diagnostic radiologist performed a CAT scan and MRI on on Mr. Doe on 4/07/06. The results reported by the radiologist was "small lacunar infarct, possibly old" **434.91**.

3. The neurologist saw Mr. Doe on 4/9/06, reviewed the MRI findings and concurred with the radiologist interpretation of Cerebrovascular Infarct **434.91** and referred Mr. Doe for admission to Community Hospital.

4. Community Hospital admitted Mr. Doe on 4/9/06 and discharged him to a rehabilitation facility on 4/15/06 with the following diagnoses: principal diagnosis: CVA **436**; other diagnoses: Parkinson's **332.0** and Emphysema **492.8**.

5. The community hospital readmitted Mr. Doe on 4/22/06, and he was discharged on 4/30/06. No diagnosis code was submitted.

6. On 4/30/06 through 5/28/06 Mr. Doe's primary care physician diagnosed Diabetes **250.00**.

Complete the following CCC record layout given the information above.

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0		10.0		11.0		12.0		13.0		14.0	
9.1		10.1		11.1		12.1		13.1		14.1	
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4		10.4		11.4		12.4		13.4		14.4	
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

MODULE 6 – EDITS

Exercise 1

Read the following scenario and determine if there is an error. If there is an error, determine if FERAS or RAPS would generate the error message. Identify the error code and explain the consequences of the error.

1. The MA organization submitted a diagnosis cluster with provider type 40. This occurred in the fourth of seven records in the batch.

2. The MA organization submitted a diagnosis cluster with information populated in the diagnosis cluster error code fields. This occurred in the second of four records in the batch.

3. The MA organization submitted a valid diagnosis that is not included on the list of model diagnoses. This was in the second of eight records in the batch.

4. The MA organization submitted a record with a from date of 20040113 and the through date of 20040115 for a hospital inpatient provider. This occurred in the fourth of nine records in the batch.

5. The MA organization submitted a record with a sequence number 0000002. This was the first of six records in the batch.

6. The MA organization submitted a record with nine diagnosis clusters, but the fifth diagnosis cluster was left blank. This was the third of ten records in the batch.

MODULE 7 – REPORTS

Exercise 1

In Figure 7E in your Participant Guide on page 7-10 an MA organization submitted a batch with eight records.

Review the report and respond to the following:

1. Which records had errors?

2. For each of the errors, identify the code, description, and steps for resolution using the form below.

Record #	Associated Error Code	Error Code Description	Resolution Steps
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MODULE 3 – DATA COLLECTION

Exercise 1

Yellowstone Health Plan collected data from one of its providers. The information submitted by the physician includes four diagnoses, each with a different date of service. From the information provided, does the health plan have the minimum data required for risk adjustment?

Answer Key – Exercise 1

The data collected by Yellowstone Health Plan includes:

a. The service from dates
b. The service through dates
c. The four ICD-9-CM diagnoses codes
d. The provider type

The example does not indicate whether or not the physician included the HIC number.

Answer Key - Exercise 2

Using Tables 3E through 3G in your Participant's Guide, determine if the Medicare Provider Numbers are from acceptable sources for risk adjustment. Also identify the location and type of facility.

Medicare Provider #	Covered or Non-covered Facility	Location	Type
27S750	**Covered**	**Montana**	**Short-term Hospital**
453350	**Covered**	**Texas**	**Children's Hospital**
345455	**Non-covered**	**North Carolina**	**SNF**
114705	**Covered**	**Georgia**	**Comm Mental Hlth Ctr**
52Y610	**Non-covered**	**Wisconsin**	**SNF**

Exercise 3

Jane Doe visited her primary care physician complaining of chronic pain and stiffness in her major muscles, accompanied by severe headaches and constant fatigue. Her physician ordered a MRI scan of the brain and a referral to the Pain Management clinic. The radiologist noted no abnormal findings in the MRI scan and the visit to the Pain Management clinic resulted in the diagnosis of fibromyalgia syndrome.

1. List the physician and specialty sources involved in Jane Doe's treatment.
2. Is the source acceptable for risk adjustment?

Answer Key – Exercise 3

Physician and Specialty Data Sources include:

a. General Practice (Primary Care Physician)
b. Diagnostic Radiology
c. Pain Management

Both general practice and pain management are acceptable sources of physician data for risk adjustment (Table 3H) however diagnostic radiology, starting in CY2006 is no longer an acceptable source.

MODULE 4 – DATA SUBMISSION

Exercise 1

Bill Doe received health care on several occasions during the second quarter of 2006. The Winfield Health Care Plan submitted the following diagnoses in one CCC record. The plan submits all diagnoses whether they are in the model or not, and filters by provider type.

1. Mr. Doe visited his primary physician on 4/5/06 for increased weakness and tremor. The physician diagnosed Parkinson's disease **332.0**, ordered a CAT scan and MRI of the brain to rule out any tumors or stroke, and referred him to a neurologist for further evaluation.

2. A diagnostic radiologist performed a CAT scan and MRI on on Mr. Doe on 4/07/06. The results reported by the radiologist was "small lacunar infarct, possibly old" **434.91**.

3. The neurologist saw Mr. Doe on 4/9/06, reviewed the MRI findings and concurred with the radiologist interpretation of cerebrovascular infarct **434.91** and referred Mr. Doe for admission to Community Hospital.

4. Community Hospital admitted Mr. Doe on 4/9/06 and discharged him to a rehabilitation facility on 4/15/06 with the following diagnoses: principal diagnosis: CVA **436;** other diagnoses: Parkinson's **332.0** and Emphysema **492.8**.

5. The community hospital readmitted Mr. Doe on 4/22/06, and he was discharged on 4/30/06. No diagnosis code was submitted.

6. On 4/30/06 through 5/28/06 Mr. Doe's primary care physician diagnosed Diabetes **250.00**.

Complete the following CCC record layout given the information above.

Answer Key – Exercise 1

1. Item 1 is from a physician office and it becomes the first cluster. Therefore, provider type 20 is entered in field 9.0. The date of service in both 9.1 and 9.2 is in the CCYYMMDD format. Field 9.3 should always contain 1 space, unless the cluster is being deleted. The diagnosis code in the scenario, 3320, is entered in field 9.4 with no decimal and one space following the code to complete the 5-character field. This is a relevant diagnosis in HCC 73. Fields 9.5, 9.6, and 9.7 are filled with spaces.

2. Item 2 is not an acceptable source of data because as of 2006 diagnostic radiology is no longer an acceptable physician source.

3. The third item is from a physician office and becomes cluster 2. Therefore, provider type 20 is entered in field 10.0. The date of service is entered in 10.1 and diagnosis code 434.91 is entered in 10.4. Code 434.9 is on HCC 96.

4. Item 4, cluster 3 is from a hospital inpatient so it is valid data. Provider type 01 is entered in field 11.0 for the principal diagnosis. The admission date is entered in 11.1 and the through date is entered in 11.2. Code 436 followed by two spaces, is entered in 11.4. Code 436 is also HCC 96.

   Item 4, cluster 4 is from a hospital inpatient, secondary diagnoses. Enter 02 in field 12.0 and the same admission and discharge dates as cluster 3. Diagnosis code 3320 plus space is entered in field 12.4, even though this is a repeat of a diagnosis, it is important that internally the plan has captured that the source of this diagnosis can also be found from an inpatient record.

   Item 4, cluster 5 repeats the data from cluster 4 with the exception of code 4928 plus a space, in field 13.4.

5. Not all of the five minimum data elements were collected from this provider. The provider information contained all of the minimum data elements except for the diagnosis code. Plans can not submit an incomplete diagnosis cluster. Therefore, this information can not be submitted.

6. Item 6 is from a primary care physician so it is valid data. Provider type 20 is entered in field 14.0 for physician. The admission date is entered in 14.1 and the through date is entered in 14.2. Code 250.00 is entered in 14.4. Code 250.00 is also HCC 19.

   Item 6 must follow item 4, cluster 5. Plans must not skip clusters when submitting active diagnosis codes.

   Since this is the final diagnosis for Mr. Doe, all other diagnosis clusters must be space filled.

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0	20	10.0	20	11.0	01	12.0	02	13.0	02	14.0	20
9.1	20060405	10.1	20060409	11.1	20060409	12.1	20060409	13.1	20060409	14.1	20060430
9.2	20060405	10.2	20060409	11.2	20060415	12.2	20060415	13.2	20060415	14.2	20060528
9.3	Space	10.3	Space	11.3	Space	12.3	Space	13.3	Space	14.3	Space
9.4	3320 *(space)*	10.4	43491	11.4	436 *(2 spaces)*	12.4	3320 *(space)*	13.4	4928 *(space)*	14.4	25000
9.5	Space	10.5	Space	11.5	Space	12.5	Space	13.5	Space	14.5	Space
9.6	Space	10.6	Space	11.6	Space	12.6	Space	13.6	Space	14.6	Space
9.7	Space	10.7	Space	11.7	Space	12.7	Space	13.7	Space	14.7	Space

MODULE 6 – EDITS

Exercise 1

Read the following scenario and determine if there is an error. If there is an error, determine if FERAS or RAPS would generate the error message. Identify the error code and explain the consequences of the error.

Answer Key – Exercise 1

1. The MA organization submitted a diagnosis cluster with provider type 40. This occurred in the fourth of seven records in the batch.
   Answer: Since this occurred in the fourth record in the batch, the error is identified in RAPS. The submitter receives error code 400 "MISSING/INVALID PROVIDER-TYPE CODE ON CCC RECORD." This diagnosis cluster with the incorrect provider type is not stored. RAPS continues editing.

2. The MA organization submitted a diagnosis cluster with information populated in the diagnosis cluster error code fields. This occurred in the second of four records in the batch.
   Answer: The submitter receives error code 307 "DIAGNOSIS CLUSTER-ERROR 1 NOT EQUAL TO SPACES" and 308 "DIAGNOSIS CLUSTER-ERROR 2 NOT EQUAL TO SPACES" from RAPS, not FERAS, because this error did not occur in the first or last CCC record in the batch. This is a record level error and causes all editing to discontinue on this record. No clusters in this record are stored. Remember, error code fields must be populated with spaces, not zeros, when submitting data.

3. The MA organization submitted a valid diagnosis that is not included on the list of model diagnoses. This was in the second of eight records in the batch.
   Answer: RAPS processes the diagnosis as valid and, assuming there are no other errors in the cluster, it is stored. However, the cluster does not count towards risk adjustment, as indicated by the informational message, error code 501 "VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD."

4. The MA organization submitted a record with a from date of 20040113 and the through date of 20040115 for a hospital inpatient provider. This occurred in the fourth of nine records in the batch.
   Answer: FERAS accepts the cluster and sends it to RAPS. Assuming there are no other errors, no edit messages are received because the from and through dates are valid.

5. The MA organization submitted a record with a sequence number 0000002. This was the first of six records in the batch.
   Answer: Because the first record in the batch should be sequence number 0000001, not 0000002, error code 302 "MISSING/INVALID SEQUENCE NUMBER ON CCC RECORD" would be issued by FERAS. FERAS would completely reject the file.

6. The MA organization submitted a record with nine diagnosis clusters, but the fifth diagnosis cluster was left blank. This was the third of ten records in the batch.
   Answer: Since this occurred in the third record in the batch, the error is identified in RAPS. The submitter receives error code 455 "DIAGNOSIS CLUSTER NOT EDITED DUE TO RECORD FORMAT ERROR." Since there was a blank diagnosis cluster followed by a populated cluster, the diagnosis clusters with this error code are not stored.

MODULE 7 - REPORTS

Exercise 1

In Figure 7E in your Participant Guide on page 7-10 an MA organization submitted a batch with eight records.

Review the report and respond to the following:

Answer Key – Exercise 1

1. Which records had errors?

The Transaction Error Report indicated errors in records three, five, and seven. Records one, two, four, six, and eight received no error code messages.

2. For each of the errors, identify the code, description, and steps for resolution using the form below.

Record #	Associated Error Code	Error Code Description	Resolution Steps
3	353	HIC NUMBER DOES NOT EXIST ON MBD.	See A below.
5 (3 clusters)	408	SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD.	See B below.
7 (cluster 1)	491	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED.	See C below.
7 (clusters 2,3)	408	SERVICE FROM DATE IS NOT WITHIN MA ORG ENTITLEMENT PERIOD.	See C below.
7 (clusters 2,3)	409	SERVICE THROUGH DATE IS NOT WITHIN M=C ORG ENROLLMENT PERIOD	See C below.

A. Record three received a HIC error code (353) indicating that the "HIC NUMBER DOES NOT EXIST ON MBD." This error code occurred during the third stage of editing. The MA organization should check the accuracy of the HIC number, and see if new information was updated in MBD overnight that would resolve the error.

B. Record five received the 408-error code on three of its clusters because the beneficiary was not enrolled in a MA organization at the time of the hospital inpatient admission. The MA organization should double-check the dates of service to ensure they are correct. If they are not correct, the clusters should be corrected and resubmitted. If they are correct, then the organization should verify that the enrollment data found in MBD is accurate. If the enrollment information in MBD is different from the information found in MCCOY, the organization can contact CSSC for assistance.

C. Record seven received errors on two of its clusters. The first cluster received a 491-error code because the MA organization attempted to delete a diagnosis cluster with the same attributes that was already deleted from the RAPS database on the same date. No further action is required. The second cluster received both 408- and 409-error codes for the physician visit because the beneficiary was not enrolled in a MA organization on both the from and through dates of service.