RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help Medicare Advantage (MA) organizations, providers, physicians, and third party submitters locate information specific to risk adjustment.

The purpose of this Resource Guide is to identify and supply resources that will simplify and clarify both the terminology and the processes employed in the submission of risk adjustment data. An emphasis is given to recent, policy-relevant material.

This Resource Guide is a helpful tool for those who need a quick reference for technical concepts, or for those who need to provide employees with an introductory presentation to the risk adjustment data process. Where possible and appropriate, "screen shots" of important resources on the Internet have been included. These pages may also be utilized as a suitable visual aid for risk adjustment data instructors to enhance their presentation.

The information listed in the Resource Guide is arranged in seven sections:

- RISK ADJUSTMENT ACRONYMS AND TERMS
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- CSSC WEB RESOURCES
- CSSC REFERENCE DOCUMENTS
- APPLICATION FOR ACCESS

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Henry Thomas: henry.thomas@cms.hhs.gov
Stephen Calfo: stephen.calfo@cms.hhs.gov
Sean Creighton: sean.creighton@cms.hhs.gov

CUSTOMER SERVICE AND SUPPORT CENTER (CSSC) – http://www.csscoperations.com
The CSSC website provides "one-stop shopping" for MA organizations regarding risk adjustment data submission needs. Visit www.csscoperations.com to register for email updates from the CSSC. The updates will serve as notification that new or updated information has been added to the website.

CSSC Contact Information
877-534-2772 (toll-free)
csscoperations@palmettogba.com

LEADING THROUGH CHANGE, INC. (LTC, INC.)
For general questions about training and Risk Adjustment User Groups, please email Leading Through Change, Inc. at TARegistration@tarsc.info.

This page intentionally left blank.

TABLE OF CONTENTS

RISK ADJUSTMENT ACRONYMS AND TERMS 1
CMS WEB RESOURCES 5
CMS REFERENCE DOCUMENTS 9
Accessing HPMS 10
Risk Adjustment Instructions (excerpt from 2009 Final Call Letter) 11
CSSC WEB RESOURCES 19
CSSC REFERENCE DOCUMENTS 29
CSSC EDI Letter 30
CMS EDI Agreement 32
CSSC Risk Adjustment Data Submitter Application 35
Risk Adjustment Connect:Direct Specifications (RAPS Application) 37
CMS Enterprise File Transfer (GENTRAN) Instructions 39
APPLICATION FOR ACCESS 41

This page intentionally left blank.

RISK ADJUSTMENT ACRONYMS AND TERMS

This page intentionally left blank.

RISK ADJUSTMENT ACRONYMS AND TERMS

ACRONYM	TERM
AAPC	American Academy of Professional Coders
ACR	Adjusted Community Rates
ACRP	Adjusted Community Rate Proposal
ADS	Alternative Data Sources
ADL	Activities of Daily Living
AGNS	AT&T Global Network Services
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI X12 837	Variable Length File Format for Electronic Submission of Encounter Data
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act 1999
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement and Protection Act of 2000
CAD	Coronary Artery Disease
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Refined Hierarchical Condition Category Risk Adjustment Model
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSSC	Customer Service and Support Center
CVD	Cerebrovascular Disease
CWF	Common Working File
CY	Calendar Year
DCP	Data Collection Period
DDE	Direct Data Entry
DHHS	Department of Health & Human Services
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DOB	Date of Birth
DoD	Department of Defense
DOS	Dates of Service
DRG	Diagnosis Related Group
DX	Diagnosis
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
ET	Eastern Time
FERAS	Front-End Risk Adjustment System
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
GUI	Graphical User Interface
H#	MA Organization CMS Contract Number
HCC	Hierarchical Condition Category
HCFA 1500	Medicare Part B Claim Filing Form
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set

ACRONYM	TERM
HHS	Department of Health and Human Services
HIC#	Health Insurance Claim Number (Beneficiary Medicare ID#)
HICN	Health Insurance Claim Number (Beneficiary Medicare ID#)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICN	Internal Claim Number
IP	Internet Protocol
IVC	Initial Validation Contractor
JCAHO	Joint Commission on Accreditation of Health Care Organizations
LTC	Leading Through Change, Inc.
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
M+C organization	Medicare+Choice Organization
MCCOY	Managed Care Option Information System
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug Modernization Act of 2003
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MnDHO	Minnesota Disability Health Options
MOR	Model Output Report
MSA	Medical Savings Account
MSG	Message
MSHO	Minnesota Senior Health Options
NCH	National Claims History
NCHS	National Center for Health Statistics
NCPDP	National Council on Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDM	Network Data Mover
NES	Not elsewhere classified
NMUD	National Medicare Utilization Database
NOS	Not otherwise specified
NPI	National Provider Identifier
NSF	National Standard Format
OIG	Office of Inspector General
OREC	Original Reason for Entitlement Code
Palmetto GBA	Palmetto Government Benefits Administrators
PACE	Program of All-Inclusive Care for the Elderly
PCN	Patient Control Number
PHS	PACE Health Survey
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
RAPS	Risk Adjustment Processing System
RAPS Database	Risk Adjustment Processing System Database
RAS	Risk Adjustment System

ACRONYM	TERM
RHC	Rural Health Clinic
RPT	Report
RRB	Railroad Retirement Board
RT	Record Type
RxHCC	Prescription Drug Hierarchical Condition Category
SAS	Statistical Analysis Software
SCO	MassHealth Senior Care Option
SH#	Submitter CMS Contract Number
S/HMO	Social Health Maintenance Organizations
SNF	Skilled Nursing Facility
SSD	Selected Significant Disease Model
SSN	Social Security Number
SUB ID	Submitter ID
SVC	Second Validation Contractor
TOB	Type of Bill
UB-04	Uniform Billing Form 04
VA	Veterans Administration
WPP	Wisconsin Partnership Program

This page intentionally left blank.

CMS WEB RESOURCES

This page intentionally left blank.

CMS Main Page
http://www.cms.hhs.gov

Advance Notice of Methodological Changes for Calendar Year (CY) 2004 (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf

Announcement of Calendar Year (CY) 2004 Medicare+Choice Payment Rates (May 12, 2003)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004.pdf

Cover Letter Regarding Revised Medicare Advantage Rates for Calendar Year (CY) 2004 (January 16, 2004)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004b.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf

Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates (April 4, 2005)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2006.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2007 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf

Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates (April 3, 2006)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2008 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2008.pdf

Announcement of Calendar Year (CY) 2008 Medicare Advantage Payment Rates (April 2, 2007)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2009 for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2009.pdf

Announcement of Calendar Year (CY) 2009 Medicare Advantage Payment Rates (April 7, 2008)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf

Medicare Managed Care Manual
http://www.cms.hhs.gov/manuals
(select Internet-Only Manuals, then select 100-16 Medicare Managed Care Manual)

Rate Book Information
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

Healthplans Page
http://www.cms.hhs.gov/HealthPlansGenInfo/

Risk Adjustment Page
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_Adjustment.asp

Health Insurance Portability and Accountability Act (HIPAA) Page
http://www.cms.hhs.gov/HIPAAGenInfo/

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates/

Official Coding Guidelines on Centers for Disease Control & Prevention Website
http://www.cdc.gov/nchs/data/icd9/icdguide.pdf

Risk Adjustment Model Output Report Letter
http://csscoperations.com/new/references/cmsinstructions.html

Medicare Advantage (MA) Prescription Drug Plans Plan Communications User's Guide
http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage

Individuals with Access to CMS Systems (IACS) User Guide and Website
http://www.cms.hhs.gov/MMAHelp/07_IACS.asp#TopOfPage

Reference to Types of Facilities and Taxonomy Codes
http://www.wpc-edi.com/codes/taxonomy

CMS Call Letters (Finals)

2005:
http://www.cms.hhs.gov/ACR/Downloads/CallLetter.pdf

Overview 2006 & 2007:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/01Overview.asp#TopOfPage

2006:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/02Bid2006.asp#TopOfPage

2007:
http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/03Bid2007.asp#TopOfPage

2008:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf

2009:
http://www.cms.hhs.gov/prescriptionDrugCocContra/Downloads/CallLetter.pdf

This page intentionally left blank.

CMS REFERENCE DOCUMENTS

This page intentionally left blank.

Health Plan Management System (HPMS)

HPMS is a CMS information system created specifically for the Medicare Advantage program that provides MA organization level information.

Accessing HPMS

- Access to HPMS is accomplished via the Medicare Data Communications Network (MDCN).
- A User ID is required for HPMS access. If you do not currently have access, complete the "Access to CMS Computer Systems" form available at www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf or at the end of this Resource Guide.

If MA organizations experience difficulty logging into HPMS, please contact Don Freeburger (don.freeburger@cms.hhs.gov) 410-786-4586 or Neetu Jhagwani (neetu.jhagwani@cms.hhs.gov) 410-786-2548.

This page intentionally left blank.

Risk Adjustment Implementation

(Attachment A – Risk Adjustment Implementation excerpt from 2009 Final Call Letter – March 17 2008, http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf)

1. Risk Adjustment Data Submission Schedule

Table 1. Risk Adjustment Implementation Calendar (below) provides the updated submission schedule for all diagnosis data submitted for all risk adjustment models. This includes data for both the Part C CMS-HCC and ESRD models and the Part D Drug risk adjustment model.

Table 1. Risk Adjustment Implementation Calendar

CY	Dates of Service	Initial Submission Deadline*	First Payment Date	Final Submission Deadline
2008	July 1, 2006 through June 30, 2007	September 7, 2007	January 1, 2008	N/A**
2008	January 1, 2007 through December 31, 2007	March 7, 2008	July 1, 2008	January 31, 2009
2009	July 1, 2007 through June 30, 2008	September 5, 2008	January 1, 2009	N/A**
2009	January 1, 2008 through December 31, 2008	March 6, 2009	July 1, 2009	January 31, 2010
2010	July 1, 2008 through June 30, 2009	September 4, 2009	January 1, 2010	N/A**
2010	January 1, 2009 through December 31, 2009	March 5, 2010	July 1, 2010	January 31, 2011
2011	July 1, 2009 through June 30, 2010	September 3, 2010	January 1, 2011	N/A**
2011	January 1, 2010 through December 31, 2010	March 4, 2011	July 1, 2011	January 31, 2012

*March and September dates reflect the first Friday of the respective month.
**All risk adjustment data for a given payment year (CY) must be submitted by January 31st of the subsequent year.

Changes in payment methodology for 2009, including Part C and Part D payment and risk adjustment, are described in the February 22, 2009, *Advance Notice of Methodological Changes for Calendar Year (CY) 2009 Medicare Advantage Payment Rates* and the April 7, 2009, *Announcement of Calendar Year (CY) 2009 Medicare Advantage Payment Rates* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

2. Part A Risk Adjustment Factor Options

- ***Determinations of Risk Status***

As stated in the April 3, 2006 *Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/), plans subject to risk adjusted payments have an option for how to treat beneficiaries with 12 months of Part A data but less than 12 months of Part B enrollment in a data collection year.

Table 2. Which Risk Adjustment Factors to Apply to Payment*

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

*Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled to benefits under Part A and enrolled in Part B.
**During data collection period (previous calendar year).

Table 2. Which Risk Adjustment Factors to Apply to Payment (above) illustrates that beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less than 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees, as they are now.

Currently beneficiaries with 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS has created an option for how the risk adjustment payments for this category of enrollees are determined. Effective as of 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision will be applied to all "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.

- ***Option to Elect Full Risk Option for "Part A-only" Enrollees***

Effective as of 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. If an organization elects to have CMS determine payment factors (i.e., new enrollee factors or full risk adjustment factors) for all "Part-A only" enrollees, then -

- The decision will be applied to all "Part-A" only enrollees in the plan;
- The option elected will remain turned "on" until CMS is otherwise notified prior to August 31st of any successive year.

Plans interested in electing this option for 2009 must contact: Henry Thomas, CMS, at henry.thomas@cms.hhs.gov by August 31, 2008.

3. Risk Adjustment Implementation

MA organizations must review the following:

- Changes in payment methodology for 2009, including Part C and Part D payment and risk adjustment, are described in the February 22, 2009, *Advance Notice of Methodological Changes for Calendar Year (CY) 2009 Medicare Advantage Payment Rates and Part D Payment Policies* and the April 7, 2009, *Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Payment Policies and CY 2009 Part D Payment Notification* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

- Two important risk adjustment memoranda dated November 27, 2007, which were published via HPMS on November 28, 2007 -
    - o CMS implementation of ICD-9 diagnosis codes for 2009 CMS implementation of ICD-9 diagnosis codes for 2009
    - o Medicaid status for Part C and D risk adjustment and Part D cost sharing; and

For additional information on risk adjustment, see 42 CFR §422.310.

4. Impact of Hospital Acquired Conditions under the Inpatient Prospective Payment System on Diagnoses Reporting for Risk Adjustment

For purposes of risk adjustment, MA organizations are required to submit discharge diagnoses from hospital inpatient settings. To the extent that any ICD-9 codes attributable to the eight selected hospital acquired conditions (surgical site infections, blood incompatibility, air embolism, object left in surgery, catheter associated urinary tract infections, pressure ulcers, hospital acquired injuries, or vascular catheter associated infection) appear in the discharge diagnoses, these codes may be submitted for risk adjustment payment.

5. National Provider Identifier (NPI)

The January 23, 2004 final rule (69 FR 3434*), HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers*, established the standard for a unique identifier for health care providers and adopted the National Provider Identifier (NPI) number as that standard. The National Provider System (NPS) was established to assign unique NPI numbers to health care providers. The NPS was designed to be used by other Federal and state Agencies as well as by private health plans, if deemed appropriate, to enumerate their health care providers that did not participate in Medicare. Consequently, the NPI can not be used to determine whether a provider is a Medicare certified provider.

On May 23, 2007, the CMS implemented the use of the NPI, for claims submitted to Fee-For-Service (Original) Medicare and discontinued issuing the Medicare Provider Identifier Numbers (legacy or OSCAR numbers). In the past, Medicare plans could use the legacy number to verify that a provider was a Medicare provider and that the provider was an acceptable source for diagnosis data for the CMS risk adjustment process.

Implementation of the NPI necessitates that Medicare plans that had been using the legacy Medicare provider numbers to verify the source of diagnoses submitted for risk adjustment purposes establish new methodologies for determining: 1) that providers are Medicare certified and 2) that diagnosis sources are acceptable. Implementation of the NPI does not change the requirement for Medicare plans to verify that the diagnosis data submitted to the CMS for risk adjustment are from Medicare certified providers and from acceptable data sources.

6. Testing Requirements

Submitter testing is required to ensure the proper flow of data from the Submitter to the Risk Adjustment Processing System (RAPS). Testing also ensures the data submitted is valid and formatted correctly.

If you would like to send data in a test format, please contact the Customer Service and Support Center (CSSC) Help Line at (877) 534-2772. By calling the CSSC Help Line prior to transmission of your first production or test file, a CSSC representative will be able to give you information on how to properly submit a test and/or production file. Information regarding the CSSC and the Risk Adjustment Processing System (RAPS) is available on the CSSC web site at http://www.csscoperations.com/.

7. Acceptable Provider Types and Physician Data Sources

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

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physician.

In addition, only those physician specialties and other clinical specialists identified in Table 3 – Acceptable Physician Data Sources of the Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions (dated April 4, 2006) are acceptable for risk adjustment. To obtain a copy of this document, please visit the CMS web site at http://www.cms.hhs.gov/healthplansgeninfo/downloads/Rev%20MA-MAPD%20call%20letter%20final.pdf. Note that registered nurses, licensed practical nurses, and nursing assistants are not included in Table 3 – Acceptable Physician Data Sources as they are unacceptable physician data sources.

MA organizations are responsible for ensuring that the data they collect and submit to CMS for payment comes from acceptable provider types and physician data sources. The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all ICD-9-CM diagnoses that are in the risk adjustment model and rendered as a result of a visit to a physician must be collected by the MA organization. This includes data collected from non-network as well as network providers. Therefore, CMS requires MA organizations to filter and submit risk adjustment data in accordance with the appropriate provider types and acceptable physician data sources as approved by CMS.

8. Integrity of RAPS Submissions

Although a plan may designate another entity to submit claims on its behalf to CMS, the plan remains responsible for data submission, accuracy and content. If your MA organization needs assistance or is experiencing data submission issues, please contact our Customer Service and Support Center (CSSC) at 1-877-534-2772 or http://www.csscoperations.com/.

9. IT Technical Assistance Outreach

The purpose of the IT Technical Assistance Outreach program is to provide Part C and Part D contracted organizations with the IT support to perform the required Risk Adjustment, Prescription Data Event and Enrollment/Payment data submissions skills and to understand the roles data play in relationship to enrollment and payment. This outreach will enable these organizations to collect and submit the appropriate data in accordance with CMS requirements; thereby, this assistance's expected outcome seeks to provide a positive impact on "the correct payment." CMS offers Monthly Risk Adjustment and Enrollment/Payment outreach sessions at its Baltimore headquarters. We anticipate conducting our regional outreach sessions in August and September of 2008.

The specific dates for the monthly and regional outreach sessions will be announced during the Risk Adjustment (i.e., Part C) User Group sessions, and will be listed on our contractor's web site. For additional information or to register for the outreach sessions and the User Group sessions, please visit our contractor's web site at http://www.TARSC.info.

10. Risk Adjustment Data Validation

42 CFR §422.310(e) requires MA organizations and their providers and practitioners to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. CMS will increase emphasis on MA organization compliance with the medical record submission guidelines.

The Centers for Medicare & Medicaid Services (CMS) conducts medical record reviews to validate the accuracy and integrity of the risk adjustment data submitted by the Medicare Advantage (MA) for payments. CMS selects MA organizations to participate in the medical record review based on a number of criteria. For example, some organizations are randomly selected while others are targeted; thus, every MA organization has a chance of being selected for validation.

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

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

a. Missing Medical Records

If your MA organization is selected for inclusion in the data validation, your MA organization would be required to submit all necessary medical record documentation as requested within the allotted timeframe. Medical records not submitted to CMS within the required timeframe will be identified as "missing medical records." A missing medical record is a risk adjustment discrepancy. Risk adjustment data characterized as "discrepant" are used to evaluate the accuracy of payments to your MA organization. The results of the risk adjustment data validation will be used to develop an estimated payment error rate for your MA organization.

b. Guiding Principle & Guidelines

Since implementation of the CMS-HCC model in 2004, we have included hospital inpatient, hospital outpatient, and physician medical records in our risk adjustment data validation. Additionally, we modified our Guiding Principle to account for acceptable provider types and physician data sources for medical record documentation. Our Guiding Principle now states:

The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, or physician) and an acceptable physician data source as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting*.

MA organizations are allowed flexibility to select and submit supporting medical record documentation when responding to a medical record request. Since plans are not required to submit multiple occurrences of a unique diagnosis for a given enrollee, a medical record from any risk adjustment data source would be acceptable. This means that the medical record submitted for validation could be based on an encounter other than the one for which the data were submitted.

According to the risk adjustment data validation guidelines:

- Enrollee risk adjustment records are selected for validation based on risk adjustment diagnoses submitted to the Risk Adjustment Processing System (RAPS).
- Since CMS does not collect provider identifiers for risk adjustment, MA organizations must be able to track and locate supporting medical record documentation for its providers.
- MA organizations must select the "one best medical record" to support each HCC identified for validation. This means the MA organizations decide whether to submit a hospital inpatient, hospital outpatient, or physician medical record when more than one type of record is available.
- The medical record documentation must support an HCC.
- Once a MA organization selects its "one best medical record," a date of service must be identified to facilitate the medical record review process. CMS coders who review medical records will not search beyond the date of service identified in the medical record by the MA organization for review.
- Payment adjustments are based on confirmed risk adjustment discrepancies.
- An appeals process is in place to address a MA organization's disagreement with a payment adjustment based on a confirmed risk adjustment discrepancy.

c. Acceptable Risk Adjustment Data Sources

CMS has provided a list of ambulatory services that are "non-covered services" and, therefore, are unacceptable for risk adjustment. (To obtain a copy of *Table 3C – Hospital Outpatient*, please visit the *2007 Risk Adjustment Data Training For Medicare Advantage Organizations, Participant Guide* available on our contractor's web site at http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf. However, we continue to receive inquiries about the use of two specific "non-covered services"—laboratory and diagnostic radiology—and their potential use in risk adjustment payment and data validation. Therefore, we would like to clarify the importance of associating risk adjustment data submission with valid clinical documentation for physician specialties.

MA organizations must not submit documentation from laboratory and diagnostic radiology services as a standalone medical record for data validation. This type of medical documentation is insufficient for coding purposes. The following ICD-9-CM guideline updated November 2006 (available on the CDC web site at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf) clarifies the appropriate use of documentation from "non-covered source" providers for determining clinical significance:

> Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

The previous version from October 2002 included the above statement along with further clarification and examples:

> The coder should not arbitrarily add an additional diagnosis to the final diagnostic statement on the basis of an abnormal laboratory finding alone. To make a diagnosis on the basis of a single lab value or abnormal diagnostic finding is risky and carries the possibility of error.
>
> It is important to remember that a value reported either lower or higher than the normal range does not necessarily indicate a disorder. Many factors influence the value of a lab sample. These include the method used to obtain the sample (for example, a constricting tourniquet left in place for over a minute prior to collecting the sample will cause an elevated hematocrit and potassium level), the collection device, the method used to transport the sample to the lab, the calibration of the machine that reads the values, and the condition of the patient. An example is a patient who because of dehydration may show an elevated hemoglobin due to increased viscosity of the blood.

As stated above, it is inappropriate for MA organizations to submit a risk adjustment diagnosis and medical documentation on the sole basis of a "non-covered service." Thus, we will identify documentation from "non-covered services" as "invalid" and, therefore, deem such documentation as a risk adjustment discrepancy.

Note that we will accept documentation from "non-covered services" provided the documentation is reviewed by the physician and the outcome of the physician's review (i.e., diagnosis) is appropriately documented by the physician in the medical record. However, we will not accept for data validation documentation whereby a MA organization submits a diagnosis based on a laboratory service within the data collection period and physician medical record documentation that is outside of the data collection period.

For additional information on data validation, please visit the *2007 Risk Adjustment Data Training For Medicare Advantage Organizations, Participant Guide* available on our contractor's web site at http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf.

d. Signatures and Credentials

For purposes of risk adjustment data submission and validation, the MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. (Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.) This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. In these instances, the coders are able to determine that the beneficiary was evaluated by a physician or an acceptable physician data source. (For additional information on acceptable physician data sources, see the above section titled *Filtering for Acceptable Provider Types and Physician Data Sources*.)

We have identified medical records where it is unclear if the beneficiary is actually evaluated by a physician, physician extender, or other. In several cases, we have found encounters that are documented on physician's stationery but appear to be signed by a non-physician provider. For example, a medical record appears on group stationery for a given date of service. The medical record is signed but the

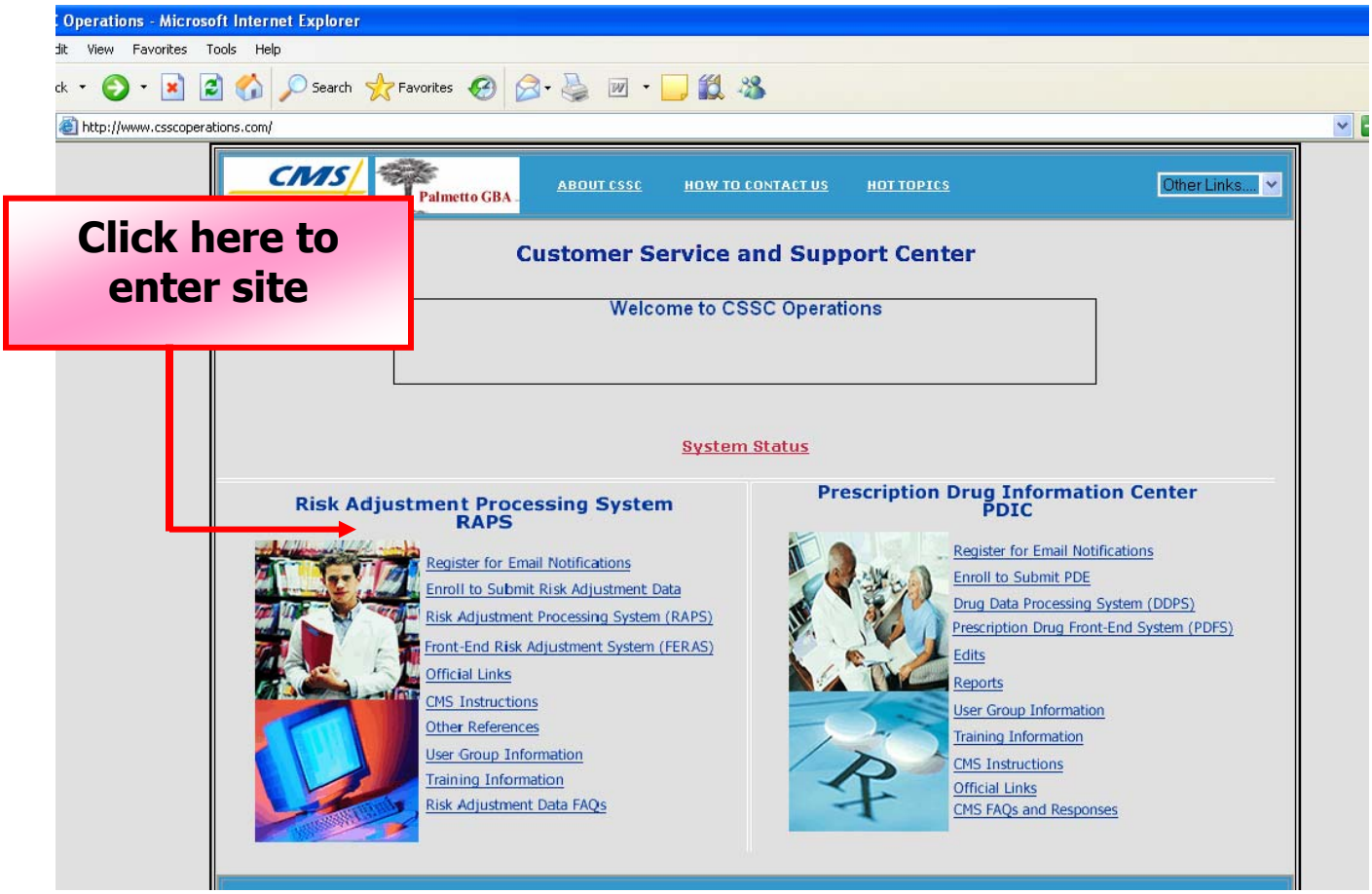
provider's name and credentials are not furnished on the stationery. Thus, the coders are unable to determine whether the beneficiary was evaluated by a physician, medical student, nurse practitioner, registered nurse, or other provider. This type of medical record documentation is incomplete and unacceptable for risk adjustment and, therefore, will be counted as a risk adjustment discrepancy.

CSSC WEB RESOURCES

This page intentionally left blank.

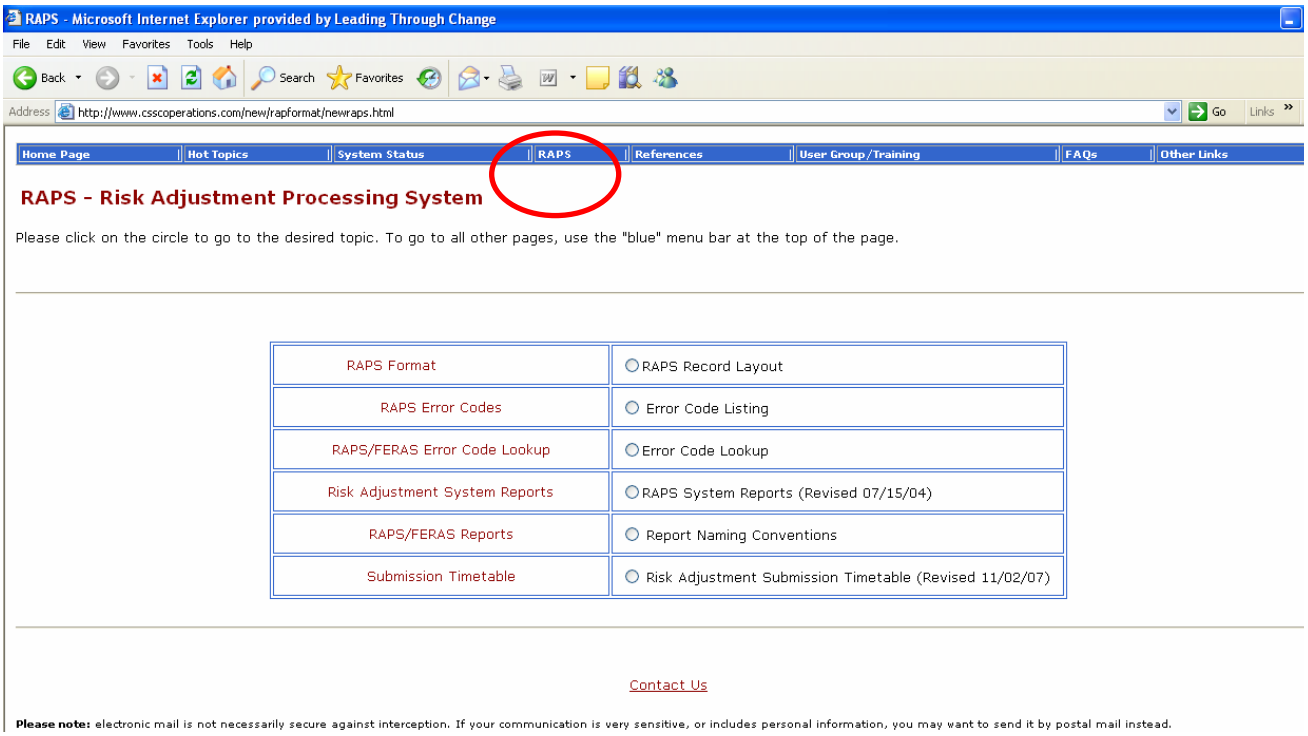
WWW.CSSCOPERATIONS.COM

http://www.csscoperations.com



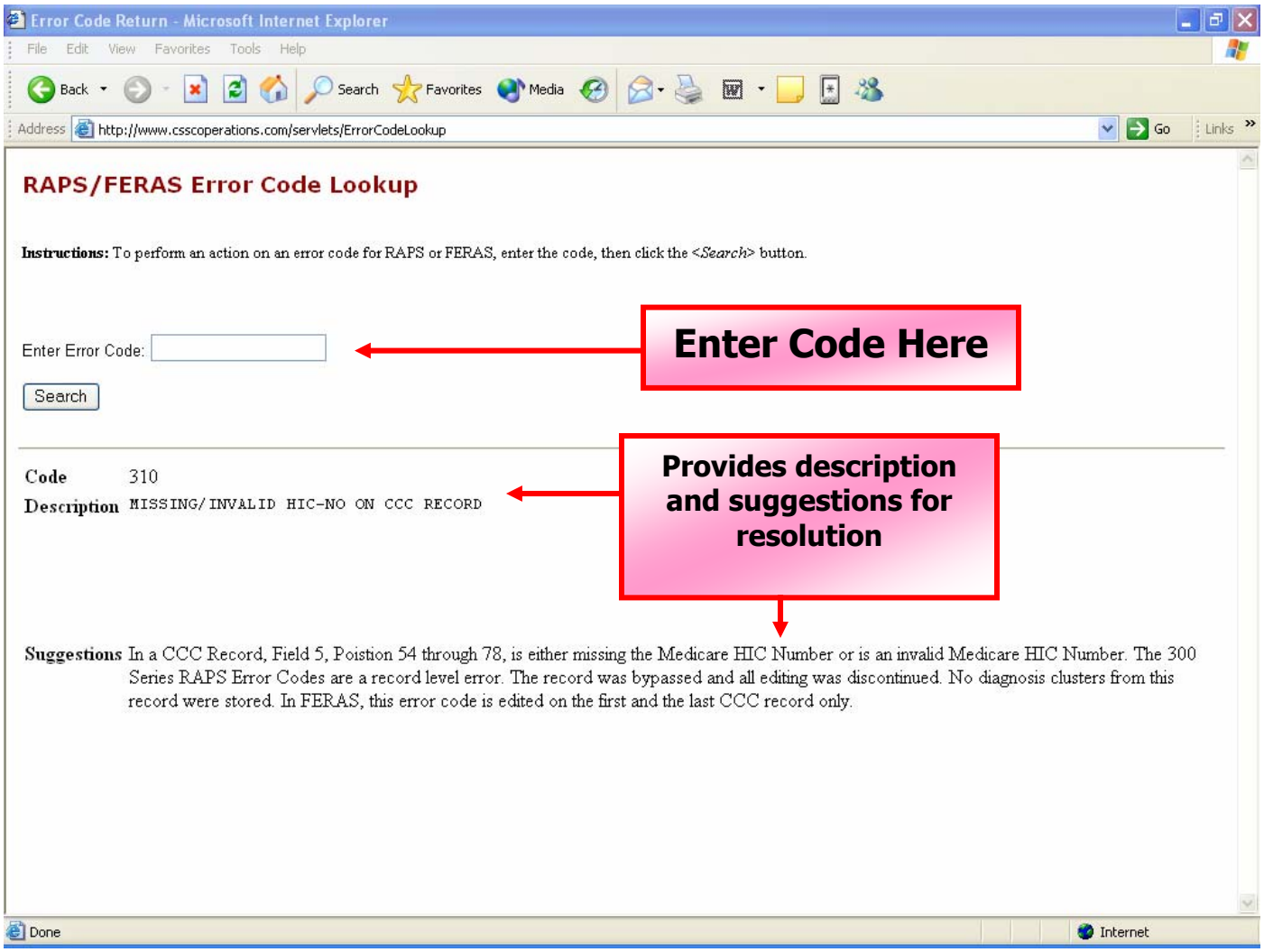
RAPS Resources

http://csscoperations.com/new/rapformat/newraps.html



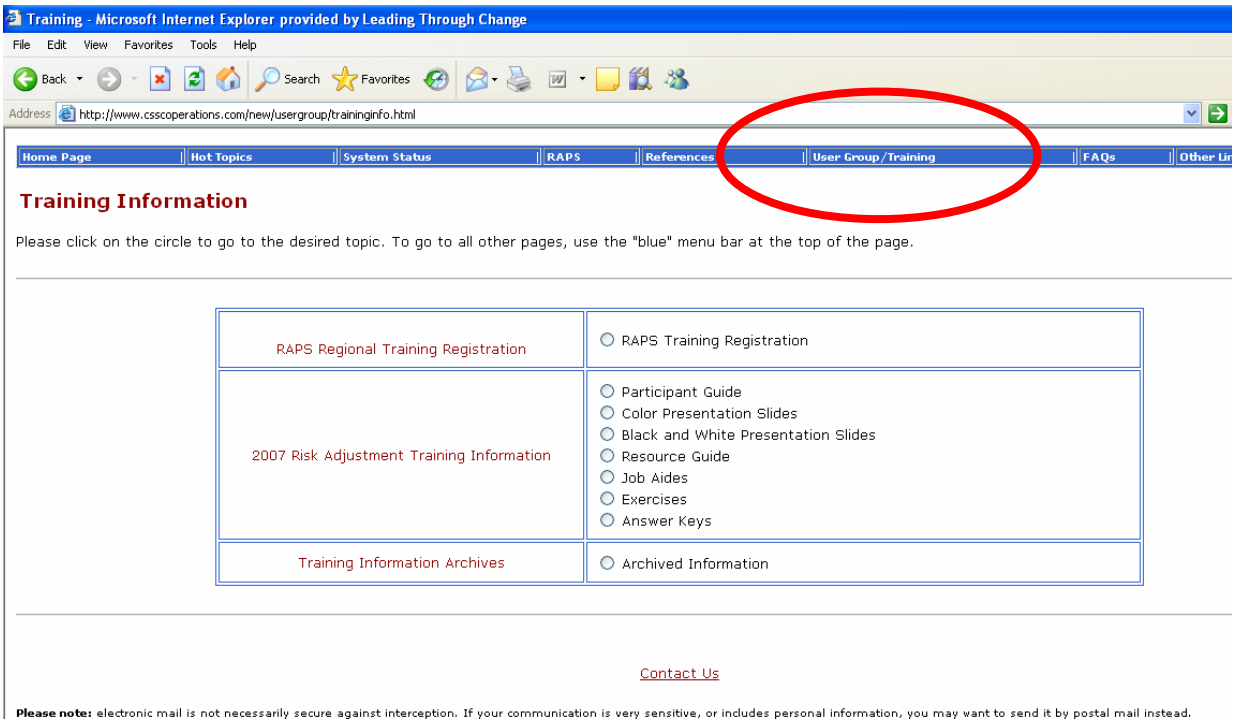
RAPS/FERAS Error Code Lookup

http://www.mcoservice.com/new/errorcodelookup_052505.htm



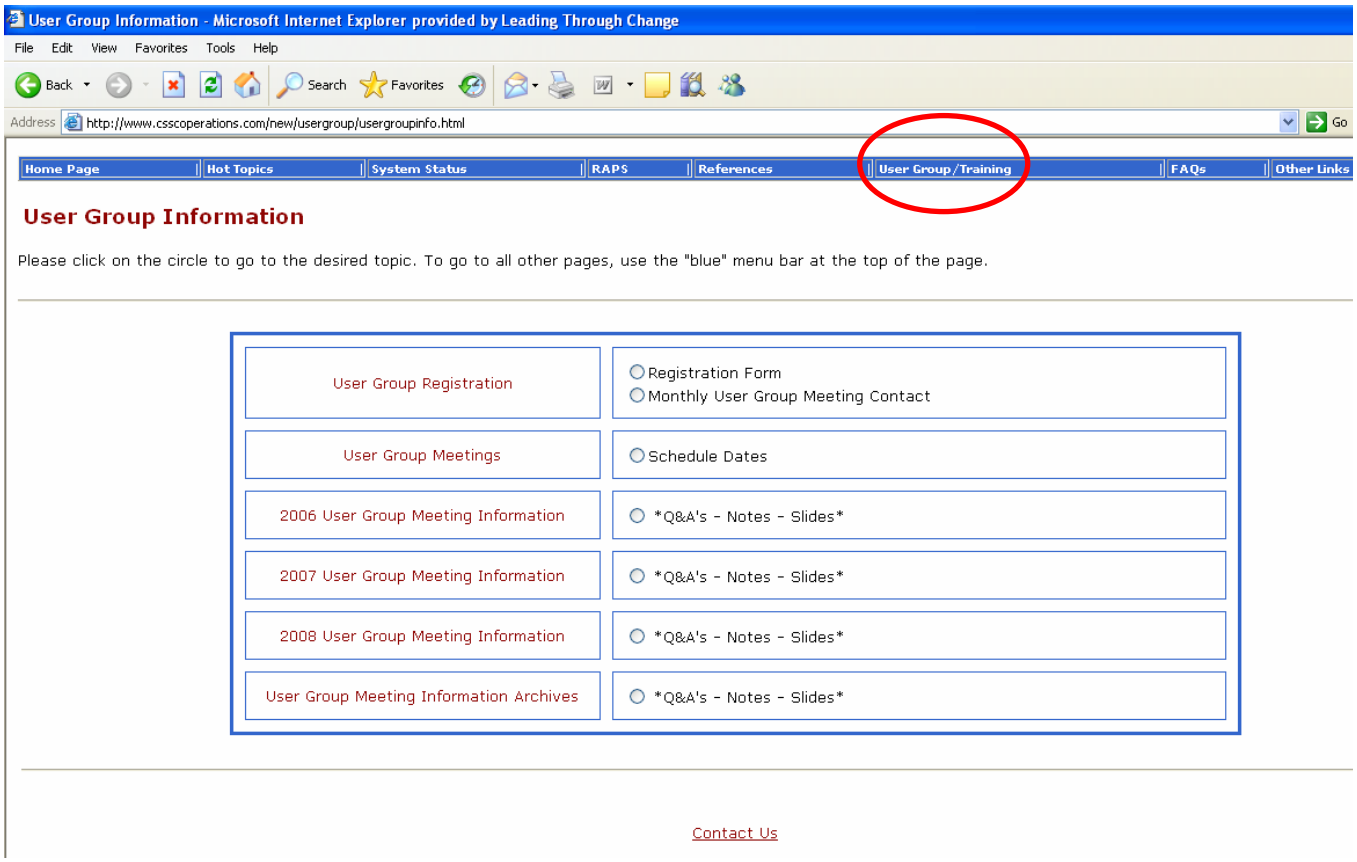
Training Guides and Updates

http://csscoperations.com/new/usergroup/traininginfo.html



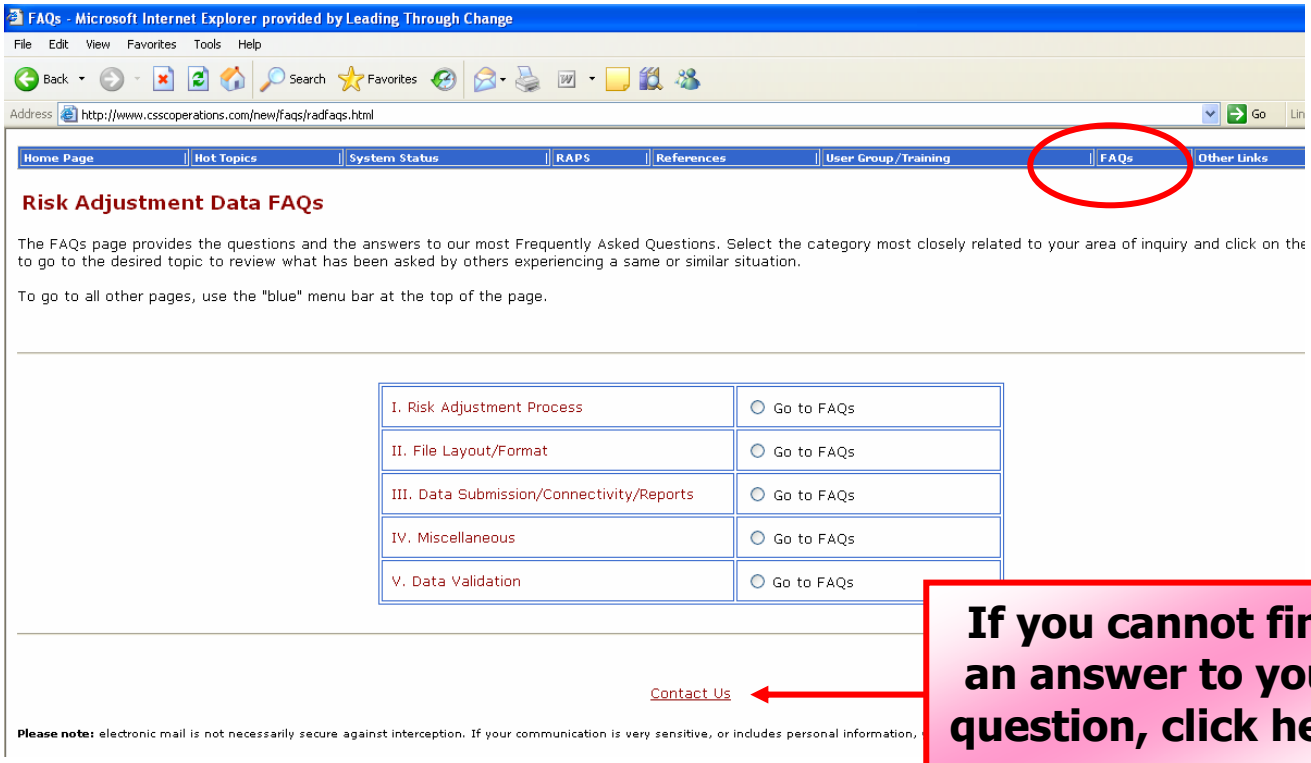
User Group Information

http://www.csscoperations.com/new/usergroup/usergroupinfo.html



Frequently Asked Questions (FAQs)

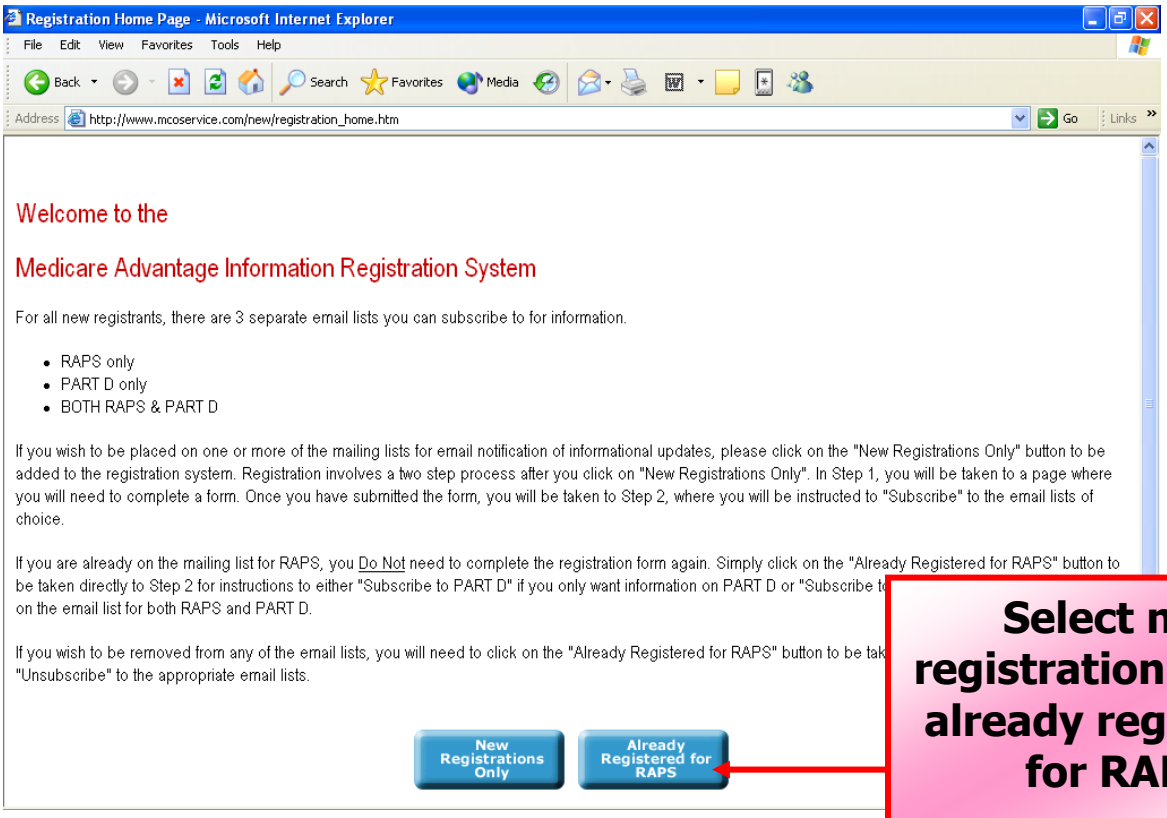
http://www.csscoperations.com/new/faqs/radfaqs.html



If you cannot find an answer to your question, click here

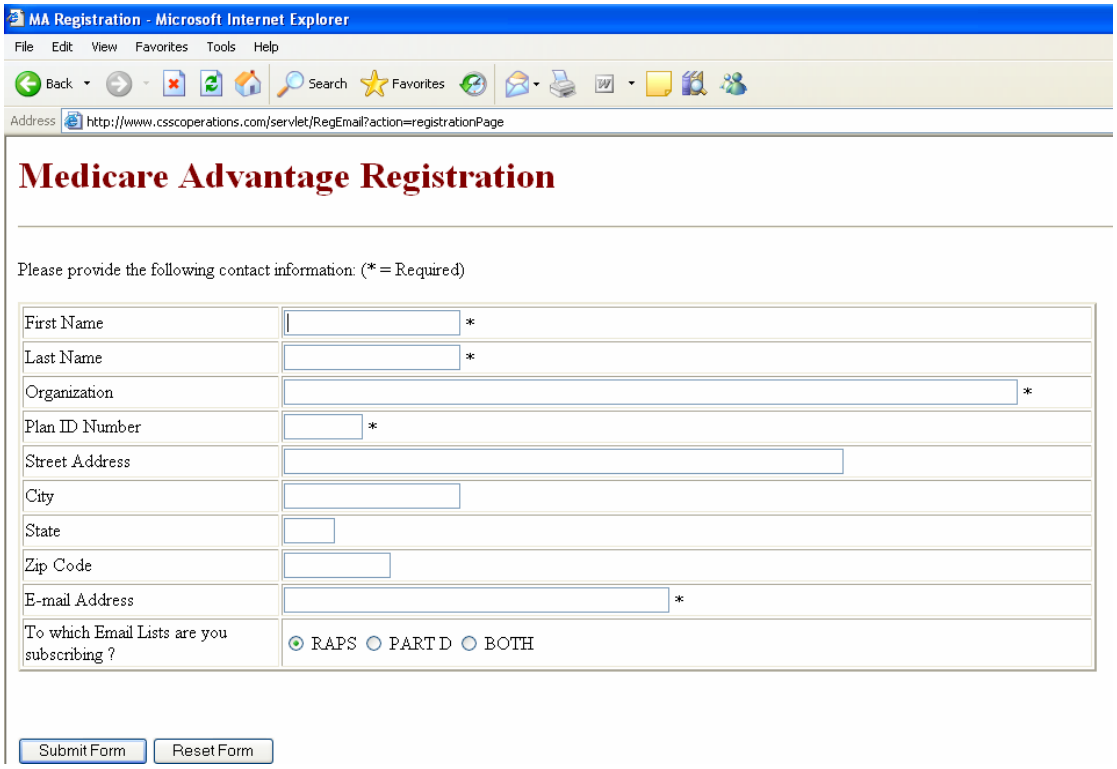
Register for Email Service

http://www.mcoservice.com/new/registration_home.htm



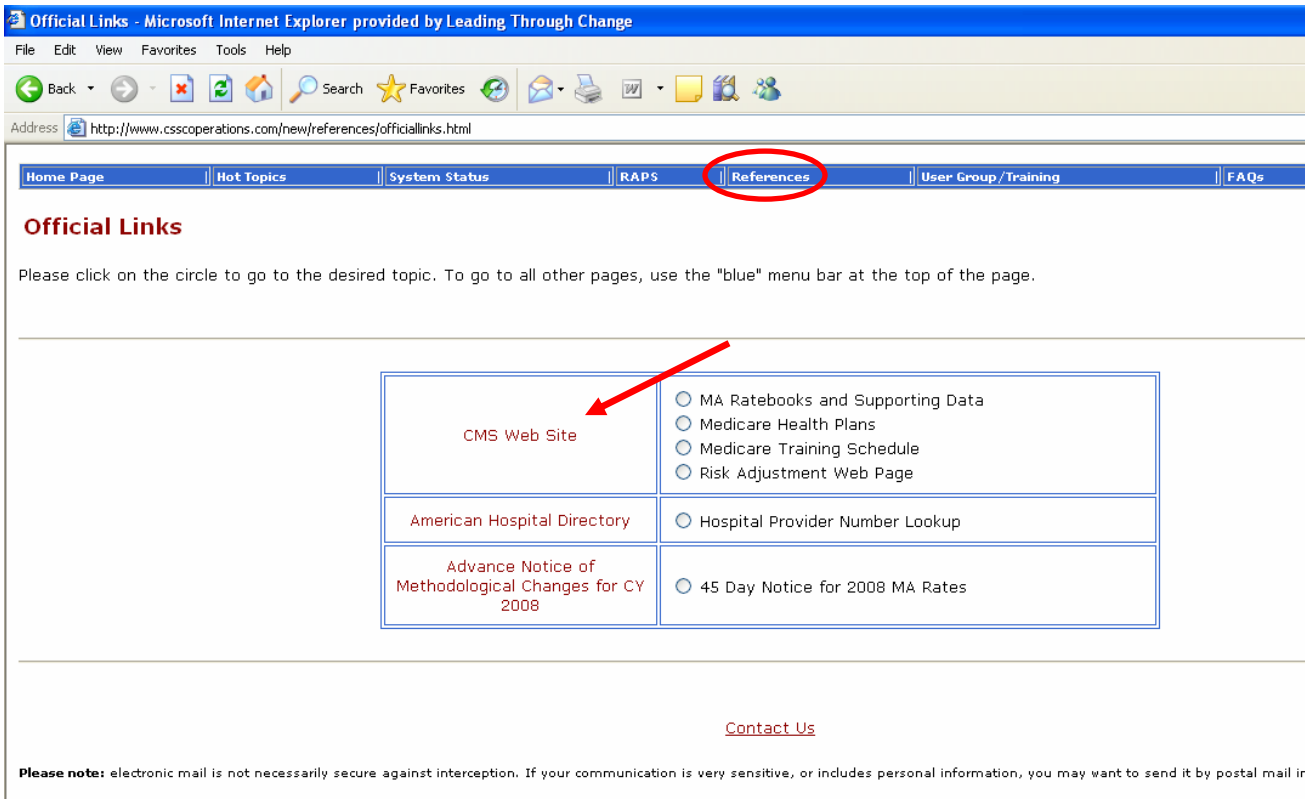
Medicare Advantage Registration

http://www.csscoperations.com/servlet/RegEmail?action=registrationPage



Link to CMS Website

http://csscoperations.com/new/references/officiallinks.html



This page intentionally left blank.

CSSC REFERENCE DOCUMENTS

This page intentionally left blank.

TO: Medicare Advantage Organizations Submitting Risk Adjustment Data

RE: EDI Enrollment and Submitter Application for Risk Adjustment Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Advantage (MA) Organizations submitting Risk Adjustment Data. The CSSC and the Front-End Risk Adjustment System (FERAS) look forward to working with you in all aspects of the submission of risk adjustment data.

The following information must be completed and sent to the CSSC for enrollment for the submission of data for Risk Adjustment:

- EDI Agreement for Risk Adjustment Data collection
- Submitter Application
- Risk Adjustment Connect:Direct Specifications (For Connect:Direct users only)

Please note the following for submitting Risk Adjustment Data:

- A CMS Risk Adjustment Data EDI Agreement must be completed for each contract number and on file with CSSC prior to submitting Risk Adjustment Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** If the submitter will be an entity other than an MA organization, the Submitter must complete the Submitter ID Application form and the EDI Agreement form. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. Regardless who submits the data, CMS holds the MA organization accountable for the content of the submission.

- A Submitter ID (SHnnnn) will be assigned to you by the CSSC and will remain effective for ongoing submission of risk adjustment data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application return it to CSSC Operations with the completed EDI Agreement.

- You will be submitting all Risk Adjustment Data to the FERAS. Data can only be submitted in the RAPS format. All data submitted to the front-end will be sent to the Risk Adjustment Processing System (RAPS) in the risk adjustment data layout.

- Datasets are required to be set up for Connect:Direct users. The Risk Adjustment Connect:Direct Specifications form should be completed and returned to the CSSC with the Submitter Application and the EDI Agreement.

- Technical Specifications are available based on the communication medium that is currently in use. Connect:Direct instructions and the FERAS User Guide are available on the csscoperations.com web site. Testing instructions for each medium are included within the document.

- On-Line transaction data entry is available through the secure MDCN FERAS web site. This option allows the user to key risk adjustment data directly into the front-end, creating the file for direct data submission.

- Reports are returned on all data submitted. The following report files are available for data submitted:

Response report generated by FERAS - per file submission

FERAS Response Report	RSP#####.RSP.FERAS_RESP
	RSP#####.ZIP.FERAS_RESP (zip format)

RAPS – CMS generated reports per file submission

RAPS Return File	RPT#####.RPT.RAPS_RETURN_FLAT
	RPT#####.ZIP.RAPS_RETURN_FLAT (zip format)
RAPS Error Report	RPT#####.RPT.RAPS_ERROR_RPT
	RPT#####.ZIP.RAPS_ERROR_RPT (zip format)
RAPS Duplicate Diagnosis Cluster Report	
	RPT#####.RPT.RAPS_DUPDX_RPT
	RPT#####.ZIP.RAPS_DUPDX_RPT (zip format)
RAPS Transaction Summary Report	
	RPT#####.RPT.RAPS_SUMMARY
	RPT#####.ZIP.RAPS_SUMMARY_RPT (zip)

RAPS - CMS generated reports monthly

RAPS Monthly Plan Activity Report	
	RPT#####.RPT.RAPS_MONTHLY
	RPT#####.ZIP.RAPS_MONTHLY (zip format)
RAPS Cumulative Plan Activity Report	
	RPT#####.RPT.RAPS_CUMULATIVE
	RPT#####.ZIP.RAPS_CUMULATIVE (zip format)
RAPS Monthly Error Frequency Report	
	RPT#####.RPT.RAPS_ERRFREQ_MNTH
	RPT#####.ZIP.RAPS_ERRFREQ_MNTH (zip)
Quarterly Error Frequency Report	
	RPT#####.RPT.RAPS_ERRFREQ_QRT
	RPT#####.ZIP.RAPS_ERRFREQ_QRT (zip)

All reference material is available on the **www.csscoperations.com** web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the information provided.

Palmetto GBA
CSSC Operations, AG-570
2300 Springdale Drive, Bldg. One
Camden, SC 29020-1728
1-877-534-2772
www.csscoperations.com
FAX: 1-803-935-0171

Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees**:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.

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

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

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

12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To**:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name: _____

_____

Contract Number:_____

Signature:_____

Name: _____

Title: _____

Address:_____

_____

City/State/ZIP: _____

Phone: _____

Email: _____

Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

MA EDI Enrollment
CSSC Operations AG-570
Columbia, SC 29202-3275
Phone (877) 534-2772
www.csscoperations.com

This page intentionally left blank.

CSSC Risk Adjustment Data Submitter Application

New Submitter ID:	☐ Yes ☐ No
If no, please provide your existing submitter number:	
If yes, please indicate who will submit your data:	☐ Self ☐ Third Party Submitter
If Third Party Submitter is selected, please provide the Third Party's name:	
Plan Name:	
Address:	
Fax Number :	
Operations Contact Person:	
E-Mail address:	
Phone Number:	
Technical Contact Person:	
E-Mail address:	
Phone Number:	

Please list any additional Plan numbers your organization will submit data for:

Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:

**If more space is needed to list additional Plan numbers, please make a copy of this page, list the Plan numbers, and attach with the application.

What Connection Type is established via the Medicare Data Communications Network (MDCN)?

Lease Line	☐
Direct Connect	☐
Dial up / Modem	☐
GENTRAN	☐

Please return the completed submitter application, EDI Agreement and NDM dataset specifications, if applicable, to CSSC Operations at the address below.

Palmetto GBA
CSSC Operations
Post Office Box 100275, AG-570 • Columbia, South Carolina • 29202-3275
www.csscoperations.com

Risk Adjustment Connect:Direct Specifications

The CONNECT:DIRECT Node connection is defined as follows:

NET ID: **SCA**
NODE ID: **A70NDM.MC**
APPLID: A70NDMMC
AGNS ID: PGBA

PLEASE ENTER YOUR Connect:Direct INFORMATION (Required):

NET ID: _____
NODE ID: _____
APPLID: ____ **_____**
AGNS ID: **_____**
Your Connect:Direct User ID and password (if datasets are racf protected)
User ID: **_____**
Password: **_____**

RAPS Transaction Submission

DSN: **MAB.PROD.NDM.RAPS.PROD.submitter id(+1)**
DISP: (NE W,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RE CFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.RAPS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, AAA 6, must also indicate "TEST" or "PROD", depending on the type of file being submitted.

Report Retrieval (enter names)

We will return reports to you in the following DSN's. These datasets need to be GDGs to allow multiple files to be sent without manual intervention or overwriting of existing files.

Front End (FERAS) Response Report

Frequency: Daily
Report **DSN**:
DCB=(DS _____ ORG=PS,LRECL=80,RECFM=FB,BLKSIZE=27920)

RAPS Return File

Frequency: Daily
Flat **DSN**:
DCB=(DS _____ ORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

RAPS Error Report
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Summary Report
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Duplicate Diagnosis Cluster Report (502 Error Report)
Frequency: Daily
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Summary Report
Frequency: Monthly
Report **DSN**:_____
DCB =(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Cumulative Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Error Frequency Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Quarterly Error Frequency Report
Frequency: Quarterly
Report **DSN**:_____
DCB=(DS ORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

Date: May 2006

To: Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PD) Contracts

Regarding: Submitting and / or Retrieving, Risk Adjustment (RA) and / or Prescription Drug Event (PDE) Data Directly to CMS Enterprise File Transfer (GENTRAN)

Plans / Contracts submitting directly to the GENTRAN application need to submit an EDI agreement and Submitter application to the Customer Service and Support Center (CSSC), 877-534-2772, www.csscoperations.com.

- **EDI Agreement:** A CMS EDI Agreement must be completed for the specific data type, RA / PDE, by each contract and on file with CSSC, prior to submitting Test or Production Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations.

- **Submitter ID Assignment:** A Submitter ID will be assigned to you by the CSSC and will remain effective for ongoing submission of RA and/or PDE data. This is the unique ID assigned to the contract that will allow data submission and report retrieval. Complete the Submitter Application and return it to CSSC Operations with the completed EDI Agreement.

The GENTRAN mailbox(s) for any PDE or RA data must be established and access granted by contacting the Customer Support for Medicare Modernization (CSMM) technical help desk at 800-927-8069 or through the website at www.mmahelp.cms.hhs.gov or e-mail at mmahelp@cms.hhs.gov.

- Contracts using GENTRAN may not have more than 100,000 enrollees.

- The files submitted may not be over 1.5 g in size for any one submission.

- A mailbox must be established for each Plan / Contract number and type of data, i.e. RA and PDE that will be submitted through GENTRAN. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Third Party Submitters submitting RA and / or PDE data through GENTRAN would have to have mailboxes created for each of the contracts for which they are submitting. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Contracts / Plans using Third Party Submitters should request through the CSMM, that a GENTRAN mailbox be established for the Plan to receive reports / files.

Contracts / Plans considering using the GENTRAN application at CMS will work closely with the CSSC and the CSMM to complete the appropriate paperwork and establish the necessary connectivity.

GENTRAN File and Report Naming Conventions

PDE Production

Plan to CMS GENTRAN Name

guid.racf.PDE.freq.ccccc.FUTURE.P guid.r

GENTRAN Report Name

RSP.PDFS_RESP_ssssss T
RPT.DDPS_TRANS_VALIDATION_ssssss T
RPT.DDPS_ERROR_SUMMARY_ssssss T
RPT.DDPS_CUM_BENE_ACT_COV_ssssss T
RPT.DDPS_CUM_BENE_ACT_ENH_ssssss T
RPT.DDPS_CUM_BENE_ACT_OTC_ssssss T

PDE Test

Plan to CMS GENTRAN Name

acf.PDE.freq.ccccc.FUTURE.T

GENTRAN Report Name

EST.RSP.PDFS_RESP_ssssss
EST.RPT.DDPS_TRANS_VALIDATION_ssssss
EST.RPT.DDPS_ERROR_SUMMARY_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_COV_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_ENH_ssssss
EST.RPT.DDPS_CUM_BENE_ACT_OTC_ssssss

RAPS Production

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.P

GENTRAN Report Name

RSP.FERAS_RESP_ssssss T
RPT.RAPS_RETURN_FLAT_ssssss TEST
RPT.RAPS_ERRORRPT_ssssss TEST
RPT.RAPS_SUMMARY_ssssss TEST
RPT.RAPS_DUPDX_RPT_ssssss TEST
RPT.RAPS_MONTHLY_ssssss TEST
RPT.RAPS_CUMULATIVE_ssssss TEST
RAPS_ERRORFREQ_MNTH_ssssss T
RAPS_ERRORFREQ_QTR_ssssss T

RAPS Test

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.T

GENTRAN Report Name

EST.RSP.FERAS_RESP_ssssss
.RPT.RAPS_RETURN_FLAT_ssssss
.RPT.RAPS_ERRORRPT_ssssss
.RPT.RAPS_SUMMARY_ssssss
.RPT.RAPS_DUPDX_RPT_ssssss
.RPT.RAPS_MONTHLY_ssssss
.RPT.RAPS_CUMULATIVE_ssssss
EST.RAPS_ERRORFREQ_MNTH_ssssss
EST.RAPS_ERRORFREQ_QTR_ssssss

CONTACTING CSSC OPERATIONS:

When a contract has established a mailbox at CMS, the following steps must be taken to make sure the connection from FERAS/PDFS to CMS GENTRAN mailbox has been generated:

- Check enrollment in HPMS
- Distinguish RAPS and/or PDE mailbox needs to be established
- Send email to CSSC technician to set up GDG Base to send either RAPS and/or PDE data and reports
- Once the above steps have been completed, EPClaims is updated for PDE contracts only (RAPS requires no additional updates in EPClaims)
- Customer is notified
- GENT RAN spreadsheet on the “U” Drive is updated
- Enter information into the INFO System

APPLICATION FOR ACCESS

This page intentionally left blank.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

EUA WorkFlow Request No.

APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

1. TYPE OF REQUEST *(Check only one)*:

❑ NEW *(Issue a CMS UserID)*
❑ CONNECT/DISCONNECT *(Add/remove access authorities)*
❑ CERTIFY *(Due date: _____/_____ mo yr)*
❑ CHANGE USER INFORMATION *(Note new info)*
❑ DELETE *(Remove CMS UserID from all CMS systems)*

USERID
(Capital Letters)

2. USER INFORMATION

❑ CMS Employee
❑ Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only
❑ Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using Other Systems
❑ CITIC Contractor
❑ Program Safeguard Contractor
❑ Medicare Contractor/Intermediary/Carrier
❑ Contractor (non-Medicare contract with CMS)
❑ Researcher
❑ Quality Improvement Organization
❑ End-Stage Renal Disease Network
❑ State Agency (State of _____)
❑ Federal Govt – Baltimore HR Center
❑ Federal Govt – Centers for Disease Control & Prevention
❑ Federal Govt – Commission Corps
❑ Federal Govt – Dept of Health & Human Services
❑ Federal Govt – HHS – OMHA
❑ Federal Govt – Dept of Justice
❑ Federal Govt – Dept of Veterans Affairs
❑ Federal Govt – Government Accountability Office
❑ Federal Govt – General Services Administration
❑ Federal Govt – Internal Revenue Service
❑ Federal Govt – Office of General Counsel
❑ Federal Govt – Office of Inspector General
❑ Federal Govt – Railroad Retirement Board
❑ Federal Govt – Social Security Administration
❑ Federal Govt – Other: _____
❑ Other: _____

First Name *(As you want it published)*	MI	Last Name *(As you want it published)*

Company/Organization/Department Name

Mailing Address *(Include Suite/Mailstop)*

City	State	ZIP Code

Office Telephone *(Include Extension)*	Company Telephone *(If different)*	E-Mail Address

IF CMS EMPLOYEE Org Name/Admin Code

Are you a Manager?
❑ Yes ❑ No

IF ONSITE AT CMS LOCATION CMS Region/Facility (Check One)

❑ R4 (AFC) Atlanta
❑ R10 (BLNCH) Seattle
❑ CO (CENTRAL) Central Office
❑ R5 (CHIICB) Chicago
❑ DC (COHEN) DC
❑ R6 (DAL1301) Dallas
❑ R8 (DENCSB) Denver
❑ R7 (FOBKAN) Kansas City
❑ DC (HHH) DC
❑ R9 (HWTHRN) San Francisco
❑ R1 (JFKBOS) Boston
❑ R2 (JKJNYC) New York
❑ CO (LBDCO) Central Office
❑ CO (NORTH) Central Office
❑ R3 (PHIPLB) Philadelphia
❑ CO (SOUTH) Central Office
❑ Other _____

Mail Stop	Desk Location

3. WORKLOAD INFORMATION

Contract Number(s) *(for Medicare Advantage/Medicare Advantage with Prescription Drug/Prescription Drug Plan/Cost Contracts — Hxxxx, Sxxxx, etc.)*

Carrier Number(s) *(for Medicare Contractors/Intermediaries/Carriers — 12345)*

Contract and Task Number *(for Contractors — CMS-05-0001 : 0001)*

Grant Number *(for Researchers)*

Inter-Agency Agreement Number

4. REQUIRED ACCESSES *(See http://www.cms.hhs.gov/mdcn/bmcjcreport.asp for list of available jobcodes)*

❑ Connect	❑ Disconnect	❑ Keep	Default CMS Employee (standard desktop & network with CMS e-mail acct)	❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	Default Non-CMS Employee (standard network access)	❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
				❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____
❑ Connect	❑ Disconnect	❑ Keep	_____	❑ Connect	❑ Disconnect	❑ Keep	_____

5. JUSTIFICATION *(If name change, show Old Name =, New Name =)*

6. APPROVALS: *(See http://www.cms.hhs.gov/mdcn/reqsigchart.pdf for approval info)*

PROVIDE SIGNATURES BELOW OR APPROVE ONLINE EUA WORKFLOW REQUEST NUMBER REFERENCED ON PAGE 1.

Authorization: We acknowledge that our Organization is responsible for all resources to be used by the person identified above and that requested accesses are required to perform their duties. We have reviewed and verified the workload information supplied is accurate and appropriate. We understand that any change in employment status or access needs are to be reported immediately via submittal of this form or EUA WorkFlow request.

1st APPROVER *(CMS Project Officer, CMS Contact, CMS Supervisor, MCIC Contact, etc.)*

Printed Name		Telephone Number
CMS UserID	Signature	Date

2nd APPROVER *(Not required for CMS employees, BHRC or Commissioned Corps)*

Printed Name		Telephone Number
CMS UserID	Signature	Date

APPLICANT: Read, complete and sign next page.

EUA WorkFlow Request No.

APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

Printed Name *(As you want it published)*

Social Security Number

CMS USERID

PRIVACY ACT STATEMENT

The information on page 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10) (The Privacy Act of 1974). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on this form will be maintained in the Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Data Center Systems of Records and may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED.REG.41329 (08-11-94) and as CMS may establish in the future by publication in the Federal Register.

The Social Security Number (SSN) is used as an identifier in the Federal Service because of the large number of present and former Federal employees and applicants whose identity can only be distinguished by use of the SSN. Collection of the SSN is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary. However, if you do not provide this information, you will not be granted access to CMS computer systems.

SECURITY REQUIREMENTS FOR USERS OF CMS COMPUTER SYSTEMS

CMS uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of Federal programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in Federal computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. CMS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. CMS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to CMS Computer Systems containing sensitive information must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Do not browse or use CMS data files for unauthorized or illegal purposes.
- Do not use CMS data files for private gain or to misrepresent yourself or CMS.
- Do not make any disclosure of CMS data that is not specifically authorized.
- Do not duplicate CMS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter CMS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of CMS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from Federal Service, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

Applicant's Signature	Date

This page intentionally left blank.