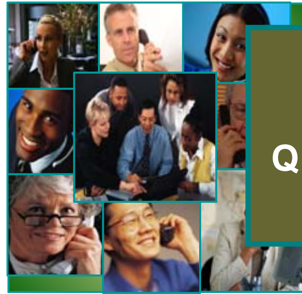
2007/08 Risk Adjustment User Group



February 2008
Questions & Answers

Date: February 13, 2008

Payment Issues

1. Q: When will plans receive the attestation for the 2007 data year?

   A: CMS will communicate the attestation due date to plans shortly after the date has been set.

2. Q: When will the sweep date occur for the January 31, 2008 submission deadline?

   A: CMS will notify plans when the sweep date occurs.

3. Q: Who should plans contact about receiving payment adjustments wired for adjustments to 2003 final reconciliation related to acquiring another plan?

   A: Submit this inquiry to Marla Kilbourne at marla.kilbourne@cms.hhs.gov and copy Sean Creighton at sean.creighton@cms.hhs.gov.

Data Submission

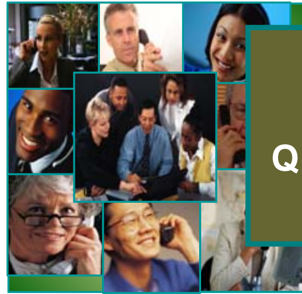
1. Q: What are the RAPS submission deadlines for 2007?

   A: The submissions deadlines for each year are January 31 for final reconciliation, the first Friday in March for mid-year, and the first Friday in September for initial. For 2007 data, these dates are March 7, September 5, and January 31.

2. Q: Can plans submit diagnoses for denied claims?

   A: Determination for whether to submit the diagnosis from a denied claim depends on the reason for the denial. For example, if a physician is not certified or is an excluded provider, then the diagnosis is not eligible for submission.

A training initiative presented b



3. Q: Can plans submit diagnoses from pending claims or claims not fully adjudicated?

   A: There is no rule to determine what plans do with pending claims. If the claim is incomplete such as missing the physician specialty, then not all of the information is available to submit the diagnosis.

4. Q: If a provider did not include a beneficiary's diagnosis with a 2007 date of service on a bill, does the provider need to re-bill the claim, or can the plan submit a HCFA 1500 with the diagnosis and no dollars?

   A: The physician does not need to submit a bill if the medical record confirms the diagnosis code. The plan can create a RAPS record and submit the confirmed diagnosis.

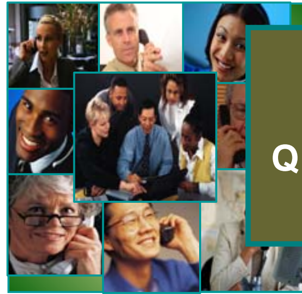
5. Q: Can a plan submit a diagnosis without a claim?

   A: Plans can submit risk adjustment data if the provider documented the diagnosis in the medical record.

Data Validation

1. Q: Are plans still able to submit diagnoses to the RAPS system related to unresolved 2006 eligibility discrepancies?

   A: No, CMS has finalized 2006 eligibility and risk scores to use in calculating Part D Direct Subsidy, Reinsurance, and Risk Corridors. CMS is not planning to re-run risk scores for periods previously finalized. However, if the plan knows that risk adjustment data is erroneous and will lead to incorrect payment, then they should contact CMS via e-mail and outline the situation.



2. Q: Is it acceptable for a plan to submit a confirmed diagnosis documented in the medical record if the physician notes refer to results from a diagnostic radiology report?

   A: Yes, if the physician interprets the diagnostic radiology report, confirms the diagnosis, and documents the diagnosis in the medical record, then the plan can submit the diagnosis.

3. Q: Is an undated/unsigned problem list acceptable documentation of a diagnosis if the progress notes refer to the list in the medical record?

   A: Plans should use the progress notes as documentation to support the diagnosis instead of the problem list. Problem lists can include any and every type of condition for a person regardless of whether the beneficiary received services for the conditions during the data collection period, and are not acceptable stand-alone documentation.

Operations Update

1. Q: What causes a diagnosis cluster to receive the 490- and 491-error code?

   A: The 490- and 491-error codes are associated with deletions. Four possible reasons for the delete errors include:

   - The plan successfully deleted the diagnosis on a previous occasion
   - RAPS never stored the diagnosis
   - There was an error in how the cluster was defined (an attribute was changed)
   - The plan submitted the diagnosis cluster to store and delete in the same file

2. Q: For a diagnosis code used on five separate claims for the same patient that received the 491-error, is it sufficient to delete the diagnosis code from only one file?

   A: If the plan submitted the diagnosis in five separate records, then the plan must delete each of the diagnosis clusters stored in RAPS.

3. Q: How does CMS calculate the 502 duplicate error rate?

   A: CMS aggregates the diagnoses in the files per contract number for a given week. To calculate the 502-error rate, divide the total number of 502-errors divided by the total number of diagnoses submitted.

4. Q: What is the purpose of the 502 duplicate error code rate?

   A: The 502 duplicate error code rate notifies CMS of plans that submitted diagnosis clusters with the same five attributes (diagnosis, provider type, from and through dates, HIC number) as a cluster previously accepted and stored. CMS requires plans 502-errors remain below the 5 percent benchmark in order to reduce the amount of editing and processing required by CMS systems.