2003 REGIONAL RISK ADJUSTMENT TRAINING FOR MEDICARE+CHOICE ORGANIZATION QUESTIONS & ANSWERS

MODULE 1- RISK ADJUSTMENT & CMS-HCC MODEL

Q: Will updates to the risk factors be provided in July and be effective for one year with updates provided only once per year?

A: The final risk factor update schedule has not yet been finalized. The risk factor will be updated in July 2004 using data from CY 2003. Then, one approach is to calculate a factor for 2005 using data from July 2003 to June 2004. Other possible approaches are also being considered. (Section 1.2)

Q: Will the risk factor updated in August be applied retroactively to January 1, 2004 and appropriate adjustments made?

A: Yes, as the schedule allows. (Section 1.2)

County Risk Rates

Q: Why does it appear as if the risk rate for some counties is decreasing when there should be a 2 percent increase?

A: If you compare the difference between the 2004 HCC risk rate and the 2003 PIP-DCG risk rate, it may appear as if the rates are decreasing. However, if you compared the correct 2003 CMS-HCC risk rate with the 2004 risk rate, you would see a 2 percent increase. (Section 1.5.1.1)

Q: Does the law allow CMS to have an increase in the risk rate of less than 2 percent of any county (regardless of budget neutrality) and, if yes, why does the rate book decrease some and not all county risk rates?

A: The law requires CMS to implement risk adjustment for 2000 and 2004. The law also requires CMS to use 1997 as the basis for the rate books. Both of these were followed as CMS implemented risk adjustment. What this particular question focuses on is whether or not a risk rate based on one rate book (PIP-DCG) was legitimately related to a risk rate based on a different rate book (CMS-HCC). CMS believes that it is. (Section 1.5.1.1)

Q: How does CMS calculate a person's age group when calculating the risk factor?

A: For a beneficiary with at least 12 months of Medicare history, age is based on the beneficiary's age as of February 1st in the payment year. (Section 1.5.3.1)

Q: Will CMS provide the individual enrollee's HCC scores that went into the plan level information on HPMS so plans can analyze the scores if they appear low?

A: No, CMS will not provide individual level scores to plans. If scores appear low, plans should review their submitted risk adjustment data because that is what the HPMS' scores are based on. (Section 1.5.3)

Q: How does the hierarchical system handle multiple HCCs within the same disease group, for example, brain cancer and another major type of cancer?   Do you use both disease groups for risk factor calculations?

A: If the diagnoses were in the same HCC, the CMS-HCC model would trigger that HCC for the beneficiary. If they were in separate HCCs, the model would determine whether one of the HCCs was included in the hierarchy system and therefore not counted towards the risk adjustment score. These are the procedures that would be used to determine whether or not the beneficiary was assigned to one or both HCCs. (Section 1.5.3.2)

Q: Is the risk score added to the rate book?

A: No, the risk score is not added to the rate book. The risk score is multiplied by the county rate book to determine payment. (Section 1.5)

Q: What is the impact score?

A: It is the change in payment that organizations would have seen in September 2002 payments, if CMS had implemented the new risk adjuster at the 70/30 blend in that month. (Section 1.12)

Q: Is the risk score based on the cohort enrolled in July 2002?

A: No, it is based on the September 2002 cohort, which is defined as the beneficiaries enrolled as of September 2002.

Q: Is it okay to apply the risk score in calculating our ACR?

A: Yes, as long as nothing has changed in the plan's population. If, for example, you cut back your service area or if there are many new enrollees because of a change that has occurred (e.g. you have created a network that changes your population, like a new asthmatic network) then you have to account for those changes as well in determining your ACR.

Q: Is the number of beneficiaries for each condition available?

A: The beneficiary numbers for Medicare fee-for-service from 1996-1997 were posted on the CMS website in mid June.

Rescaling Factor

Q: What is the purpose of the rescaling factor?

A: The purpose of the rescaling factor is to standardize county rates to reflect average costs for that county based on the new risk adjustment model. The demographic county rate tells the organization the average costs in the county measured using demographics. The rescaling factor takes the risk rate divided by the demographic rate, and produces a number used to restandardize the demographic rate book into the right risk rate book. The rescaling factor is the result of four things: restandardization, normalization adjustment, fee-for-service, and budget neutrality. (Section 1.5.2)

Q: Can the information contained in the Minimum Data Set be viewed in the BENM screen of the CWF?

A: No, it may not. However, the long-term institutional indicator will be found on the Monthly Membership Report (MMR).

Institutional and Community Models

Q: If an enrollee's payment changes from the community model to the institutional model, do the plans continue to submit institutional status for demographic payments?

A: There is no change to that element of the demographic factor. M+C organizations are not responsible for reporting a beneficiary's institutional status under risk adjustment. Skilled nursing facility data, based on 90-day assessments, determine the beneficiary's institutional status. (Section 1.6)

Q: Are plans going to have to reconcile if discrepancies are found?

A: Plans may choose to reconcile, but it is not required. Remember that to be considered under institutional status under risk adjustment, a patient must be institutionalized for at least 90 days. Nursing facility information will be read into the Minimum Data Set (MDS). CMS staff believes it is much harder to get a false positive than a false negative reading on long-term institutional status. CMS would have to receive an assessment on someone that is no longer a nursing home resident for a false positive reading. This is much less likely to happen than not getting an assessment on someone who still resides in a long-term nursing home. (Section 1.6)

Q: Is the 90-day stay in the institutional facility defined as a skilled stay (as defined by Medicare coverage criteria) or are all the days counted if provided by a Medicare certified facility?

A: Days in a Medicare certified facility are included in the determination. (Section 1.6)

Q: Do beneficiaries in a community model cost more than those in an institutional model?

A: If their illnesses are similar, those in a long-term institutional stay cost less than those in short-term institutional stays that are incorporated into the community model**.** (Section 1.6)

Q: Does a beneficiary have to be confined for 90 consecutive days to be considered under the institutional model?

A: Yes, a person must have a 90-day assessment, have been institutionalized for 90 days, and not have been discharged. (Section 1.6)

Q: Does a beneficiary's risk adjustment factor follow the beneficiary from one managed care organization to another?

A: Yes. The diagnoses for which the patient was treated in the past submission year would be the same regardless of the plan in which the beneficiary was enrolled. Therefore, the risk factor score will also remain the same. (Section 1.6)

 Q: If a beneficiary is enrolled in a PACE plan and a permanent resident in a Skilled Nursing Facility (SNF), would he/she be considered under the community factor or the institutional factor?

A: The beneficiary, under those conditions, would be paid using the institutional model without the frailty factor. (Section 1.7)

Frailty Factor

Q: What is the purpose of the frailty adjuster?

A: The frailty adjuster is included as part of risk adjusted payments for PACE and certain demonstrations, under the CMS-HCC model. It is not part of the risk adjusted payment for M+C organizations. Its purpose is to predict Medicare expenditures of the functionally impaired that are unexplained by the risk adjustment methodology alone. This adjuster is a measure of the relative frailty of an organization in terms of the number of functional limitations determined using the Activities of Daily Living (ADL) scale. (Section 1.7)

Q: How did CMS determine that Evercare members should not be factored for frailty?

A: CMS analyzed the Risk Adjustment model to see if it appropriately accounted for the cost of institutionalized persons. The analysis showed that if the frailty factor were applied to Evercare members, it would be negative. So CMS decided to drop institutionalized members from the frailty factor rather than subtracting payments from them. (Section 1.7.1)

Q: Will a beneficiary have a risk adjustment factor if he/she joins an M+C organization during the course of a year but has more than twelve months in Medicare?

A: Yes, but it may take CMS a few months to calculate the risk adjustment factor for that person. (Section 1.7.5)

ESRD Model

Q: How much will the End-Stage Renal Disease (ESRD) model change before it is implemented and are additional reviews expected?

A: CMS is using the ESRD model for the ESRD demonstration program in 2004. CMS is continuing to develop the ESRD model and exploring ways to improve it. (Section 1.8)

Q: If there is a 3-part implementation process for the dialysis payment methodology, does that mean the monthly amount given for dialysis will remain the same as the current demographic dialysis rate?

A: No. Under the ESRD risk adjustment model, dialysis payment rates will be dependent upon the health status of the beneficiary, and the dialysis rate book will be rescaled in a manner similar to that of the regular risk adjustment rate book. (Section 1.8)

Non-Lagged Payment Opt Out

Q: For those who choose to opt out and continue to receive payment under the lagged payment time schedule, how will their payment schedule differ?

A: If the organization opts out, the 2004 payment will be based on the June to July data year. Sometime in March of 2005, the plan will be paid retroactive adjustments using the CY 2004 non-lag factor. The plan, by opting out, is only delaying when the risk factor change will occur. (Section 1.11)

Q: For those plans that do not opt out, will the July 2004 factor will be the correct factor applied retroactively to January?

A: If the plan does not opt out, CMS will recalculate the factor in July to try to get closer to the actual factor for reimbursement. However, the payment will still be considered an interim payment. (Section 1.11)

Q: Can a plan opt in or out of the elimination of lagged payment more than once?

A: No, a plan must choose whether or not it would like to continue under the lagged payment in writing by March 31, 2004.   It is a one-time decision. (Section 1.11)

Q: Will the risk adjustment factors for Part A and B be the same in 2004?

A: Yes. They will remain the same unless we change risk adjustment models. (Section 1.11)

Q: How will plans identify the non-lagged factors from the lagged factor when submitting the ACRP for 2005?

A: We are still determining whether we will be able to provide updated risk scores to plans that opt-out. (Section 1.11)

MODULE 2 - RISK ADJUSTMENT PROCESS OVERVIEW

Q: Are diagnosis clusters stored in NMUD (National Medicare Utilization Database)?

A: Diagnosis clusters are not stored in NMUD, but fee for service data is stored in NMUD. Finalized diagnosis clusters are stored in the RAPS database. (Section 2.2.4)

MODULE 3 - DATA COLLECTION

Provider Types and Provider Numbers

Q: Will CMS continue to update the provider number Public Use File that is published on the CMS website?

A: The free file of hospital only provider IDs is no longer being updated by CMS. The full provider of service file with all Medicare certified provider IDs (hospitals, SNFs, HHAs, etc.) is available for a charge from CMS. The AHA free search function is also an option. (Section 3.1.2)

Q: Are providers with Medicare provider number 77777 covered under risk adjustment?

A: This Medicare provider number often indicates a VA/DoD provider. M+C organizations should access the list of acceptable VA/DoD providers on the mcoservice.com website. (Section 3.1.2)

Q: Is there a complete list of inappropriate providers for the Risk Adjustment model?
A: While there is not a complete list of inappropriate providers, any providers that are not included in the following tables, in Module 3 of your Participant Guide, are not permissible for risk adjustment purposes. (Section 3.1.2)
　　Table 3B – Hospital Inpatient Covered Entities,
　　Table 3C – Hospital Outpatient Covered Entities, and
　　Table 3D – Acceptable Physician Data Sources.

Q: What will happen if a plan submits data from a non-covered provider?
A: M+C organizations are responsible for ensuring that data submitted is correct. If a plan determines that it submitted incorrect data, it must delete the incorrect data. Submission of data from non-covered providers is a violation of the M+C contract and may be punishable under the False Claims Act. (Section 3.1.2)

Q: Does a physician encounter have to be an office visit?
A: Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only). (Section 3.1.2)

Q: Are services provided incident to a physician service acceptable for risk adjustment?
A: For physician data, the service being rendered is not relevant. The diagnosis must be noted in a medical record as the result of a face-to-face encounter with a physician or non-physician practitioner as defined in Table 3D. (Section 3.1.2)

Q. Is a diagnosis from a home health provider acceptable for risk adjustment?
A. Home health services are not acceptable. (Section 3.1.2)

Q: What licensure, degree, and/or certification does a licensed clinical social worker need to have?
A: This can vary from state to state. CMS/Medicare does not regulate this. As long as providers are practicing according to state guidelines and are included in the list of acceptable provider types, diagnoses from their services can be submitted. (Section 3.1.2)

Q: Do Nurse Practitioners, Social Workers, and Occupational Therapists need to be Medicare certified for us to submit their encounters for risk adjustment?
A: Medicare does not certify individual practitioners. Individuals in the specialties listed in Table 3D must meet the requirements established in the state in which they are licensed or certified. Verification of their qualifications is part of the credentialing process at the M+C organization. (Section 3.1.2)

Q: Can encounters with patients in their home be used for risk adjustment?
A: Home health services shall not be submitted. A house call by a physician, if not acting as a home health agency staff member, may be submitted. (Section 3.1.2)

Collection Formats

Q: If a physician has recorded a diagnosis only on a Superbill, but a nurse reviewer reviews records and identifies an EKG or lab test that reflects a different diagnosis, can the plan assign a diagnosis?

A: No. For a diagnosis to be properly documented, it has to be recorded in the medical record by a physician or other acceptable provider.   A lab test or EKG result would not be sufficient documentation for submitting a diagnosis. A physician must analyze the results of the EKG, along with other related patient information, and note the appropriate diagnosis in the medical record in order for that diagnosis to be submitted. (Section 3.2.1)

Q: Are inpatient hospital one-day stays acceptable for risk adjustment under the CMS-HCC model?

A: One-day stays are acceptable. (Section 3.2.1)

Q: How should M+C organizations handle data collected from reinstated providers?

A: The reinstatement must be in the CMS system. If the M+C organization is approaching the annual deadline, contact CMS to determine the required steps. (Section 3.1.2)

HIPAA

Q: Is an encounter from a provider to a health plan considered a HIPAA transaction?

A: An electronic claims transaction from a provider to a health plan is considered a HIPAA transaction. A transaction between a plan and CMS is not subject to HIPAA transaction standards. In that situation, CMS is acting as a health plan, so the information you send is considered a plan-to-plan transaction. (Section 3.3.1)

Q: Once information has been submitted to CMS, can a plan request data from a provider again for clarification or correction?

A: Yes, plans can request information to clarify or correct data, but cannot request the same data twice. For example, plans cannot request data from a provider because the plan wants the data in a different format. (Section 3.3.2)

Q: Is RAPS file submission covered by HIPAA?

A: A RAPS file submission from a plan to CMS is not covered by HIPAA transaction standards. It is subject to HIPAA privacy and security rules. CMS systems and the MDCN comply with those rules. (Section 3.3.1)

MODULE 4 - CODING WORKSHOP

Up Coding

Q. If someone has an arm fracture with a history of diabetes, can the doctor document the diagnosis for diabetes even if the diabetes is not being specifically addressed in that visit?

A. Yes, chronic conditions affecting a beneficiary's daily care should be addressed and therefore documented in the record. In this case, the diabetes is likely to impact healing and the patient is probably on daily medication for it. It should already be in the medical record and it can be coded. Most likely it also would be captured in the reporting period from another visit or hospitalization. (Section 4.4.1)

Q. If a patient is hospitalized and both the hospital and a physician bill are for the same visit but the physician does not report a condition because he/she cannot report "rule out" diagnoses, how will this be handled?

A. For Risk Adjustment, both bills are valid for reporting diagnosis codes. CMS reviewers will apply the separate guidelines regarding "rule out" conditions for the associated place of service if the cases are selected for review. (Section 4.4.3)

Q: When and how can a physician's problem list be used to code a diagnosis for submission?

A: When it has been clearly updated in the medical record, and reflects the physician's evaluation of the patient's condition at the time of the encounter.

Q. In a medical record review, is it true that if the documentation for a date of service does not contain all of the pieces, I may have to look at something else, like lab reports?

A. Lab reports per se are not appropriate. However, the physician could use the lab report to confirm a diagnosis and note this in the medical record. If lab results are received after the original date of service, the documentation should be added as an addendum and the physician should update the diagnosis documentation. (Section 12.3)

Q. Do progress or discharge notes stand alone?

A. No, progress or discharge notes do not suffice as documentation. A coder must research the medical record further to confirm what is written in the progress notes. For example, if the notes stated just "fracture," a coder would look for more specificity in other documentation for that date of service to determine the site and type of fracture. (Section 4.1)

Reduced Code Set

Q. In the reduced code set, what do the asterisks stand for?

A. It represents a category that has fourth and/or fifth digits available for specificity. (Resource Guide page 55)

Q. Using the reduced code set, is there a difference in risk adjustment factors between the 410 or 410.00?

A. There is no difference between 410 and 410.00 with respect to the CMS-HCC group. 410 is specific enough to allow appropriate grouping for risk adjustment purposes. However, 410 is a category code and therefore is not a valid ICD-9-CM code for most purposes. Without the fourth and fifth digits, coders lose the information on the site of the myocardial infarction and whether it is an initial or subsequent visit, which may impact other business uses of diagnosis data. (Section 4.5.2)

Q: What are the differences in coding practices between hospitals and physicians.

A: The coding guidelines for inpatient hospital are slightly different than those for physician and hospital outpatient services.

The guidelines for inpatient hospital stays are as follows:

> "…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 guidelines for coexisting conditions that should be coded for hospital outpatient and physician services are as follows:

> "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."

Physicians and hospital outpatient departments shall not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working" diagnosis. Rather, physicians and hospital outpatient departments shall code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. (Resource Guide page 18)

MODULE 6 - DATA SUBMISSION

Diagnosis Filtering

Q: Should plans submit all diagnosis data or filter data to submit only CMS-HCC model diagnoses?

A: CMS does not recommend one method or the other because it depends on several factors, including the size of your data set, what type of format you are using for collection and submission of data, and how often you submit. These are just some of the considerations. (Section 6.3)

Q: If plans submit only model diagnoses, how will that impact the 70% demographic factor?

A: Diagnoses have no impact on the demographic portion of the payment.   Submitting only model diagnoses will provide sufficient data for CMS to calculate accurate risk adjustment factors, which affect the other 30% of the payment. (Section 6.3)

Connectivity

Q: Do third party administrators (TPAs) need to complete EDI agreements?

A: Plans that use third party administrators to submit data must ensure that both their plan and the TPA complete EDI agreements with the CSSC. A sample EDI agreement and a memo explaining how to complete the agreement are in the resource guide. (Resource Guide page 37)

Q: How do you know who is listed as the EDI Point of Contact at your location?

A: M+C organizations should contact CSSC for this information. (Section 6.1)

Q: When determining what connectivity option to select, how does CMS classify small, medium, and large data sets?

A: This classification is subjective and depends on a number of factors such as how often data is submitted and how many clusters are being submitted. This is only one of several considerations plans should review prior to determining what connectivity option to select. (Section 6.2)

Direct Data Entry

Q: If the date of birth field does not match what is on the direct data entry system (DDE) on the secure website, will the record be rejected?

A: Although DDE will not let plans enter incorrectly formatted information in a particular field, it does not edit fields against any other database to confirm that the fields are correct. Therefore, as long as the date of birth is in the correct format, DDE will accept it. If the record passes the Front End Risk Adjustment System (FERAS) edits, RAPS will edit date of birth against what it has received from the Medicare Beneficiary Database (MBD). If the date of birth does not match MBD information, you will get a 354 error and RAPS will not process or store that record. (Section 6.16)

Q: If plans submit data using the secure website or FTP (File Transfer Protocol), can DDE be used to make corrections?

A: Yes, DDE can be used to correct any record that has been accepted and stored in RAPS. This includes all submission formats: the NSF (National Standard Format), UB-92, ANSI (American National Standard Institute), or the RAPS format. (Section 6.16)

RAPS SUBMISSION

Q: Does the RAPS system automatically insert a service through date for outpatient and physician services if plans leave that field blank?

A: Yes, if the plan leaves the service through date field blank, RAPS will fill that field with the same date as the service from date. (Section 6.10)

Q: How should a plan submit 15 diagnosis clusters?

A: Each C record in RAPS accepts only 10 diagnosis clusters. Plans should enter the first 10 clusters, then create a second C record for the remaining 5 clusters. (Section 6.10)

Q: Will RAPS accept a duplicate diagnosis code with the same provider and diagnosis?

A: It will accept the cluster but not store it. RAPS will only store unique records. However, if one diagnosis cluster element is different, such as the from date or through date, the cluster will be accepted and stored because it is unique. (Section 6.10)

Q: Can plans submit interim bills?

A: An interim bill is not acceptable under risk adjustment because it does not have a discharge diagnosis. Plans may pay interim bills if that is how their contractual arrangements work, but the diagnosis should not be submitted until the plan receives the final bill from the hospital with the discharge diagnosis. (Section 6.8)

Q: Is there a limit to the number of diagnoses that can be submitted per patient?

A: No, there is no limit. However, the number of fields on the collection or submission format they choose may limit the number of diagnoses that can be submitted using one record. (Section 6.8)

Data Correction

Q: If a plan submits data from an unacceptable provider type or an invalid service type, should the plan delete the information?

A: Yes, all information that is submitted must be correct. If a plan identifies incorrect or invalid information that has been submitted, it must delete that information. If a plan is submitting all diagnoses regardless of whether or not the diagnosis is in the model, then the plan can determine whether or not it wants to resubmit records that have non-model diagnoses. (Section 6.11)

Q: If a plan has corrected a submission format issue and resubmits all of its C records, will this cause a problem?

A: Resubmitting all the C records will not cause a problem. Note that for those files where the initial submission did not error out, RAPS will accept the record, but not store it because RAPS does not store duplicate records. However, deleting the same record twice on the same day will cause problems. (Section 6.11)

Q: How closely does data need to match to process a deletion?

A: All fields in the diagnosis cluster must exactly match for a delete to be processed. (Section 6.12)

Q: What should a plan do if it has submitted diagnosis clusters using an incorrect HIC number?

A: If the HIC number is incorrect because it belonged to another beneficiary, the plan must delete all diagnosis clusters and resubmit them using the correct beneficiary HIC number. If the plan realizes that the submitted HIC number belongs to a beneficiary whose HIC number has been changed, the plan should note the new HIC number for future submissions, but does not need to delete and resubmit those clusters already submitted. The CMS systems will cross-reference this beneficiary's information using both HIC numbers. (Section 6.12.1)

Q: When deleting a cluster, is the submitter required to enter the correction at that time?

A: It is not a requirement to perform a delete and correction at the same time. M+C organizations should be careful to submit the corrected data within the quarter. (Section 6.12.3)

Q: When deleting and correcting a cluster within the same submission, are submitters required to enter the deleted cluster before the corrected cluster?

A: The submitter is not required to enter the deleted cluster first. (Section 6.12.2).

Q: Can plans make corrections to reconciled data that are not in the abbreviated format and is submitted under the old system?

A: No, plans cannot correct those records. Please contact Jeff Grant (jgrant1@cms.hhs.gov) at CMS about these types of errors. (Section 6.12.4)

Optional Fields

Q: Do M+C organizations need to submit date of birth?

A: The date of birth field is optional. However, if you submit data in this field, it must be correct. The date of birth field was included as a tool for plans to use to confirm that they are submitting data for the correct beneficiary. (Section 6.10)

Q: Is there an indicator that could differentiate (in an automated system) between an interim 114 bill type and a final bill type of 114?

A: If billed correctly, a 114 is only a final bill. The first interim bill will be a 112, all subsequent interims will be 113, and the final bill will be a 114. (Section 6.8)

MODULE 7 - DATA EDITS

Q: If a submitter receives an error message 490-499, what fields should be checked?

A: The system is looking at field 9.3 in the first diagnosis cluster field 9.3, 10.3 through 19.3. These errors are generated if the M+C organization attempts to delete a cluster that was never submitted or already deleted from the database. (Section 7.4)

Q: What are 500 level error codes?

A: The 500 level error codes are informational edits. Plans will receive error message 500 if a beneficiary's HIC number has changed. Error code 501 indicates that a submitted diagnosis code is not in the CMS-HCC model. (Section 7.4)

Date Span Limitations

Q: What can we do when system errors, related to submitting physical therapy clusters, indicate that the service dates are longer than a 31-day period? The plan's staff cannot split the services into 31-day increments because the staff does not know which diagnosis goes with each date of service.

A: You should contact the submitting provider to obtain the specific diagnoses dates of service information. Afterwards, submit the diagnoses within the 31-day timeframe. (Section 6.8)

Q: Will everything submitted that exceeds 31 days error out?

A: Physician and hospital outpatient diagnosis clusters that exceed a 31-day span will be rejected with an error code 460 indicating date span exceeds 31 days. Inpatient clusters must be submitted with from date equal to admit date and through date equal to discharge date, and therefore may exceed 31 days. (Section 7.5.8)

Q: When submitting more than one encounter by splitting them, are there any restrictions on the patient control numbers?

A: There are no restrictions on repeating patient control numbers on multiple CCC records if you split a claim across several records. The PCN field is an optional field that was created for your use. So, you can use the same identifier several times in the PCN field if you choose. (Section 7.5.8)

Data Inconsistencies

Q: What should plans do if there are discrepancies between the reported date of death and claims files the plan received?

A: M+C organizations can change the through date on the diagnosis cluster to be equal to the CMS date of death. (Section 7.4)

Q: How should the M+C organization submit data if they received an error due to the patient not being in the plan at the time of service?

A: First, determine if the service dates are correct and fall into a plan enrollment period. If the dates are not correct, fix the service dates and re-submit. If the dates do not fall into a plan enrollment period, there is no correction to be made. The data will not be accepted. If the dates are correct and fall into what you believe to be a plan enrollment period but MBD does not list it accurately, contact the CSSC. If the MBD data is incorrect, you may resubmit the information after MBD is updated. (Section 7.5.7)

Q: If a beneficiary's HIC number changes, can plans still submit under the old HIC number?

A: Yes. However, CMS prefers that the cluster be submitted under the corrected HIC number. As long as the older HIC number is submitted, the 500 error code message will be returned. (Section 7.4)

MODULE 8 - REPORTS

Using Reports

Q: Are there any plans to turn all reports into flat files?
A: No, CMS does not plan to provide all reports in flat file format. Only the RAPS return file is provided in flat file format. However, some plans have identified systems that can strip the data and create a flat file. (Section 8.3)

Q: How long will risk adjustment reports be available to the M+C organization?
A: The reports will be available in the submitter's mailbox for 14 days, but will be available through CSSC for seven years. (Section 8.1)

Q: If RAPS determines that a record contains an incorrect HIC number (a 500 error), will it provide the corrected HIC number?
A: Yes. The corrected HIC number will be reported back on your RAPS Return File and the RAPS Transaction Error Report. (Section 8.4)

Q: If you have an error on a C record, will it list all errors associated in that record?
A: It depends on what type of error you have. If you have a series 300-349 error on a C record, the RAPS system will discontinue editing and will not store any diagnosis clusters from that record. If you have a 350-399 series error, the RAPS system will perform all possible edits, but will not store any diagnosis clusters. Each diagnosis cluster has two fields for reporting errors. If there are more than two errors in a cluster, the system will not be able to report more than the first two it encounters. (Section 8.4)

Management Reports

Q: Why would data be accepted by RAPS but not stored?
A: As long as there are no errors, RAPS will accept data. However, it will only store unique clusters. (Section 8.4)

Q: What is the difference between total stored and total model stored?
A: The total stored includes all non-duplicate clusters accepted, while the total stored in the model includes only model diagnoses. (Section 8.4)

Q: How far back does the cumulative report go?
A: The cumulative report shows a rolling twelve months of data. (Section 8.4)

Q: What will happen if you have a cluster that appeared under the unidentified column of the report?
A: If a file is unidentified, it will also be counted under the rejected column. (Section 8.4)

Q: Will CMS release 1999-2000 fee-for-service benchmarks for HCC level frequencies based on 5% sample used to calibrate the model?
A: Yes, CMS will do this in the future. (Section 8.4.1)

Benchmarks

Q: Do you have any standards regarding error rejection?
A: The national average is 1%. (Section 8.4)

Q: Which source of data should produce the highest number of diagnosis clusters: physician office, hospital inpatient, or hospital outpatient?
A: Physician data should have the highest number of diagnosis clusters on reports because beneficiaries are more likely to need a medical visit with a physician than an inpatient hospitalization or an outpatient procedure. (Section 8.4.1)

Q: What should a plan do if it has a large percentage of errors?
A: The plan should stop submitting data, determine the problem(s), correct the problem(s) and resubmit the data. (Section 8.4)

Q: When reviewing benchmarks, can CMS determine what percentage of the time plans are getting model diagnoses exclusively from the physician versus those from multiple sources?
A: CMS has not unduplicated across provider types, since no single provider type has primacy over all others. However, our analyses indicate that about 70% of beneficiaries that have relevant diagnoses (about 35% of all enrollees) will have diagnoses only from ambulatory sites of service (physician or outpatient), and most of the diagnoses will come from the physicians. Overall, we estimate that over 75% of physician diagnoses are not duplicated by a corresponding inpatient diagnosis. (Section 8.4.1)

MODULE 10 - MEDICARE BENEFICIARY DATABASE

Accessing MBD

Q: How can plans get access to the MBD?
A: Plans can get access by completing an application, which is in the back of the Resource Guide in your Participant Guide. (Section 10.2)

Q: Is there a limit to the number of users a plan can have?
A: No, there is no limit to the number of users per plan. M+C organizations should contact their regional office representative for more details. (Section 10.2)

Q: How can plans find out about training classes for MBD?
A: Go to the CMS website or ask your regional office contact for training class information. (Section 10.2)

Q: What should plans without MBD access do?
A: Until the plan obtains access, the CSSC can look up the information. Contact the CSSC to determine what communication method would work best for getting your information. (Section 10.2)

Q: How would PACE without an H number check the Medicaid status of beneficiaries?
A: If a PACE plan does not yet have an H number, it cannot check a beneficiary's Medicaid status on the MBD. However, the plan can contact the State Medicaid agency to determine eligibility. (Section 10.2)

Features of MBD

Q: What is the MBD?
A: The Medicare Beneficiary Database is the primary source of beneficiary eligibility, enrollment, and demographic data, and will support the plan enrollment function when MMCS goes live. (Section 10.1)

Q: Is MBD interactive?
A: The MBD allows plans to check information on a beneficiary's eligibility status, demographic information, Medicaid eligibility, and health status. You can check the MBD using a beneficiary's HIC number or social security number. In addition, plans can update the mailing address for beneficiaries enrolled in their own plan. (Section 10.1)

Q: How often is the MBD updated?
A: Information in MBD is updated nightly with GHP files. In 2004, the Medicare Managed Care System (MMCS) will replace GHP. If plans identify inaccurate information in the MBD, please contact the CSSC. The CSSC will research each issue, log errors, and produce problem reports for CMS. (Section 10.3)

Q: When searching MBD for a member with an old HIC number, will the system provide beneficiary information with the new HIC number?
A: Yes. The MBD keeps historical data on file, so if a beneficiary's HIC number is changed, the MBD will cross-reference the old and new numbers. (Section 10.1)

Q: Will there be a batch mode for MBD?
A: MBD does not currently have batch inquiry capabilities. (Section 10.4)

Risk Adjustment and MBD

Q: How is RAPS interacting with the McCoy system now?
A: RAPS is basing Medicare+Choice eligibility verification on data from MBD. MCCoy provides an interface between M+C organizations and the GHP system, where managed care enrollment takes place and where payment based on those enrollments is calculated. GHP is the source system for the plan enrollment data in MBD. MBD should reflect the same data that can also be viewed in GHP through McCoy. If the two systems do not agree, contact the CSSC. (Section 10.3)

Q: Whom do I contact if a patient's gender is listed incorrectly in the Medicare Beneficiary Database (MBD)?
A: Contact the CSSC. (Section 10.4)

MODULE 11 - VERIFYING RISK SCORES

Impact Data Report

Q: Are the beneficiaries listed on Table 2 of the Impact Data Report posted on HPMS unique?
A: Yes, each beneficiary appears only once in Table 2. In Table 3, a beneficiary may appear in several categories. (Section 11.3)

Q: Will the data on Table 1 change each quarter?
A: No, the Impact Data Report is provided as a snapshot to be used as a projection tool. It will only appear once, when the estimator data is reported. (Section 11.3)

Monthly Membership Report

Q: Is the Monthly Membership Report (MMR) the same report as the one currently accessed through GROUCH?
A: The MMR is generated by GHP and is downloaded via GROUCH usually during the third week of the month. It will be continued under the CMS-HCC model. (Section 11.1.3)

Q: Is congestive heart failure (CHF) part of the CMS-HCC model?
A: It was always part of the risk adjustment model, but included extra benefits that occurred as part of the PIP-DCG implementation. This is no longer necessary, since the CMS-HCC model utilizes data from ambulatory settings. (Section 11, Attachment A)

Q: In 2004 when the ESRD field of the MMR report is used, how will plans know if they are being paid under the ESRD model?
A: In 2004, only ESRD demonstrations are paid under the ESRD risk adjustment model. All other plans will be paid 100% demographic ESRD rates. The ESRD flag will indicate that this rate is being used. When CMS begins using the ESRD model for all of M+C, a "Y" in the ESRD field will indicate that the beneficiary's risk adjustment factor was calculated using the ESRD model. (Section 11, Attachment A)

Q: The MMR report gives the final risk adjustment factor for a beneficiary. How can a plan see the root HCCs for a particular beneficiary?
A: The HCCs are displayed on the Risk Adjustment Model Output report. This report accompanies the MMR report. (Section 11.1.4)

Q: Will a beneficiary's risk adjustment score change from month to month?
A: Risk adjustment scores are calculated according to the schedule in Section 1, and the risk factors from each model run will reflect all fee-for-service and RAPS data that CMS has from the relevant data collection period at the time the model is run. During reconciliation, a risk factor may be changed from month to month to reflect changes in any of the concurrent markers within risk adjustment. These include: Medicaid in the new enrollee model, institutional status, and some parts of the ESRD model. (Section 11, Attachment A)

Q: How long is the MMR report and flat file layout?
A: The flat file MMR report contains 200 bytes, and includes fields to incorporate the CMS-HCC model information. (Section 11, Attachment A)

Q: Where will plans obtain the MMR report and when is it available?
A: The report will be available through GROUCH beginning in January 2004 when plans receive their first payments. CMS will send a letter to plans with the first report. In the letter there will be an updated list of central office regional contacts that work in the applicable systems area. If plans have technical questions about how to read the report, such as what a specific field represents, they should get in touch with the contact for their region. (Section 11.1.3)

Q: For those plans that have special payment blends, like 90/10 for the year 2004, does the plan need to recalculate the payments based on this blend?
A: No, the MMR report will calculate the blended payment based on the plan-specific blend. (Section 11, Attachment A)

Q: We have noticed several discrepancies in the originally disabled flags on the MMR? Where can we send discrepancies in the originally disabled flags on the MMR to achieve resolution so the errors will cease and not negatively affect our risk-adjusted payments?
A: Originally disabled is based on the original reason for entitlement code (OREC) flag in the EDB, which comes from SSA files. Many plans confuse a previous Medicaid disabled status with a previous Medicare disabled status. Our flag only applies if the person was originally entitled to Medicare due to a disability. While it is possible that information on an individual beneficiary is wrong, in our experience, plans do not usually have information on entitlement that alter what SSA records indicate about beneficiaries with respect to this variable. If you believe the SSA records are wrong on a specific beneficiary, you must contact SSA to have the information changed. If you believe there are many errors, it is likely that you are incorrectly identifying the original reason for entitlement in your systems and you should contact CMS for clarification. (Section 11.1.3)

Q: Will the risk-adjusted payment on the MMR report include the frailty adjustments?
A: Yes, it will be incorporated into that payment. (Section 11, Attachment A)

Running the Model & Calculating Risk Scores

Q: How can a plan replicate the payment methodology that CMS goes through to decide what to pay?
A: Plans can use the model software that was made available to run the model. (Section 11.1.5)

Q: If a beneficiary's age group changes during the year, will the CMS-HCC model take that into account and pro rate the payments?
A: Each year's risk score is based on the beneficiary's age as of February 1st of the data year. The model does not pro rate payment as the age group changes. (Section 11.2)

Q: Where can a plan find beneficiary-specific information about the diagnoses used to calculate a risk score?

A: HCC level information on a beneficiary basis is available on the Risk Adjustment Model Output Report, available through the GROUCH system as a supplement to the MMR report. It will be available for download through GROUCH at the same time as the MMR. (Section 11.2)

Q: If a plan enrolls beneficiaries in a county where there has not been any Medicare+Choice enrollment, how will CMS calculate the risk scores? For example, a plan is going into two counties where there are zero enrollees in M+C plans from July 1, 2002 to June 30, 2003. How will our new member risk scores be calculated?

A: Risk factors will be calculated using M+C and/or fee-for-service data, for members with 12 months of Medicare Part B enrollment. A new enrollee factor will be calculated for enrollees without 12 months of enrollment. Payments will be initially made using a default risk score for new members for whom we have no CMS-HCC risk factor. The default risk score is the same as the new enrollee risk score. When new scores are calculated, new members will have accurate risk scores calculated. (Section 11.2)

Q: Should M+C organizations incorporate diagnoses from services provided outside of the nursing home for institutional beneficiaries?

A: Yes, if the diagnoses are from data for physician services and inpatient and outpatient hospitals. (Section 11.2)

Risk Adjustment Model Output Report

Q: Does the Output Model Report provide a description of the HCC?

A: The report format file identifies the HCC number and full description. The flat file has flags, the values of which have been identified with long and short names as well as descriptions. (Section 11.1.4)

Q: Is the Risk Adjustment Model Output Report available?

A: The Risk Adjustment Model Output Report will be available in January 2004; thereafter, it will be available monthly. (Section 11.1.4)

Q: Does this report reflect any hierarchies that were applied?

A: Yes, hierarchies are reflected in the report, and are rated by seriousness of condition. (Section 11.1.4)

Q: Does the Risk Adjustment Model Output Report have a hierarchy?

A: Yes, if, for example, you have several forms of diabetes, the most severe will be displayed. (Section 11.3)

Q: What level of diagnosis will the Risk Adjustment Model Output Report show?

A: It will show the highest disease level or most severe diagnosis. (Section 11.3)

Q: Is the Risk Adjustment Model Output Report cumulative?

A: No, the report indicates information for that month. (Section 11.2.4)

Q: Will there be a need for us to create a file for various reports?

A: CMS will produce a flat file that each plan will need to import into its information system structure. Most plans develop their own custom database to handle the report information. CMS has provided short and long names and descriptions of every element on the file to aid in database development. (Section 11.2.4)

Benchmarks

Q: Where are the county risk rates located?

A: They may be found at "**cms.hhs.gov/healthplans/rates/2004**." (Section 11.4)

Q: On what year are the HCC benchmarks, discussed during training, based?

A: The benchmarks are based on 1997 data. (Section 11.4)

MODULE 12 - RISK ADJUSTMENT DATA VALIDATION

Q: If an audit of medical records is done, what information from medical records will be required?

A: Actual medical records documentation must be provided to CMS in the case of an audit. Diagnostic information that is submitted for payment purposes must be supported by medical record documentation per the guiding principle. The guiding principle states that, "The medical record documentation must show that the 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, it must be coded according to ICD-9-CM Guidelines for Coding and Reporting." (Sections 12.2 and 12.3)

Q: Does the potential exist to be audited on one H number one year and another H number the next year?

A: Yes, M+C organizations may be selected at random or they may be selected based on targeting criteria. As a result, it is possible that a plan with the same 'H' number may be selected to participate in consecutive years. Likewise, 'H' numbers from within the same umbrella organization may be selected within the same or across consecutive years.

Q: Will CMS offer compensation to plans volunteering for the pilot test, so they may use outside contractors?

A: Plans that participate will be offered a flat rate of $10 per record submitted. (Section 12.10)

Medical Record Requests

Q: If CMS performs data validation with a plan, does the plan have to pull the medical records and will CMS furnish a letter to the provider?

A: CMS will send a medical record request package to the plan. It is the plan's responsibility to collect and submit the requested medical record documentation for medical record review. CMS will provide a letter on CMS letterhead to providers requesting their cooperation in the medical record request process. M+C organizations may choose to share this letter with providers in the process of collecting medical records. (Section 12.5)

Q: Will medical record requests be available in flat file format?

A: In the past CMS has provided electronic medical record request lists in an Excel file format. In the future, if this is not convenient we may be able to provide a different format. (Section 12.5)

Documentation Requirements

Q: What standards would a CMS auditor use when reviewing a chart to validate the existence of reported diagnoses?

A: Expert coders and physicians will be conducting the medical record reviews. Physicians will be involved in the process to provide clinical guidance in the review of the records. (Note, physicians will review all discrepant records associated with payment inaccuracy.)

The components of medical record documentation vary across physicians, however, problem lists, progress notes, and the history and physical component of the medical record will be a key source of documentation necessary to support a diagnosis. The physician must document in the medical record the patient's diagnosis and also sign and date the documentation. Note that Superbills and signed physicians attestations are not acceptable, because they are not legal medical record documentation.

The coders will apply the ICD-9-CM coding guidelines to determine whether the documentation supports a diagnosis submitted for payment. In addition, the coder will confirm that a physician assigned the diagnosis, there is a confirming physician signature, and there is a date within the correct data collection period associated with the validated diagnosis. If, for example, the physician documents in the progress notes of a patient's medical record that the patient is on Lasix for congestive heart failure, the coder would identify the patient as having a diagnosis of CHF.   If the progress notes indicate that patient has been prescribed Lasix and the physician identifies no medical condition, the coder would not be able to confirm a diagnosis of CHF. The coder will also check for a correct date and signature. Note, coders will not use lab tests or nutritionist reports to evaluate a diagnosis or interpret a report for a patient. (Section 12.3)

Q: When and how can a physician problem list be used to code an encounter and validate submitted diagnoses?

A: A problem list in the medical record may be used as valid supporting medical record documentation for a diagnosis; however, it must meet certain criteria. The problem list must be current and have been updated by the physician within the correct data collection period. This means that within the correct data collection period, the physician must have reviewed each of the beneficiary's diagnoses listed in the problem list at the time of the face-to-face encounter. The physician must have noted in the problem list all diagnoses that are no longer a problem for the beneficiary and all diagnoses that the beneficiary still has. If the problem list is not completely current, it will not be considered valid supporting documentation. Additional documentation (e.g., from the physician's notes) may be used in confirming the problem list. (Section 12.3)

Q: Why is the super bill not acceptable for risk adjustment data validation?

A: The super bill is not acceptable as medical documentation because it is not signed by a physician and is not a legal document. (Section 12.3)

Q: Is a phone call from a plan to a physician sufficient support for submitting a diagnosis?

A: Yes, as long as the physician has documented the diagnosis in the medical record. (Section 12.3)

Q: Is a hospital discharge summary considered sufficient documentation if it validates the diagnosis?

A: Sometimes a hospital discharge summary may not carry out the specificity necessary to document a diagnosis. If a professional coder can abstract the correct code from that summary, then that should be sufficient. The plan must be clear when talking about the discharge summary. (Section 12.3)

Q: Are plans going to receive some form of feedback at some point at year's end?

A: Plans receive ongoing feedback from the Front End Risk Adjustment System and Risk Adjustment Processing reports and from CSSC and CMS based on error ratio and data volume submissions. Also, monthly User Group meeting provide feedback, and data validations contain feedback mechanisms (e.g., letter, teleconferences and reports). Plans will also receive periodic updates of the number of enrollees per HCC via HPMS. (Section 12.9)

Q: Will a CMS auditor be reviewing primary versus secondary diagnoses submitted for hospital inpatient stays?

A: It will not be necessary for the validation coders to differentiate between primary and secondary diagnoses, because the CMS-HCC model does not differentiate between primary and secondary diagnoses. The model will evaluate primary and secondary diagnoses to determine the HCCs that should be assigned. (Section 12.3)

Q: If the order of diagnoses is not relevant, why are diagnoses classified as primary and secondary in RAPS?

A: The original PIP-DCG model considered principal versus secondary inpatient diagnoses. CMS maintained this data collection format to allow for the continued collection of inpatient data for the PIP-DCG model. In addition, while it will not affect your risk scores, the principal versus secondary diagnosis distinction is important. CMS is going to pull reconciliation data from the system for 2003. All 2003 reconciliation data is in RAPS format. Data for 2003 must differentiate between principal and secondary diagnoses. Differentiation also helps in assessing your RAPS volume relative to benchmarks. (Section 6.7)

Q: Who will conduct data validation appeals for CMS?

A: The requested medical records are subject to medical record review by the initial validation contractor. Discrepant records are subject to a second review by a second independent contractor. The second independent contractor will conduct the appeals process. The current second independent medical record review contractor is AdvanceMed and they will be conducting the appeals process for the PIP-DCG model. CMS has not yet determined who will manage the appeals process for the CMS-HCC validation. (Section 12.7)

GENERAL

Q: What should you do if you have follow-up questions from the CMS Regional Risk Adjustment Training?

A: For systems-related questions, contact the CSSC. Questions can be submitted by phone or through the www.mco*service.com website. If the question concerns policy-related questions or how a plan's risk scores were calculated, contact CMS. In addition, questions can be raised during monthly user group meetings.

Q: How can I provide feedback about the User Group Meetings?

A: Please submit any User Group feedback to Stacy Watts at **swatts@aspensys.com**. CMS and Aspen Systems Corporation rely on User Group participants' feedback. You also may ask questions during the Question/Answer portion of the User Group session.

Q: Are additional copies of the physicians' training CD available?

A: The physicians' training CD is being produced, and we will provide one copy per organization. M+C organizations will be free to make as many copies as they need.

Q: What format is the training material on the CD?

A: It will be a PDF file.