2007/08 Risk Adjustment User Group

March 2008 Meeting Notes

Meeting Date: March 12, 2008

Meeting Time: 1:30 p.m. – 2:30 p.m. EST

In Attendance:

Panelists: Henri Thomas, Sean Creighton, Louis Johnson, Mary Guy, Chanda McNeal, Joyce Pedigo, Sheila Young, and Tiffany Valery.

(Participants should reference the PowerPoint slides when reviewing the notes from the User Group Session.)

Topics:

Payment Process

2005 Final ESRD Payments

CMS completed the system clean-up for the 2005 ESRD final payments. These payments will appear in the April 2008 monthly payment and on the Monthly Membership Report. CMS needs to resolve approximately 100 beneficiaries for the 2005 ESRD payment, and will keep plans informed of the progress.

2006 Final ESRD Payments

CMS made 2006 Final ESRD payments to plans in August 2007.

2008 Mid-Year Payment Adjustment

CMS anticipates making the 2008 mid-year payment adjustment in the July payment.

2006 Final ESRD Payments

CMS expects to make the final 2007 payment in August 2008.

Submission Deadlines and Sweep Dates

CMS will not extend the deadlines for submitting data due to the processing schedule of the CMS Data Center. Plans should submit data according to the submission schedule and not the sweep date.

Data Validation

Calendar Year (CY) 2007

CMS plans to begin the 2007 data validation sample in April 2008, and will notify the selected Medicare Advantage (MA) Organizations between May and June 2008.

CY 2006

Medical record reviews for CY 2006 are in progress, and the SVC (Second Validation Contractor) is reviewing the medical records. CMS will validate findings using the quality assurance process and identify confirmed discrepancies based on the reviews by the Initial and Second Validation Contractors.

CY 2005

On March 6, 2008, CMS mailed the 2005 Data Validation results to selected MA organizations. These results were sent to the Medicare Compliance Officer at the selected MA Organization, and were sent overnight via Federal Express. CMS used email alerts to inform plans of the mailings' addresses and of the March 12, 2008 teleconference. If plans participated in the data validation sample and did not receive a mailing or have other questions, they should email Michelle Hill of

Bearing Point, the Initial Validation Contractor, at michelle.hill@bearingpoint.com and copy Mary Guy at Mary.Guy@cms.hhs.gov. The Second Validation Contractor for the 2005 data validation was the Ascellon Corporation.

CY 2005 Data Validation Teleconference

During the March 12 teleconference, CMS will communicate national findings, discuss the appeals process, and answer questions regarding results and payment adjustments. Plans can submit questions to Michelle Hill and Mary Guy in advance of the teleconference.

CY 2005 Data Validation Appeals Process

The 2005 appeals process is now in affect for selected MA plans. Plans may appeal missing medical records, invalid medical records, and ICD-9 coding errors findings according to the instructions provided in the Appeals Process & Guidelines, which were included in the results' mailings. The appeal process includes submitting appeals within 60 days of receiving the 2005 data validation results (i.e., March 7 and May 6), using a traceable mail carrier (e.g., FedEx, USPS, etc.), and sending an appeal letter and documentation to the SVC with a copy to the CMS Project Officer, Mary Guy. The SVC will implement the appeals process.

CSSC Operations Update

Stored and Model Stored Diagnosis Clusters

The Risk Adjustment Database stores unique, valid diagnosis clusters, which includes relevant diagnosis clusters in the CMS-HCC model and those that are valid, but not included in the payment model. Monthly reports show all diagnoses accepted as "Stored" and those in the CMS-HCC model as "Model Stored." The Model Stored diagnoses are included in calculating payment.

CMS Operations Update

History & Physical (H&P)

Inpatient H&P medical records do not contain reportable, final, or confirmed diagnoses as documentation to support a diagnosis. H&Ps typically contain admission symptoms and co-existing conditions as well as admission diagnoses that may or may not be one of the final diagnoses for the inpatient admission. Plans must submit discharge or final diagnoses for the inpatient admission, not the H&P alone. Data submissions must follow inpatient ICD-9 coding guidelines.

According to the guidelines, if a physician submits a separate claim from an inpatient stay, based on the evaluation of the patient, the H&P is a face-to-face encounter and viewed as a physician visit. The H&P from a physician visit includes reportable, documented diagnoses acceptable for submission for risk adjustment. However, the submission must follow outpatient ICD-9 coding guidelines.

Risk adjustment requires final, confirmed diagnoses. Plans should submit risk adjustment diagnosis clusters based on the H&P only when there is an independent physician claim associated with the diagnosis. If an MA organization submits H&P as stand-alone physician documentation for a Data Validation, reviewers will apply the outpatient guidelines to determine if there is a confirmed diagnosis.

Lab and Pathology Reports

According to the Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings), "*Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance."* Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding. For example, written interpretation of a tissue biopsy is not equivalent to the attending physician's medical diagnosis based on the patient's complete clinical picture.

Outpatient pathology facilities are unacceptable risk adjustment provider sources. However, physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting diagnoses based on physician specialty code 22, plans should refer to the guidance as stated on slide number 16.

According to the diagnostic radiology guidelines, plans do not submit risk adjustment diagnoses based on any diagnostic radiology services. Diagnostic radiologists typically do not document confirmed diagnoses. Diagnosis confirmation comes from referring physicians or physician extenders. Confirmed

diagnoses are typically not assigned when reviewing medical record documentation from diagnostic radiology services alone. This submission guideline exists regardless of the type of diagnostic radiology bill (outpatient department, or physician component).

Training Update

Monthly Technical Assistance Sessions

Registration is open for the monthly Enrollment and Payment Session on Wednesday, March 26, 2008 and the Risk Adjustment Session on April 30, 2008. Plans can register for monthly Technical Assistance Sessions at www.tarsc.info. Limited space is available for these sessions.

Regional Technical Assistance Sessions

Registration for the Regional Technical Assistance Sessions will begin by March 31. For information on dates and locations for the sessions, log on to www.tarsc.info and look under Hot Topics. Continue to visit the website for detailed information on registration requirements and how to register at that time.

Next User Group meeting: Wednesday, ***April 16***, 2008 at 1:30 pm EST.