TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Purpose (Slide 3)

The purpose of this training is to provide participants with information and resources specific to the role they play in the risk adjustment process. This information will lead to improvements in the quality and quantity of risk adjustment data submitted and ultimately more accurate payment by CMS.

About This Training

ICON KEY	
Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

This training is organized into twelve modules:

1. **Risk Adjustment & the CMS-HCC Model**
   Provides an understanding of the final CMS-HCC model
2. **Risk Adjustment Process Overview**
   Identifies the systems and timeline of the risk adjustment process
3. **Data Collection**
   Describes the acceptable sources of risk adjustment data and data collection formats
4. **Coding Workshop**
   Provides important medical record documentation and coding guidelines
5. **Data Collection Strategies**
   Participating organizations share their risk adjustment data collection strategies
6. **Data Submission**
   Describes the acceptable formats for submitting risk adjustment data
7. **Risk Adjustment Data Edits**
   Identifies systems error codes and errors that can be avoided
8. **Reports**
   Identifies risk adjustment reports and report receipt timeline
9. **RAPS Strategies**
   Participating organizations share systems implementation of risk adjustment
10. **Medicare Beneficiary Database**
    Identifies how M+C organizations can access and use the Medicare Beneficiary Database
11. **Verifying Risk Scores**
    Describes the process and tools used to reconcile risk adjustment data
12. **Risk Adjustment Data Validation**
    Identifies the data validation approach under the CMS-HCC model

This participant guide is designed as the foundation of the training program. The presentation slides complement the participant guide and both will be used extensively throughout this training. The participant binder includes the participant guide, presentation slides, a resource guide, and job aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant risk adjustment information • Case studies • Exercises • Answer keys
Slides	• Organized by module • Printed two slides per page
Resource Guide	• List of common acronyms • Risk adjustment instructions • Contact information • Other source documents

TABLE A – TRAINING TOOLS

Future Use of This Participant Guide

The participant guide, slides, and resource guide are designed for use when participants return to their organization. Additional copies of the training materials are available at www.mcoservice.com. As CMS revises the training materials, replacement pages are identified on the cover page of the document. An appropriate label will appear in the footer of those pages affected by the revision. Organizations are encouraged to register with the mcoservice.com website to receive notification of updates to this document.

Audience (Slide 7)

This training is designed for staff at Medicare+Choice organizations, capitated demonstration plans, and specialty plans, which are responsible for the collection and submission of risk adjustment data. Additionally, the training will be useful for third party submitters, contracted to submit on behalf of Medicare+Choice organizations. Throughout this training, the term M+C organization includes all organizations listed in Table B.

NAME	DESCRIPTIONS
M+C Organizations	Organizations, including M+C organizations, private fee-for-service organizations, preferred provider organizations, and provider sponsored organizations that receive capitated payments to provide comprehensive medical services to Medicare beneficiaries.
PACE	Program of All-inclusive Care for the Elderly serves a community of frail and elderly individuals who are eligible for nursing home placement based on State Medicaid criteria.
MSHO/ MnDHO	Minnesota Senior Health Options: MSHO and MnDHO are managed care products that integrate Medicare and Medicaid financing; acute and long-term care service delivery for dually eligible and Medicaid eligible physically disabled adults and elderly in a ten county area in Minnesota, including the Twin Cities. MnDHO is implemented in Hennepin, Ramsey, Dakota and Anoka counties and will expand to three more of the 10 MSHO counties.
S/HMO	Social Health Maintenance Organizations offer seniors an expanded care benefits package that may include prescription drugs, eyeglasses, hearing aids, and community-based services, which enables them to maintain independence by avoiding nursing home placement.
WPP	Wisconsin Partnership Program is a comprehensive program for Medicaid and Medicare beneficiaries who are elderly or disabled and meet the State's nursing home criteria. WPP integrates health and long-term support services, and includes home and community-based waiver services (HCBS), physician services, and all other medical care.
EverCare	The EverCare demonstration was developed to study the effect of providing enhanced primary and preventive care to Medicare beneficiaries who are long-stay nursing home residents. EverCare's model uses nurse practitioners as care providers and coordinators for the chronically ill and frail elderly living in nursing facilities.
Capitated Demonstration Projects	Capitated demonstration projects use alternative capitated financing to allow the provider to offer comprehensive medical service.

TABLE B – ORGANIZATION DESCRIPTION

This training is designed for the two specific audiences indicated in Table C.

TRACK	AUDIENCE
IT/Systems	Information needs of systems/information technology participants who are primarily responsible for the submission of risk adjustment data to CMS.
Data Collection/Clinical Coding	Information needs of staff responsible for data collection and who need information about clinical coding and medical record documentation.

TABLE C – TRAINING TRACKS (Slide 6)

Learning Objectives (Slide 8)

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

- Identify the final CMS-HCC model and payment methodology
- Describe the requirements for data collection
- Determine the process for submitting data to CMS
- Interpret the editing rules and the resolution of errors
- Gain an understanding of strategies employed by other organizations
- Understand how to verify risk scores by using the Monthly Membership Report (MMR)
- Understand the data validation approach under the CMS-HCC Model

The roles and contact information for important resources are provided in Table D.

Important Resources

ORGANIZATION	ROLE	CONTACT INFORMATION
Centers for Medicare & Medicaid Services (CMS) Center for Beneficiary Choices	Develops and implements the risk adjustment payment methodology for the Medicare+Choice program. Monitors plans to improve the quality of data	Cynthia Tudor ctudor@cms.hhs.gov Jeff Grant Jgrant1@cms.hhs.gov Bobbie Knickman bknickman@cms.hhs.gov Jan Keys jkeys@cms.hhs.gov Henry Thomas hthomas@cms.hhs.gov
CMS Regional Offices	Provide assistance to M+C organizations and beneficiaries regarding various issues related to the Medicare program	
Palmetto Government Benefits Administration (Palmetto GBA)	Manages the Front-End Risk Adjustment System (FERAS) and the Customer Service and Support Center (CSSC)	www.mcoservice.com mcoservice@palmettogba.com
Aspen Systems Corporation	Training Contractor responsible for risk adjustment training initiatives, including regional training programs, and User Group meetings	Encounterdata@aspensys.com Angela Reddix Areddix@aspensys.com

TABLE D – RISK ADJUSTMENT PROCESS POINTS OF CONTACT

MODULE 1 – RISK ADJUSTMENT & THE CMS-HCC MODEL

Purpose (Slide 2)

To provide an explanation of risk adjusted payment under the CMS-HCC payment model for the M+C program.

Objectives (Slide 3)

At the completion of this module, participants will:

- Understand the purpose of risk adjustment
- Understand the components of risk adjusted payments and know how to calculate a risk factor
- Understand the new enrollee factors
- Understand the long-term institutional model
- Understand the frailty adjuster
- Understand the new schedule based on elimination of the payment lag
- Understand plan-level data reported in HPMS

ICON KEY

Example 

Reminder 

Resource 

IT/Systems Track 

Data Collection Track 

1.1 The Purpose of Risk Adjustment

Purpose: To pay Medicare+Choice (M+C) organizations accurately and fairly by adjusting payment for enrollees based on demographics and health status.

- Traditionally payments to M+C organizations were based solely on demographic information.
- Risk adjustment provides more accurate payments for M+C organizations. Payments are higher for less healthy enrollees and lower for more healthy enrollees.

1.2 Background of Medicare+Choice Risk Adjustment

- Balanced Budget Act of 1997 (BBA) (42 CFR 422)
  - Created the Medicare+Choice program
  - Mandated risk adjustment payment methodology to increase payment accuracy
  - Mandated the implementation of a frailty adjuster for the Program for All-Inclusive Care for the Elderly (PACE) organizations
- August 1998
  - Hospital inpatient encounter data collection began
- January 2000 – Principal Inpatient Diagnostic Cost Group (PIP-DCG) Payment Model Implemented
  - Gradual phase-in of risk adjustment based on principal inpatient diagnosis and demographic factors (age, sex, Medicaid status, original reason for Medicare entitlement)
  - Implemented at 10% PIP-DCG and 90% demographic for payment years 2000 - 2003
  - The PIP-DCG model is based on hospital inpatient diagnoses only
  - Uses inpatient discharge diagnoses to assign an enrollee's risk group
- Benefits Improvement and Protection Act of 2000 (December)
  - Established the current implementation schedule to achieve 100% risk adjusted payment in 2007
  - Mandated the incorporation of ambulatory data
- October 2000 – CMS began collecting physician data
- April 2001 – CMS began collecting hospital outpatient data
- May 2001 – Secretary of the Department of Health and Human Services suspended collection of ambulatory data to seek burden reduction for M+C organizations
- January 2002 – CMS announced new risk adjustment data processing system—RAPS (Risk Adjustment Processing System)
  - Burden reduced by 95%
  - Required data elements reduced from 50 to 5
  - Required only the submission of those diagnoses needed for calculating risk adjusted payment
- March 2002 – Draft CMS-Hierarchical Condition Category (CMS-HCC) Payment Model Selected
  - New risk adjustment model needed to accommodate other types of data (hospital outpatient and physician)
  - Included approximately 61 condition groups with reduced number of diagnostic codes
  - Proposed for implementation in calendar year 2004

 http://www.cms.hhs.gov/healthplans/riskadj

- February 3, 2003 – CMS-HCC model discussed at national public meeting and addressed the elimination of the data lag for payment
- March 28, 2003 – Advanced Notice of Methodological Changes (i.e., 45-Day notice) published describing the final CMS-HCC model, frailty adjuster, and elimination of the data lag
- May 12, 2003 – Published final M+C rates for 2004 payment
  - Announced final CMS-HCC model, including the institutional and community models
  - Provided risk adjustment new enrollee factors
  - Delayed implementation of ESRD model for M+C until 2005
  - Described process for elimination of the data lag

 2004 45-Day Notice: http://cms.hhs.gov/healthplans/rates/2004/45day.pdf
May 12, 2003 Announcement: http://cms.hhs.gov/healthplans/rates/

1.3 CMS-HCC Risk Adjustment Payment Model (Slide 5)

In 2003, after public comment, the CMS-HCC model was finalized as the risk adjustment payment model. The goal was to select a clinically sound risk adjustment model that improved payment accuracy while minimizing the administrative burden on M+C organizations. The model is a revision of the Hierarchical Condition Category model, originally developed by Health Economics Research, Inc. The CMS-HCC model functions by categorizing ICD-9-CM codes into separate groups of clinically related codes, e.g., diabetes, cancer, ischemic heart disease, infections, etc.

Characteristics of the CMS-HCC Model

- ***Selected Significant Disease (SSD) Model***
  - **Serious manifestations of a condition are considered rather than all levels of severity of a condition**
  - **Model is additive**
  - **Includes most body systems and conditions with a high prevalence among the frail elderly**
  - **Incorporates conditions that are likely to be disease managed**
  - **Community version includes 65 disease groups**
- ***Prospective Model***
  - **Like PIP-DCG, CMS-HCC uses diagnostic information from a base year to predict costs and adjust payment for the following year**
- ***Demographic Variables***
  - **Demographic variables will continue to be components of the risk adjusted payment calculation even at 100% model implementation**
  - **Demographic variables are: age, sex, Medicaid eligibility, disabled status, and reason for original entitlement to Medicare (i.e., disability)**
- ***Site Neutral***
  - **Model does not distinguish payment based on a site of care**
- ***Considers Multiple Chronic Diseases***
  - **Risk adjusted payment is based on assignment to disease groups, also known as HCCs**
- ***Includes Disease Interactions and Hierarchies***
  - **Interactions allow for additive factors based on chronic conditions and disabled status to increase payment accuracy**
  - **Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist**
- ***Distinguishes Between Community-Based and Long-Term Institutionalized Enrollees***
  - **Different than institutional factor used in the demographic-only model**
  - **Long-term institutionalized defined as enrollees with greater than 90 days residence in an institution**
  - **Payments for institutional enrollees are generally less than payments for similarly ill beneficiaries residing in the community**
  - **Institutional model includes 47 disease groups**

1.4 Changes in M+C Payments

Prior to 2000, M+C payments were computed using only demographic characteristics. The demographic factors were age, sex, Medicaid, institutional status, and disabled status. The demographic factors were then multiplied separately by the Part A and Part B county rates and then added. M+C organizations were paid 100 percent of this rate.

Under the PIP-DCG model, M+C payment calculations involved two steps. The first step was to calculate the demographic portion of the payment (as stated above). The second was to calculate a risk factor for an individual, composed of demographic characteristics within the risk model (i.e., age, gender, Medicaid status, original reason for Medicare entitlement) as well as the PIP-DCG category (if applicable) for an individual. Under the PIP-DCG model, CMS used the same Part A and Part B county rates (used for demographic payments) and multiplied them by a rescaling factor to derive the county rate for risk adjustment. This amount was then multiplied by the individual's PIP-DCG risk factor. For 2000-2003, M+C organizations were paid using 90% of the demographic payments and 10% of the PIP-DCG payments.

1.5 M+C Payments Under the CMS-HCC Model

A similar process will occur with the implementation of the CMS-HCC model. For 2004-2006, a CMS-HCC score will be calculated (which includes imbedded demographics and one or more disease categories in the CMS-HCC model). This number is multiplied by the risk adjusted county rate which is calculated in the same way that the county rate under the PIP-DCG model was calculated. Payments to M+C organizations in 2004 will be calculated as 70% of the demographic model and 30% of the CMS-HCC model. In addition, separate risk adjustment models have been developed for community residents, including beneficiaries with short term institutional stays, and long term institutional.

📖 For a complete explanation of the derivation of the demographic and risk adjusted rate book, see the following: http://cms.hhs.gov/manuals/116_mmc/mc86toc.asp

1.5.1 County Rate Book (Slide 7)

Since the inception of the M+C managed care program, capitated payments to plans have been set using county-level rates for aged and disabled beneficiaries and state-level rates for beneficiaries with end-stage renal disease. The BBA mandated that the 1997 pre-BBA rate book was the basis for the new M+C rate book.

1.5.1.1 Characteristics of the Managed Care Rate Book Prior to 1997

- Managed care capitated rates were based on average cost experience found in a county for fee-for-service Medicare, using a five year moving average of the county's share of the national average costs.
- County average per capita costs were standardized according to the average demographics observed for beneficiaries in that county—age, sex, institutional status, Medicaid eligibility, and beginning in 1995, working aged status.
- Average county fee-for-service costs were discounted by 5% due to cost efficiency of managed care health management

1.5.1.2 County Rate Book Calculation after the BBA (Slide 8)

In 1997, the BBA changed the method for computing the county rate book. This was done to meet a number of policy objectives, including a desire to create a minimum rate for traditionally low rate counties, and a flattening of the variability of county rates by basing these rates in part on local factors and in part by national experience. Every year after 1997, the M+C rates for each county are defined as the maximum of three possible categories: the blended capitation rate, minimum "floor" amount, or minimum 2 percent increase. This formula broke the direct link between managed care payment rates and fee-for-service spending at the county level.

The M+C rates for each county are defined as the maximum of three rates: the blended capitation rate, minimum "floor" amount, or minimum percent update rate.

Blended Rates	Floor Amounts	Minimum 2%
• Blended rates are a combination of national average rates and local rates. • Under the BBA, the "local" rate is the 1997 county rate (tied to county fee-for-service costs) updated each subsequent year by a national factor—the national M+C growth percentage. • The national rate is a weighted average of all local rates. • The blend percentage for 2003 and beyond is 50%.	• Floor amounts were set by the BBA. • Floor rates are increased annually by the national M+C growth percentage.	• The minimal percentage update amount has generally been an increase of 2% over the M+C rate in the county for the prior year.

TABLE 1A – COUNTY RATE BOOK

Once we know which of the 3 rates is the highest in each county, a budget neutrality factor is applied. The budget neutrality-adjusted rates must be equal to aggregate national Part A and B estimated payments (using the national per capita costs trended 1997 rate book). If rates are not equal, then rates are reduced for blended rate counties in order to attain budget neutrality. In 2004, there are no blended rate counties.

1.5.2 Risk Rate Book (Slide 14)

Once the demographic rates are determined, a rescaling factor is used to convert the demographic rate book to get the risk adjusted rate for each county (referred to as restandardizing the rate book). (Note: The risk adjusted ratebook under the PIP-DCG model and the one under the new CMS-HCC model may be different for a county.) The rescaling factor is defined as the county rate properly standardized to the new risk adjustment factors divided by the demographic county rate.

Two adjustments are included in the 2004 rescaling factor. The first is an adjustment to make risk adjustment budget neutral (distinct from the budget neutrality for rate-setting discussed above) and the second is the fee-for-service normalization factor.

1.5.2.1 Adjustment for Budget Neutrality (Slide 15)

While risk adjustment (without the implementation of budget neutrality) would reduce aggregate payments to the M+C program, budget neutrality redistributes these payments as a constant percentage to organizations affected by risk adjustment (including M+C organizations, PACE, and certain demonstrations). The budget neutrality proportion is calculated as the difference between payments under 100 percent of the risk adjustment method (i.e., under the CMS-HCC model) versus payment under 100 percent of the demographic only method. The budget neutrality adjustment for 2004 is 1.163.

1.5.2.2 Fee-for-service Normalization Adjustment (Slide 16)

The purpose of fee-for-service normalization is to adjust the restandardized rate book to the appropriate denominator for the payment year. The number represents the national average predicted fee-for-service expenditures per beneficiary in that year. Every year there are shifts in the Medicare population. Specifically, fee-for-service coding has not yet stabilized the way hospital coding has. Therefore, a change to the rate book to adjust for coding patterns is necessary. The adjustment for CY2004 is 1/1.05 or .9524.

For a discussion of these issues refer to May 12, 2003 Announcement:
http://cms.hhs.gov/healthplans/rates/

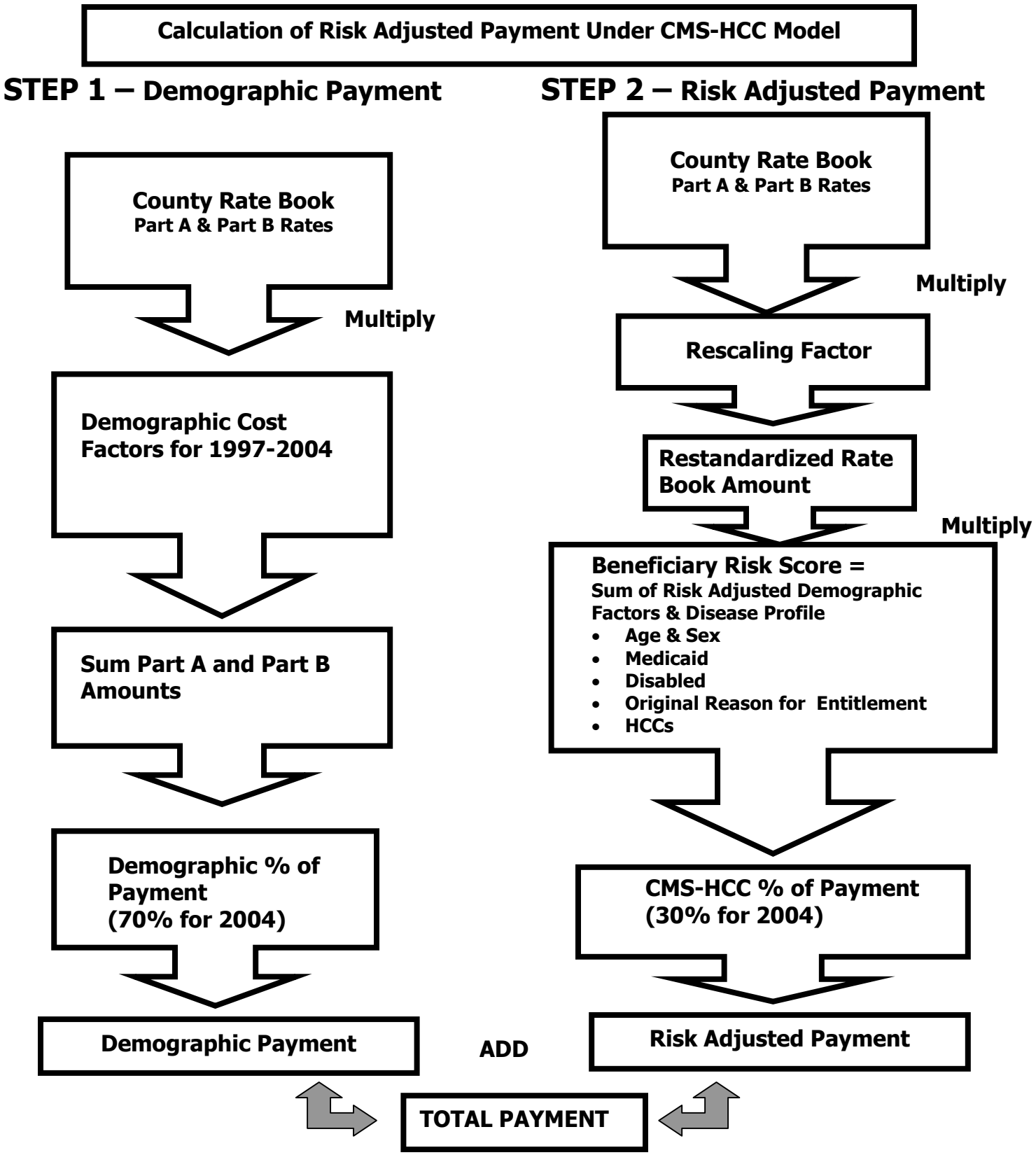


Figure 1A – Calculation of Risk Adjusted Payment Under CMS-HCC Model

NOTE: Until the CMS-HCC is implemented at 100% in 2007, a demographic payment as calculated above will continue to be part of the risk adjusted payment.

📖 The county rate book for 2004 payment is available at: http://cms.hhs.gov/healthplans/rates/

1.5.3 Components of the Risk Score

The risk score used in calculating payments under the CMS-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The model allows for the recognition of coexisting diseases when calculating payment by recognizing multiple chronic conditions that the beneficiary has. Interactions (i.e., combinations) are used to account for expected costs that are higher because, for example, multiple, coexisting diseases cause additional complications. Hierarchies are imposed to provide payments only for the most severe manifestation of a certain disease.

1.5.3.1 Demographic Factors (Slide 18)

The risk score uses five demographic factors in calculating the risk score under the CMS-HCC model, including age, sex, Medicaid status, disability and original reason for Medicare entitlement (i.e., disability). Each of these characteristics was part of the PIP-DCG calculation as well.

Age and Sex: Based upon the enrollee's age and sex, risk adjusted demographic factors are assigned for the calculation of the enrollee's risk factor.

In the past, the model has considered a person's increasing age by placing them into age groups during a given year by either switching the payment group during the year in the demographic payment model or by paying a weighted average of the 2 groups each month to avoid having to switch age groups during the year (as with the PIP-DCG model). Under the CMS-HCC model CMS will now base payments for the entire payment year upon the age an enrollee attains as of **February 1st** of each year. This change will help simplify the M+C payment system.

📖 See Attachment C for the complete list of age and sex risk factors for 2004

Medicaid: The Medicaid status of an enrollee will continue to be part of the risk adjusted payment calculation under the CMS-HCC model, but only for individuals residing in the community.

Medicaid status is defined as at least one month of Medicaid eligibility during the data collection period (which is typically defined as the year prior to payment). New enrollees with Medicaid status will be identified for each month in the payment year and paid at reconciliation.

An individual's Medicaid status will be identified using the Medicare Beneficiary Database (MBD). The source of the Medicaid designation is either from the health plan or from third party payor files.

📖 See Attachment C for the complete list of Medicaid factors for 2004

Disabled Status: Under the CMS-HCC model, additional payments are made for disabled individuals residing in the community. The disabled factors for enrollees under 65 years-old are labeled as "disabled"

and those over 65 years-old are labeled as "aged". Disabled status is identified in the Medicare Beneficiary Database (MBD).

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

1.5.3.2 Disease Groups/HCCs (Slide 21)

Disease groups contain major diseases and are broadly organized into body systems. For risk adjustment purposes, we will refer to disease groups as HCCs. The HCC assigned to a disease is determined by the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modification) diagnosis codes that are submitted during a data collection period. Only selected diagnosis codes are included in the CMS-HCC model. There are 65 distinct disease groups for payment for community residents and 47 disease groups for payment for long term institutionalized persons.

Example 1

Disease Group/HCC	Description
HCC 92	Specified Heart Arrhythmia
HCC 158	Hip Fracture/Dislocation

1.5.3.3 Disease Interactions (Slide 22)

Certain combinations of coexisting diagnoses present in an individual can increase their medical costs. The CMS-HCC model recognizes these higher costs through incorporating payments for disease interactions.

There are 6 disease interactions in the community model and 2 in the institutional model. Examples of the disease interactions include a two-way combination of diabetes mellitus (DM) and congestive heart failure (CHF) or a three-way combination of chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), and coronary artery disease (CAD).

In calculating this part of the risk score for an individual, the individual score for each HCC is added and then the disease interaction score is added. In the example below, the risk adjusted payment would include an additional factor when an enrollee has both diabetes mellitus and congestive heart failure.

Example 2

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

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

In this case, the enrollee receives an additional interaction instead of only 2 factors for HCC15 and HCC80.

1.5.3.4 Disabled/Disease Interactions

Another type of interaction accounted for in the CMS-HCC model involves certain diseases and the disabled status for an enrollee. There are 5 disabled/disease interactions in the community model and two in the institutional model.

Below is an example of an individual who is disabled and has been diagnosed with rheumatoid arthritis and an opportunistic infection.

Example 3

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

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

See Attachment C for the complete list of all HCCs and interactions

1.5.3.5 Disease Hierarchies (Slide 23)

Finally, the CMS-HCC model incorporates disease hierarchies. These hierarchies are used to provide payments for only the most severe manifestation of a disease, when diagnoses for less severe manifestations of a disease are also present in the beneficiary during the data collection year. For example, an individual with diabetes that progresses over a year from having no complications (HCC19) to having acute complications (HCC17) would trigger the payments for HCC17 but not for HCC19. (Note that payments for HCC17 are higher than for HCC19.)

Example 4

Cancer

CMS-HCC DISEASE HIERARCHIES			
If the Disease Group is Listed in This Column…		**…Then Drop the Associated Disease Group(s) Listed in This Column**	
HCC	**Disease Group Label**	**HCC**	**Disease Group Label**
9	Lymphatic, head & neck, brain & other major cancers	10	Breast, prostate, colorectal & other cancers & tumors

See Attachment C for the complete list of disease hierarchies

1.5.4 Beneficiary Disease Profile Data

CMS uses diagnoses from either Medicare fee-for-service or from RAPS for determining the HCCs for an enrollee. Medicare fee-for-service data is utilized for risk adjusted payment when an enrollee joins a M+C organization (or PACE/demonstration) after opting-out of traditional Medicare fee-for-service coverage. That is, if an enrollee new to a M+C organization enrolls in January of a calendar year, then CMS will use up to 12-months of prior fee-for-service data within the data collection period (both Part A and Part B) to obtain diagnostic data. Where data for a person have been submitted via RAPS, those data are also used in calculating the risk score for a person.

1.5.5 New Enrollee Factors (Slide 31)

New enrollee factors have been developed for the CMS-HCC model. The model includes factors for different age and gender combinations by Medicaid status and the original reason for Medicare entitlement. If a beneficiary has less than 12 months of enrollment in Part B during the data collection period, then he/she will be assigned a new enrollee factor. During the payment year, a default factor, which is defined as a new enrollee factor, will also be assigned to any beneficiary whose risk score is not available. In this case, the beneficiary's correct risk score will be determined during the next reconciliation.

New enrollee factors for 2004 are available at:
http://cms.hhs.gov/healthplans/rates/2004/cover-exhibit-3.asp

1.6 Long-Term Institutional Model (Slide 32)

The risk adjustment approach for 2004 now includes separate models for enrollees that reside in a long-term stay institution. Separate models were necessary because there are significant cost differences between the traditional community-based M+C beneficiary population and a long-term institutionalized beneficiary with the same disease profile. An adjustment for place of residence improves the payment accuracy of risk adjustment.

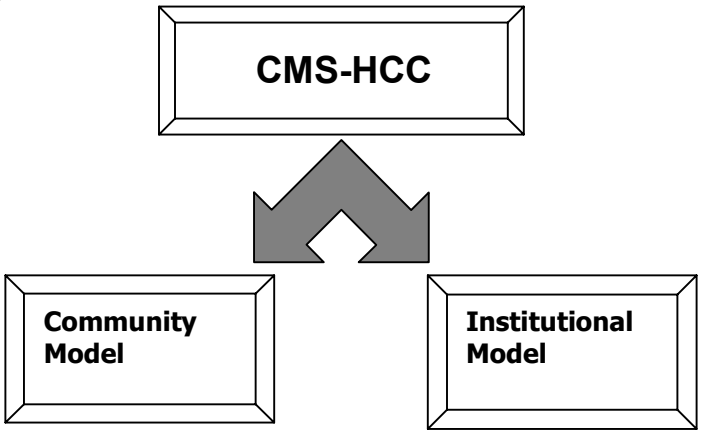


Figure 1B – CMS-HCC Model

A long-term institutionalized M+C enrollee is defined as someone who resides in an institution for more than 90 days as identified using the Minimum Data Set (MDS). The costs of the short term institutionalized (less than 90 days) are recognized in the community model.

As described above, institutional status will be determined from information included in the Minimum Data Set (MDS) that is reported by Medicare certified nursing homes. Under the CMS-HCC model, M+C organizations **will not report** the institutional status of their enrollees. Note: M+C organizations may continue to track the institutional status of their enrollees to ensure that CMS correctly identifies institutional status for demographic payments.

CMS-HCC Model Considerations

Community-Based	Long-Term Institutionalized
• Disease-related incremental payments for the community population are generally higher • Community-based payment includes costs for the short term institutionalized (i.e., less than 90 days in an institution) • Community-based population payment would overpredict costs for long-term institutionalized population, even with the same health status • Currently, most M+C organizations have a small proportion of long-term institutionalized enrollees (less than 20 organizations have more than 5% long-term institutionalized enrollees) • Initially, CMS will assume that all enrollees in most M+C organizations are community-based. Payments will be based during the payment year on the community version of the risk adjustment model. This will minimize tracking problems for M+C organizations. The final reconciliation for a payment year will incorporate the correct institutional status for each enrollee for each month.	• Age and sex payment factors are higher for the long-term institutionalized population • Much of the costs of the long-term institutionalized population are not paid for by Medicare • Institutional model merges a number of disease groups to assure stable coefficients for this population • Long-term institutional status will be recognized in the payment year—more flexible • Minimum Data Set (MDS) collected from nursing homes will be used to identify long-term institutionalized enrollees • The presence of a 90-day assessment and current residence in an institution = long-term institutionalized enrollee • No additional reporting by M+C organizations is required • Enrollees remain in long-term institutionalized status until discharged to the community for more than 14 days

TABLE 1B – COMMUNITY VS. LONG-TERM INSTITUTIONALIZED POPULATIONS

Example 6

Below is an example of the different HCC factors for community versus long-term institutional enrollees.

Disease Group	Description	Community Factor	Institutional Factor
HCC1	HIV/AIDS	0.685	1.344
HCC 8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.464	0.540

See Attachment C for the complete list of CMS-HCC payment factors

1.7 Frailty Adjuster (Slide 34)

The new frailty adjuster is included as part of risk adjusted payments for PACE and certain demonstrations. The purpose of the frailty adjuster is to predict Medicare expenditures 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. A sample of individuals are surveyed to determine this measure.

1.7.1 Why Do We Have a Frailty Adjuster? (Slide 35)

- The Balanced Budget Act of 1997 (BBA) mandated that Medicare capitated payments to PACE (Program for All-Inclusive Care for the Elderly) organizations be based on M+C payment rates, adjusted to account for the comparative frailty of PACE enrollees.
- Risk adjustment does not explain all of the variation in expenditures for the frail, community-based population. So the frailty adjuster is used to explain the Medicare expenditures of community populations with functional impairments that are unexplained by risk adjustment.

1.7.2 Which Organizations Will Be Paid Under Frailty Adjustment? (Slide 36)

Type of Health Plan	Frailty Adjuster is Part of Risk Adjusted Payment
M+C Organizations	NO
PACE (includes all National PACE & PACE demonstration plans)	YES
WPP	YES
MSHO/MnDHO	YES
S/HMOs	YES
EverCare	NO

TABLE 1C – WHO RECEIVES FRAILTY ADJUSTMENT

1.7.3 How Does the Frailty Adjuster Work Under the CMS-HCC Model? (Slide 37)

The frailty adjustment factors were designed to explain (or predict) the difference between actual expenditures and expenditures predicted by risk adjustment for groups with similar functional impairments. Therefore, frailty adjustment is applied in conjunction with the CMS-HCC model. Since the CMS-HCC model adequately predicts the Medicare expenditures of the long-term institutionalized and the under-55 disabled populations, frailty adjustment is needed only for community residents who are 55 and over.

CMS will calculate an organization-level frailty score based on the difficulties in activities of daily living (ADLs) that are reported by enrollees. The frailty score will then be added to the risk score for each 55 and over community resident.

1.7.4 How is ADL Information Collected?

CMS will collect the ADL data from organizations using either the Health Outcomes Survey (HOS) or the PACE Health Survey (PHS). CMS pilot-tested the PHS in 2002 and is implementing it for PACE, MSHO/MnDHO, and WPP in 2003 to support payment adjustment for these organizations in 2004. CMS will use 2003 HOS data to support payment adjustment for S/HMO organizations in 2004.

1.7.5 Calculating the Frailty Score (Slide 38)

The organization-level frailty score will be calculated as the weighted average frailty factor across all 55 and over community survey respondents for that organization. The number of such respondents with difficulty or inability with an ADL will be counted. There are six ADLs: 1) bathing and showering; 2) dressing; 3) eating; 4) getting in or out of bed or chairs; 5) walking; and 6) using the toilet. These counts will be multiplied by the corresponding frailty factor. The resulting products will be summed for each organization. This sum will be divided by the number of 55 and over community respondents, yielding a weighted average factor (or frailty score) for each organization. The same frailty score will be used for all 55 and over respondents and non-respondents of a plan who reside in the community.

This frailty score will be added to the risk score of each 55 and over community enrollee in the organization (including new enrollees), resulting in a risk+frailty score for each individual. Payments to these plans will be the product of this combined score and the risk adjusted county rate. Figure 1-3 below illustrates this calculation and includes the ADL-based frailty factors.

Frailty Adjustment Calculation

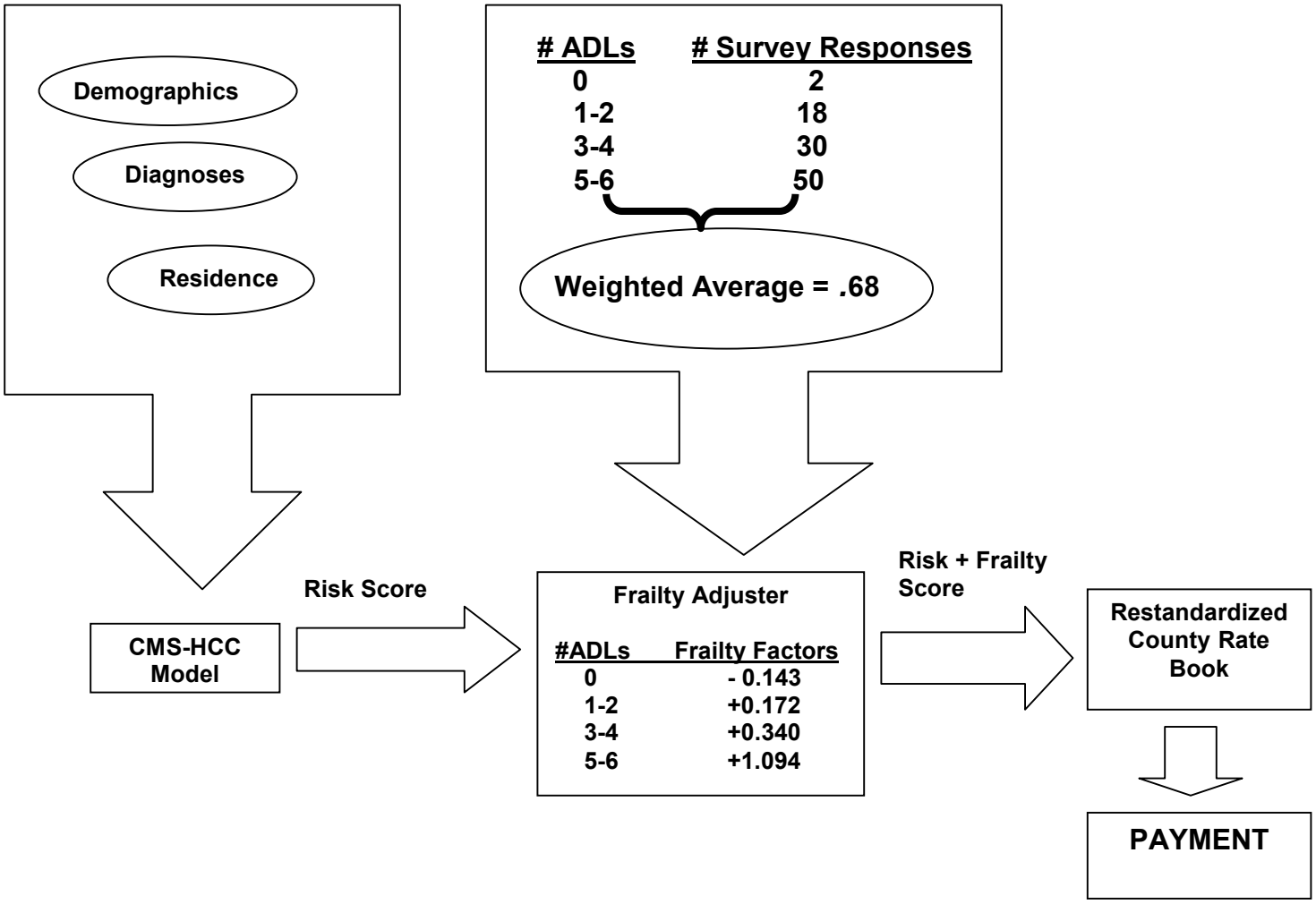


Figure 1C – Frailty Adjustment Calculation

Note: For new PACE organizations not active as of January 1, 2002, the frailty score will be the weighted average factor across all community respondents of all PACE organizations.

1.8 Payment Methodology for M+C End Stage Renal Disease (ESRD) Enrollees (Slide 39)

The implementation of a new payment methodology for ESRD was discussed at the February 3, 2003 national public meeting and addressed in the 45-Day notice published on March 28, 2003. The May 12, 2003 announcement indicated that the ESRD model will be delayed for the M+C program. However, implementation of the ESRD model for the new ESRD demonstrations will occur during 2004. The delay for M+C is due, in part, in response to industry concerns regarding financial impacts on M+C organizations. For 2004, CMS will continue the current method of applying age and sex adjusters to 100% ESRD enrollee payments.

To prepare M+C organizations, however, we are providing a brief description. The ESRD model has 3 parts: a CMS-HCC model for patients receiving dialysis services, a lump sum payment for individuals receiving a transplant, and a modified version of the regular CMS-HCC model for people who have successful kidney transplants.

Dialysis Patients: The dialysis model has the same HCC categories as the CMS-HCC model for the non-ESRD population, except that HCCs with kidney disease diagnoses are excluded (HCC128-HCC132). The model is calibrated only on dialysis patients, so the disease weights used for payments recognize disease and expenditure patterns unique to this population.

Transplant Patients: To pay more accurately for the high costs of kidney transplants CMS will make transplant specific payments to M+C organizations for three months for each member who received a transplant (the three month period begins with the month of the transplant). To derive this amount, CMS calculated a national average cost for three months (the transplant month and two subsequent months) (or $40,000) and divided the average for the three months by three to get the monthly average costs (about $13,333). The ratio of this monthly cost to the national average monthly cost for dialysis patient is the factor. This factor is multiplied by the rate in the dialysis ratebook to determine payment. The draft factor is 3.81 (or $13,333/$3500—which is the national average monthly dialysis cost).

Functioning Graft: The model for functioning graft enrollees is based on the model for the general population, except that HCCs for kidney transplant status, dialysis status, and renal failure are excluded. This means that for their members with functioning grafts, M+C organizations will be paid based on the diseases reported for these members in the prior year. The payment model is a slight modification of the regular model; all the coefficients are the same (with the exclusions noted above) but a factor for the average additional costs of these beneficiaries will be included. (This number has not yet been released.)

Note that a new enrollee model for ESRD beneficiaries has also been developed and will be assigned when the beneficiary has ESRD status and also less than 12 months of Part B experience during the data collection year. The default factor for ESRD beneficiaries with no other risk factor (e.g., dialysis) will be assigned based on this new enrollee model.

1.9 Final Submission of Risk Adjustment Data (Reconciliation) (Slide 40)

CMS will continue to allow a period (approximately 6-8 months after the payment year) for submitting final RAPS data for the appropriate data collection period. Final submission of risk adjustment data (or reconciliation) applies to data that is late or incorrect and was not received by the initial submission deadline for a data collection period. In addition to incorporating new RAPS and FFS diagnoses, the

reconciliation also includes changes to any demographic variables in the model. Note: CMS reconciles risk adjusted payments for a calendar year only one time.

1.10 Payment Blends (Slide 41)

In 2004, the CMS-HCC model will be implemented at a 30% risk adjusted payment, with the remaining 70% represented by the demographic payment. The portion of risk adjusted payment will increase to 50 percent in 2005, to 75 percent in 2006 and finally to 100 percent in 2007. The CMS-HCC implementation schedule is shown in Table 1D below.

Payment Year	Model	Payment
2004	CMS-HCC	70% Demographic 30% CMS-HCC
2005	CMS-HCC	50% Demographic 50% CMS-HCC
2006	CMS-HCC	25% Demographic 75% CMS-HCC
2007	CMS-HCC	100% CMS-HCC

TABLE 1D – RISK ADJUSTMENT IMPLEMENTATION SCHEDULE FOR M+C ORGANIZATIONS

Table 1E below illustrates the risk adjustment implementation schedules for certain specialty plans.

Type of Health Plan	Transition Blend: Represents the percentage of current versus risk adjusted payment portion of payment				
	2004	2005	2006	2007	2008
Program for All-inclusive Care for the Elderly (PACE)	90/10%	70/30%	50/50%	25/75%	100%
Wisconsin Partnership Program (WPP)	90/10%	70/30%	50/50%	25/75%	100%
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	90/10%	70/30%	50/50%	25/75%	100%
Social Health Maintenance Organizations (S/HMOs)	90/10%	70/30%	50/50%	25/75%	100%
EverCare	70/30%	50/50%	25/75%	100%	100%

TABLE 1E – PAYMENT BLENDS FOR SPECIALTY PLANS

1.11 Risk Adjustment Schedule & Elimination of the Payment Lag (Slide 42-44)

Risk adjusted payments were originally implemented with a 6-month payment lag from the end of the collection period to the start of revised payments based on the data collected.

Example 7

Data Collection Period: July 1, 1998 through June 30, 1999
Data Collection End Date: June 30, 1999
CY Year 2000: First payment made based on this collection period = January 1, 2000

As you can see, payments began 6 months after the end of the data collection period.

The purpose of eliminating the lag between the end of the data collection period and the payment based on that year's data is to pay more accurately based on the most recent data.

- Beginning with risk-adjusted payments in about July 2004, the 6-month lag will be eliminated.
- As in the previous years, CMS will calculate a preliminary risk factor based on lagged data (for 2004, it will be based on data from July 2002 through June 2003). Payments from January 2004 through June 2004 will be based on this factor.
- In July 2004 CMS will use a risk factor based on non-lagged data (i.e., from calendar year 2003) for calculating payments. That factor will be used for the remainder of the year.
- The majority of M+C organizations supported the elimination of the data lag.
- By eliminating the lag, the collection period will change from July 1 through June 30 to January 1 through December 31 (or a calendar year).

Process for CY 2000-2003

Data Collection Year:	July 1 through June 30
Submission Deadline for Data Collection Period:	First Friday in September
CMS Risk-Adjusted Payment Calculation Period:	October 1 through November 15
Payment Begins Based on Data Collection Period:	January 1 through December 1
Data Lag Period:	6 months

Initial Process for CY 2004 (Lagged)

Data Collection Year:	July 1, 2002 through June 30, 2003
Submission Deadline for Data Collection Period:	September 5, 2003
CMS Risk-Adjusted Payment Calculation Period:	October 1,2003 through November 15, 2003
Payment Begins Based on Lagged Data Collection Period:	January 1, 2004 through June 1, 2004
Data Lag Period:	6 months

Process for CY 2004 (Elimination of the Lag)

Data Collection Year:	January 1, 2003 through December 31, 2003
Submission Deadline for Data Collection Period:	March 5, 2004
CMS Risk-Adjusted Payment Recalculation Period:	April 1, 2004 through May 15, 2004
Payment Begins Based on Non-Lagged Data Collection Period:	July 1, 2004*
Retroactive Payment Adjustments for January through June 2004:	Approx. August 1, 2004*
Data Lag Period:	0 months

*current estimate

TABLE 1F – RISK ADJUSTED PAYMENT SCHEDULE

Opting-Out of the Elimination of the Lag

- Because a few organizations were concerned about changing risk scores in mid-year (which occurs under the implementation plan for eliminating the lag), CMS is allowing organizations to opt-out of this approach for payment year 2004.
- For organizations that opt out, CMS will use the risk factor based on lagged data (July 1, 2002 through June 30, 2003) for making payments throughout CY 2004.
- In approximately March 2005, CMS will make payment adjustments for the 2004 payments to reflect the difference between payments based on the non-lagged factor and those based on the lagged factor.
- No interest will be paid on these deferred adjustments.

Organizations that desire to opt-out of the standard implementation approach for elimination of the payment lag must notify CMS in writing by March 31, 2004.

CMS Opt-Out Q&As

Q: Can organizations that appear to have lower average non-lagged risk factors than lagged average risk factors (and therefore would owe CMS money) legally opt-out of the implementation approach?
A: This scenario is not likely to occur if organizations submit diagnostic data on a regular basis. CMS will increase the monitoring of data submissions from all organizations to prevent this situation from occurring. The current data requirement is that plans submit some diagnostic data to CMS at least quarterly. This requirement will be strictly upheld; M+C organizations will be required to submit at least 25% of their data on a quarterly basis.

Q: Is CMS able to provide the non-lagged factors on an individual beneficiary level?
A: CMS is examining privacy and operational issues related to this and will provide updates to organizations that opt-out of the implementation approach.

1.12 2003 Estimator Data Impacts (Slide 45)

- In 2003, CMS allowed M+C organizations to submit ambulatory data from July 2001 through June 2002 in order for CMS to calculate an impact estimate based on the CMS-HCC model.
- The deadline for submission of estimator data is June 16, 2003.
- Plan-level impacts based on CMS-HCC 2001/2002 estimator data will be posted in the Health Plan Management System (HPMS).
- Estimates were calculated based on hospital inpatient, hospital outpatient, and physician data.
- These counts include relevant diagnosis codes from Medicare fee-for-service, "encounter" data submitted in the old format, and RAPS data.
- The HPMS Impact Report will include:
  - Number of new enrollees
  - Number of institutional beneficiaries
  - Number of community beneficiaries
  - Risk score for the plan (H number)
  - Risk score for all M+C organizations
  - Estimated percent change in payment for the plan (H #)
  - National estimated percent change in payment
  - Number of beneficiaries per number of CMS-HCC conditions
  - Number of beneficiaries in each HCC

 For more information about accessing HPMS go to the Resource Guide

1.13 Quarterly Diagnosis Counts Report (Slide 46)

- Similar information to that posted for estimate data will be posted in HPMS on a quarterly basis.
- The first counts will be posted in approximately November 2003 and may include only RAPS data.
- Quarterly Reporting:
  Q1 October through December – Posted approx. February 7
  Q2 January through March – Posted approx. May 7
  Q3 April through June – Posted approx. August 7
  Q4 July through September – Posted approx. November 7.

The HPMS report will include two tables:

- Table 1: Number of beneficiaries per number of CMS-HCC conditions
- Table 2: Number of beneficiaries in each HCC

MODULE 2 – RISK ADJUSTMENT PROCESS OVERVIEW

Purpose (Slide 2)

The success of Medicare+Choice risk adjustment is dependent on organizations understanding the process of collecting and submitting accurate risk adjustment data. The purpose of this module is to provide the participants with important terms, key resources, and schedule information that will provide the foundation for this training.

Learning Objectives (Slide 3)

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

- Identify common risk adjustment terminology
- Demonstrate knowledge in interpreting key components of the risk adjustment process
- Interpret the risk adjustment schedule
- Identify the CMS outreach efforts available to organizations

ICON KEY

Example 

Reminder 

Resource 

IT/Systems Track 

Data Collection Track 

2.1 Common Risk Adjustment Terms

Table 2A provides descriptions for common risk adjustment terminology.

TERM	DESCRIPTION
FERAS	Risk adjustment submitters send data to Palmetto through the **Front-End Risk Adjustment System**.
RAPS	Risk adjustment data is processed by the **Risk Adjustment Processing System.**
RAS	The **Risk Adjustment System** will calculate the risk adjusted payment.
MBD	The **Medicare Beneficiary Database** maintains Medicare beneficiary eligibility data.
HPMS	The **Health Plan Management System** is a CMS M+C information system that contains health plan-level data.
Relevant Diagnosis	ICD-9-CM diagnosis code in the CMS-HCC model.

TABLE 2A – RISK ADJUSTMENT COMMON TERMS

2.2 Risk Adjustment Process Overview (Slide 5)

Hospital inpatient, hospital outpatient, and physician risk adjustment data must be submitted at least quarterly. Risk adjustment data will be processed through the Risk Adjustment Processing System (RAPS).

2.2.1 Risk Adjustment Data Requirements

- The data required under the risk adjustment process include:
    - HIC Number
    - Diagnosis Code
    - Service From/Through Dates
    - Provider Type (hospital inpatient, hospital outpatient, physician)
    - Patient Control Number (optional)
    - Date of Birth (optional)
- M+C organizations must submit data at least quarterly to CMS.
- Each quarterly submission should represent approximately one-fourth of the data that the M+C organization will submit during a data collection year. M+C organizations will be monitored to ensure compliance.
- All beneficiary ICD-9-CM diagnosis codes relevant for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period.

2.2.2 Risk Adjustment Data Collection

- M+C organizations may choose to collect data from providers in a variety of formats:
    - Standard fee-for-service claim or encounter formats
        - Full or abbreviated UB-92 v6.0
        - HCFA 1500
        - NSF v3.01
        - ANSI X12 837 v30.51 or v40.10 (HIPAA mandated transactions must use v40.10)
    - Superbill
    - RAPS format
        - HIC Number
        - Provider Type
        - Diagnosis Code
        - Service From Date
        - Service Through Date

2.2.3 Risk Adjustment Data Submission

- M+C organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing any of the following formats:
    - Full or abbreviated UB-92 v6.0 (hospital inpatient and hospital outpatient)
    - NSF v3.01 (physician)
    - ANSI X12 837 v30.51 or v40.10 (all types of data) (HIPAA uses v40.10)
    - RAPS format (all types of data)
    - Direct Data Entry Screen (all types of data)

2.2.4 Risk Adjustment Dataflow (Slide 5)

- Hospital/physician submits data to M+C organization via:
  - Full or abbreviated UB-92 v 6.0, HCFA 1500, NSF v3.01, ANSI x837 v30.51 or v40.10, Superbill or RAPS format.
- The M+C organization submits the data on at least a quarterly basis to Palmetto GBA.
- If the M+C organization submits data via the UB-92, NSF, or ANSI formats, Palmetto will translate the data to the RAPS format.
- If the M+C organization submits the data via Direct Data Entry or in the RAPS format, data does not need translation.
- The data are sent to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
- If any data are rejected, then data will be reported on the FERAS Response Report.
- After passing the FERAS checks the file is submitted to RAPS where detail editing is performed.
- The RAPS Return File is returned daily and shows all records approved and where errors occurred.
- The RAPS Transaction Error Report displays records on which errors occurred.
- The RAPS Transaction Summary Report is sent to the M+C organization daily and identifies the data that have finalized in RAPS database.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report will provide a summary of all diagnoses stored for a given time period.
- RAPS database stores all finalized diagnosis clusters.
- RAS calculates the Risk Adjuster Factors by executing the CMS-HCC model.
- MMCS is used in the calculation of payments and determination of plan payments. MMCS will replace GHP in mid-2004.

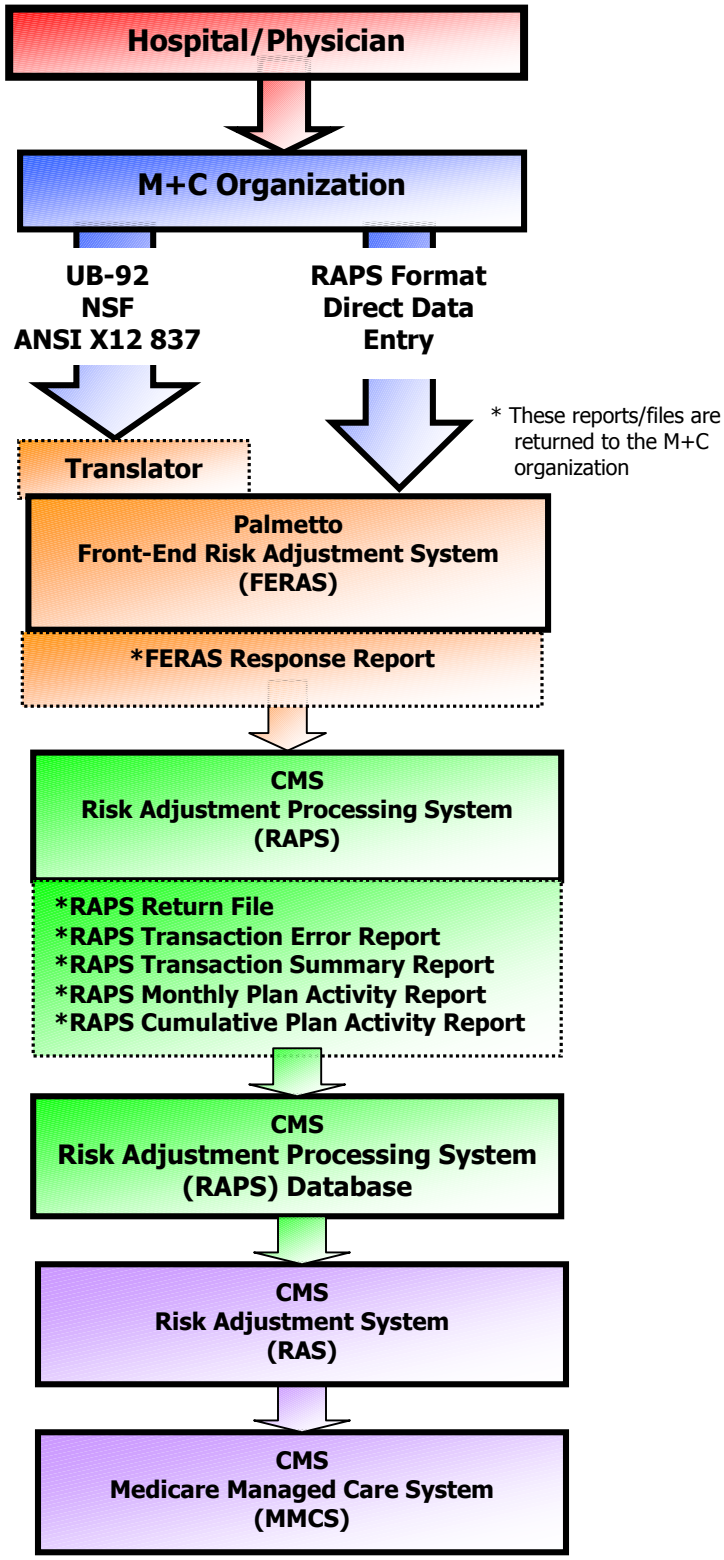


Figure 2A – Risk Adjustment Dataflow

2.2.5 Important Information About Risk Adjustment Processing

- M+C organizations transmit data to the Front-End Risk Adjustment System (FERAS) at Palmetto GBA. If the data are submitted to FERAS via the UB-92, NSF, or ANSI X12 837 formats, the file is automatically translated to the RAPS format.
- FERAS performs format and face validity checks on the file and batch level as well as formatting verification on the first and last detail record (CCC) in the file.
- If the data fail the front-end checks, the complete file is rejected at the front-end.
- The FERAS Response Report identifies whether the file is accepted or rejected up front.
- Once the file has passed front-end checks, it moves to RAPS. All validity edits on detail-level data are performed in this system.
- Processing time from beginning-to-end should take approximately 1 to 2 days.
- After the file has processed through RAPS, the M+C organization will receive a RAPS Return File and RAPS Transaction Error Report identifying any errors.
- All ICD-9-CM diagnoses that pass validity edits are stored in the RAPS database.
- The M+C organization will also receive a RAPS Transaction Summary Report reflecting all finalized data that have been sent to the RAPS Database and all rejected data.
- The M+C organization will also receive two risk adjustment management reports: 1) the RAPS Monthly Plan Activity Report and 2) the RAPS Cumulative Plan Activity Report (monthly).
- All data will be converted to the RAPS format and returned in the RAPS Return File.
- Interim hospital inpatient bills (112, 113, and 114 bill types) must not be submitted. If an M+C organization receives interim bills, submit the hospital inpatient diagnoses on receipt of the final bill (114). This means the appropriate discharge diagnoses will be submitted, rather than the admitting diagnoses, for risk adjustment.

2.3 Submission Schedule (Slide 7)

The elimination of the payment lag changes the submission schedule. This will require the M+C organizations to meet three submission deadlines—the first Friday in September, the first Friday in March of each year, and a yearly reconciliation deadline of March 31 beginning in 2005. These changes are illustrated in Table 2B.

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2003	July 1, 2001 through June 30, 2002	September 6, 2002	January 1, 2003	September 26, 2003
2004	July 1, 2002 through June 30, 2003	September 5, 2003	January 1, 2004	NA*
2004	January 1, 2003 through December 31, 2003	March 5, 2004	July 1, 2004	March 31, 2005
2005	July 1, 2003 through June 30, 2004	September 3, 2004	January 1, 2005	NA*
2005	January 1, 2004 through December 31, 2004	March 4, 2005	July 1, 2005	March 31, 2006
*With elimination of the payment lag, the final submission deadline (reconciliation) changes to March 31st of each year. There is no September 30, 2004 deadline.				

TABLE 2B – SUBMISSION TIMETABLE

2.4 Training and Support (Slide 8)

In an effort to ensure that participating organizations have the necessary tools and information to be successful with the risk adjustment process, CMS has planned the following outreach efforts as described in Table 2C.

INITIATIVE	DESCRIPTION
Customer Service & Support Center	This toll free help line (1-877-534-2772) is available Monday– Friday 9a.m. to 7p.m. ET (with the exception of corporate observed holidays) to provide assistance. The support center provides ongoing assistance. The FERAS system is available for submission of risk adjustment data 24 hours a day, 7 days a week regardless of holidays. The only exception would be from midnight Saturday through noon Sunday when the systems and equipment are routinely maintained.
MCOservice.com	The CSSC website, mcoservice.com is the gateway to the Risk Adjustment Processing System. Visitors to the site can access information about RAPS/FERAS, including opportunities to register for service, enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. Monthly user group and other training information are regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions about risk adjustment. To register for email updates, go to www.mcoservice.com and click on M+CO Email Registration. Then click on "new registration" and complete the registration form.
Onsite Consultation	Onsite consultation visits provide M+C organizations with the opportunity to gain valuable information about risk adjustment data submission and data validation processes. These consultations generally occur between April and May. Each visit includes a review of the M+C organization's system.
Getting Started Training Program	The program presents the basics about the risk adjustment process for M+C organizations and staff new to risk adjustment. It includes a self-paced video, workbook, and resource guide. Expected availability in August 2003.
Regional Training Program	The program provides practical training for new and current users.
Regional Training Video	A video version of the June 2003 training. Expected availability is July 2003.
Physician Training CD	An interactive CD provides important risk adjustment medical record documentation and coding guidelines in accordance with the CMS risk adjustment data collection requirements. It is expected in September 2003.

TABLE 2C – TRAINING AND SUPPORT

MODULE 3 – DATA COLLECTION

Purpose (Slide 2, 2)

For the purpose of risk adjustment, M+C organizations must collect data from hospital inpatient facilities, hospital outpatient facilities, and physicians. The collection of data from the appropriate risk adjustment sources and formats is critical for accurate risk adjusted payment for your organization. This module is designed to offer participants an opportunity to apply data collection principles in accordance with CMS requirements.

Learning Objectives (Slide 3, 3)

Through the analysis of three case studies presented in this module, participants will:

- Identify the sources of risk adjustment data
- Identify risk adjustment and Health Insurance Portability and Accountability Act (HIPAA) rules related to data collection
- Discuss factors that may impact each case study
- Identify potential steps that could be taken to achieve successful data collection

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

3.1 Case Study 1 – Sources of Data (Slide 5)

The Rosemount Health Plan has approximately 25,000 Medicare+Choice enrollees, and has implemented a data collection process for risk adjustment. The plan collected diagnoses for over 300,000 services from various providers for the 2003 data collection period.

The Rosemount Health Plan project manager contacted the CSSC with questions regarding four of the services collected. The first service was submitted for a stay at a network hospital for provider number 33U020. The second service submitted was from a hospital outpatient facility and included several diagnoses from provider number 330033. On the second service, one of the procedures submitted was for a radiology service for a cancer diagnosis. The third service had three diagnoses derived from a home health agency following discharge from the hospital. The fourth service seemed to have a connection to the radiology service submitted on the second service described, except the radiologist submitted it.

Guiding Questions

3.1.1 What are the appropriate sources of data? (Slide 6)

Hospital Inpatient Those facilities that offer medical services that require an overnight stay.

Hospital Outpatient Therapeutic and rehabilitation services for sick or injured persons who do not require inpatient hospitalization or institutionalization.

Physician Medical services provided by a physician or by specific non-physician practitioners as the result of a face-to-face visit.

3.1.2 Are the providers covered entities for risk adjustment? (Slide 7, 6)

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

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

The provider number has six characters. The first two characters are numerals and represent the State/territory as illustrated in Table 3A.

STATE	CODE	STATE	CODE	STATE	CODE
Alabama	01	Kentucky	18	Oklahoma	37
Alaska	02	Louisiana	19	Oregon	38
American Samoa	64	Maine	20	Palau	N/A
Arizona	03	Maryland	21	Pennsylvania	39
Arkansas	04	Massachusetts	22	Puerto Rico	40
California	05	Michigan	23	Rhode Island	41
Colorado	06	Minnesota	24	South Carolina	42
Connecticut	07	Mississippi	25	South Dakota	43
Delaware	08	Missouri	26	Tennessee	44
District of Columbia	09	Montana	27	Texas	45
Florida	10	Nebraska	28	Utah	46
Georgia	11	Nevada	29	Vermont	47
Guam	65	New Hampshire	30	Virgin Islands	48
Hawaii	12	New Jersey	31	Virginia	49
Idaho	13	New Mexico	32	Washington	50
Illinois	14	New York	33	West Virginia	51
Indiana	15	North Carolina	34	Wisconsin	52
Iowa	16	North Dakota	35	Wyoming	53
Kansas	17	Ohio	36		

TABLE 3A – PROVIDER NUMBER STATE ASSIGNMENTS

States and territories are included in the list of Medicare provider numbers.

The third character may be a numeral or a letter, with the exception of **U, W, Y, Z, 5 or 6**. These exceptions indicate that the service was provided in a swing bed component of a hospital or a skilled nursing facility (SNF). The last three characters are numerals unique to the facility. As an additional check, refer to Tables 3B and 3C that provide the acceptable ranges for each of the three sources. The tables below reflect the range of provider numbers for risk adjustment covered hospital entities. Services rendered from provider numbers outside of these ranges are not acceptable risk adjustment data.

Skilled Nursing Facilities and home health care are not covered entities for risk adjustment data.

Type of Hospital Inpatient Facility	Number Range
Short-term (General and Specialty) Hospitals	XX0001 – XX0899 XXS001- XXS899 XXT001 – XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225 – XX1399
Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1990 – XX1999
Long-term Hospitals	XX2000 – XX2299
Rehabilitation Hospitals	XX3025 – XX3099
Children's Hospitals	XX3300 – XX3399
Psychiatric Hospitals	XX4000 – XX4499

TABLE 3B – HOSPITAL INPATIENT COVERED ENTITIES

Type of Hospital Outpatient Facility	Number Range
Short-term (General and Specialty) Hospitals	XX0001 – XX0899 XXS001- XXS899 XXT001 – XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225 – XX1399
Community Mental Health Centers	XX1400 – XX1499 XX4600 – XX4799 XX4900 – XX4999
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1800 – XX1999
Long-term Hospitals	XX2000 – XX2299
Rehabilitation Hospitals	XX3025 – XX3099
Children's Hospitals	XX3300 – XX3399
Rural Health Clinics, Freestanding and Provider-Based	XX3400 – XX3499 XX3800 – XX3999 XX8500 – XX8999
Psychiatric Hospitals	XX4000 – XX4499

TABLE 3C – HOSPITAL OUTPATIENT COVERED ENTITIES

M+C organizations may access the American Hospital Directory www.ahd.com/freesearch.php3, for assistance in determining hospital provider numbers. This web-based search database allows M+C organizations the opportunity to access the Medicare provider number by entering key words, city, state, zip code, or area code. When using the search tool, users should be aware of the following:

- The most effective search option is to select the State where the provider is located.
- When entering the hospital name, users should be aware that the official name of the hospital might be different than what is included in the database.
- Avoid entering abbreviations.

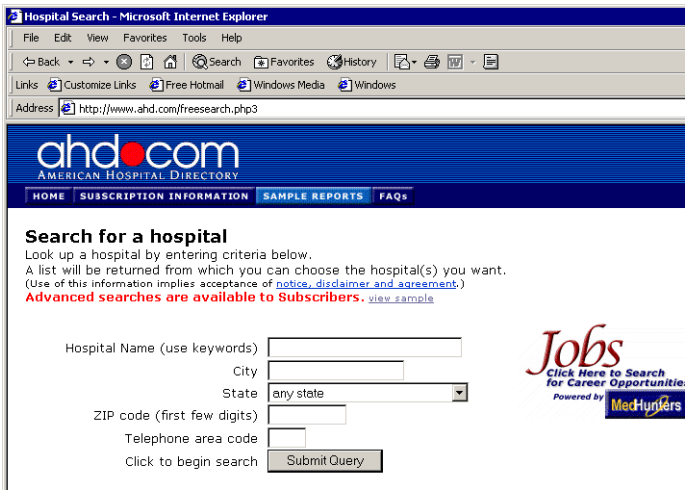


FIGURE 3A – AMERICAN HOSPITAL DIRECTORY

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

Code	Specialty	Code	Specialty	Code	Specialty
01	General Practice	29	Pulmonary Disease	68*	Clinical Psychologist
02	General Surgery	30*	Diagnostic Radiology	70*	Multispecialty Clinic or Group Practice
03	Allergy/Immunology	33	Thoracic Surgery	76	Peripheral Vascular Disease
04	Otolaryngology	34	Urology	77	Vascular Surgery
05	Anesthesiology	35	Chiropractic	78	Cardiac Surgery
06	Cardiology	36	Nuclear Medicine	79	Addiction Medicine
07	Dermatology	37	Pediatric Medicine	80	Licensed Clinical Social Worker
08*	Family Practice	38	Geriatric Medicine	81	Critical Care (Intensivists)
10	Gastroenterology	39	Nephrology	82	Hematology
11	Internal Medicine	40	Hand Surgery	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	41	Optometry (specifically means optometrist)	84	Preventive Medicine
13	Neurology	42	Certified Nurse Midwife	85	Maxillofacial Surgery
14*	Neurosurgery	43	Certified Registered Nurse Anesthetist	86*	Neuropsychiatry
16*	Obstetrics/Gynecology	44*	Infectious Disease	89	Certified Clinical Nurse Specialist
18	Ophthalmology	46*	Endocrinology	90	Medical Oncology
19	Oral Surgery (Dentists Only)	48*	Podiatry	91	Surgical Oncology
20*	Orthopedic Surgery	50*	Nurse Practitioner	92	Radiation Oncology
22*	Pathology	62*	Psychologist	93	Emergency Medicine
24	Plastic and Reconstructive Surgery	64	Audiologist	94*	Interventional Radiology
25	Physical Medicine and Rehabilitation	65	Physical Therapist	97	Physician Assistant
26*	Psychiatry	66	Rheumatology	98	Gynecologist/Oncologist
28	Colorectal Surgery	67	Occupational Therapist	99	Unknown Physician Specialty

*indicates that a number has been skipped

TABLE 3D – ACCEPTABLE PHYSICIAN DATA SOURCES

Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).

Table 3E provides an abbreviated list of excluded facility and service for all types of data. It may be helpful for M+C organizations to develop an internal list of non-covered providers unique to their M+C organization.

PROVIDER TYPE	NON-COVERED FACILITIES/SERVICES
Hospital Inpatient	• Skilled Nursing Facilities • Swing Bed Units of Acute Care Hospitals • Intermediate Care Facilities • Respite Care • Hospice Facilities
Hospital Outpatient	• Laboratory Services • Radiology Services • Ambulance • Durable Medical Equipment • Prosthetic • Orthotics • Freestanding Surgical Centers • Surgical Centers • Dialysis Centers • Supplies
Physician	• Telephone consults • Telemedicine

TABLE 3E– NON-COVERED FACILITIES/SERVICES

Skilled Nursing Facilities and home health care are not covered entities for risk adjustment data.

M+C organizations are responsible for ensuring that data collected and then submitted is acceptable for the risk adjustment process. The Medicare provider number is the most efficient trigger in determining the appropriateness of the covered hospital entities for the purposes of risk adjustment data collection Table 3F illustrates several situations regarding the provider number for covered hospital entities.

Situation	Issue	Action
Situation 1	The provider number has been identified.	Determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, then submit the data.
Situation 2	An in-network provider submitted a claim but did not include the provider number.	Obtain the provider number and determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, then submit the data. NOTE: All network providers are required to have certified Medicare provider numbers; therefore, do not submit risk adjustment data for this provider until the provider number can be obtained.
Situation 3	An out-of-network provider submits a claim without a provider number.	Try to obtain a provider number, if possible. If no provider number is available check the list of Veterans Administration and Department of Defense (VA/DoD) listings published on the mcoservice.com website. If the provider is listed there, submit the data. If the provider is not on the VA/DoD list then the organization may need to contact CMS to determine if the provider is acceptable for risk adjustment.

TABLE 3F – DETERMINING COVERED HOSPITAL ENTITY PROVIDER NUMBERS

3.1.3 Which of the diagnoses presented in Scenario 1 may be included for risk adjustment? (Slide 12)

- Service 1 – The two diagnoses derived from a New York facility, provider number 33U020, were from the swing bed component of the hospital. Diagnoses derived from this record are not acceptable for risk adjustment. The professional component may be submitted as physician data if the physician is not a member of the SNF staff.

- Service 2 – The diagnoses were submitted as hospital outpatient data. Radiology services from a hospital outpatient facility are not acceptable for risk adjustment.

- Service 3 – Diagnoses generated from home health agencies are not acceptable.

- Service 4 – While radiology services are not acceptable under hospital outpatient services, the radiologist may submit the diagnosis on a professional bill.

NOTE: Medicare will not pay for items or services rendered to beneficiaries and recipients by an excluded provider or by entities owned or managed by an excluded provider. Providers are excluded for the following reasons: a program related crime, patient abuse or neglect, health care fraud in any health care program, and convictions relating to controlled substances.

The HHS monthly exclusion notification can be found at http://oig.hhs.gov/fraud/exclusions.html.

3.2 Case Study 2 – Data Collection Formats (Slide 13)

The Greentree Foundation Health Plan is new to the M+C program and has approximately 80 beneficiaries and is growing. The plan has recently contracted with the North Group. This 3-person physician practice currently has 10 beneficiaries that are enrolled in the Greentree Foundation. Greentree Foundation has negotiated a capitated arrangement with the North Group. The providers that cover the remainder of their beneficiaries are through a variety of capitated and fee-for-service contracting relationships. The operations staff realized there were several issues that impacted how they collect data from providers and physicians. The plan is considering the use of superbills for all capitated arrangements including the North Group. The management team has been charged with deciding on the best collection tools for their business.

Guiding Questions

3.2.1 What are the acceptable formats for data collection?

Under the risk adjustment process, CMS allows more flexibility for collecting and submitting risk adjustment data. The focal point of the data collection is the diagnosis. M+C organizations are required to submit, at a minimum, only those ICD-9-CM diagnosis codes that are in the CMS-HCC risk adjustment model. In addition, ICD-9-CM diagnosis codes must be sufficiently specific to allow appropriate grouping of the diagnosis by the model.

The CMS approved formats for data collection are identified below in Table 3G.

Hospital Inpatient/Hospital Outpatient	• Full UB-92 • Abbreviated UB-92 • ANSI X12 837 4010 & 3051 • RAPS format
Physician	• HCFA 1500 • NSF 3.01 • ANSI X12 837 4010 & 3051 • RAPS format • Superbill

TABLE 3G – DATA COLLECTION FORMATS

3.2.2 How much data is necessary to support my organization's business needs?

The risk adjustment model requires that M+C organizations collect a subset of data from their providers/physicians. The minimum data elements that must be collected are:

- HIC Number
- ICD-9-CM Diagnosis Code(s)
- Service From Date
- Service Through Date

While CMS requires that only the minimum data are collected for risk adjustment, M+C organizations should also consider their business needs.

- The organization may decide to collect full claims data for a variety of reasons:
    - The organization has fee-for-service contracts and pays providers and physicians based on the specific service provided to patients.
    - The organization is earning or maintaining Health Plan Employer Data and Information Set (HEDIS) accreditation and is therefore required to collect data that will be used by the National Committee for Quality Assurance (NCQA) to evaluate the plan's performance in areas of customer service, access to care, and claims processing.
    - The organization has established an internal process for credentialing purposes that require evidence of compliance with regulatory and other standards of practice such as Joint Commission on Accreditation of Health Care Organizations (JCAHO). The JCAHO certification requires extensive onsite review to evaluate the health organization's performance in areas that impact healthcare.
- The organization may decide to collect the minimum data set for a variety of reasons:
    - The organization has a capitated payment arrangement with physicians and providers, and pays a fixed amount for services provided.
    - The organization's physicians are paid employees of the managed care plan.

3.2.2 Which data collection tool is best for my organization's needs? (Slide 10)

The decision regarding the data collection tool should be considered carefully, as it may impact the volume and accuracy of data received from physicians and providers. When examining the data collection options, the organization's management should consider the features of each of the approved data collection tools. Table 3H describes key features of each of the data collection tools.

Format	Data Collection Tool Features					
	Paper Format	Full Claims Data	Minimum Data Set	Electronic	Physician Services	Hospital Inpatient/ Outpatient Services
HCFA 1500	●	●			●	
UB-92		●		●		●
Abbreviated UB-92		●		●		●
NSF		●		●	●	
ANSI X12 837		●		●	●	●
Superbill	●		●		●	
RAPS Format	●		●	●	●	●

TABLE 3H – DATA COLLECTION FORMATS AND FEATURES

3.2.4 Are organizations required to collect using one standard format?

The data collection options provided by CMS offer the M+C organization the ability to determine which format works best for each of their providers. A variety of collection formats may be used for different providers. If you are planning to use multiple collection formats, then you may need to consider the complexity and costs associated with supporting these formats (e.g. systems, processes, staffing, etc.).

3.2.5 Do physicians have specific data collection issues?

- Physicians who are accustomed to billing Medicare fee-for-service will utilize the HCFA 1500 or NSF and will be required to use ANSI v40.10 when HIPAA mandated transactions are effective.
- M+C organizations should consider that physicians use data collection formats as part of their normal physician office operations. A common format for collecting data is a superbill.
- As part of the provider contracting process, consider how data will be collected from physicians.

3.2.6 What is the best data collection method for Greentree? (Slide 13)

- Greentree has providers that are under a capitated arrangement. It would be appropriate for these providers to submit data using any of the collection options identified in Table 3H. Greentree should make every attempt to allow the physicians the option that is as close to the collection option currently being used. This will increase the likelihood of receiving accurate and timely data from physicians and providers.
- Since Greentree has a mixture of fee-for-service and capitated arrangements, the superbill is probably not the most appropriate method if a uniform collection method is desired by Greentree.

3.3 Case Study 3 – Risk Adjustment and HIPAA Rules (Slide 14)

The Fair House Health Plan has grown by leaps and bounds. Their Chief Financial Officer (CFO) believes that this is due to the variety of physicians and providers offered to their organization's enrollees. During May 2003, the plan received over 4,000 claims from their providers/physicians by ANSI X12 837 40.10. About 50 percent were from their fee-for-service providers. Another 35 percent were from their capitated providers and about 15 percent were from their staff model providers. They received all of their data in the ANSI format, but realized that they preferred to have all providers use the new RAPS format. The project manager drafted a letter requesting that all providers resubmit their data with dates of service January 2003-May 2003, using the RAPS format.

Guiding Questions

3.3.1 Do the Administrative Simplification Standards adopted by Health and Human Services (HHS) under the HIPAA of 1996 impact the decision on data collection methods? (Slide 15, 12)

- The implementation date of the HIPAA transaction standards has been extended until October 16, 2003. All electronic claims or encounters sent from providers/physicians to M+C organizations (health plans) will constitute a HIPAA-covered transaction.
- When HIPAA goes into effect, all electronic forms must be submitted using the ANSI X12 837 v.40.10.
- HIPAA regulations also state that once electronic data are received, the M+C organizations shall **not** request that identical information in a different format.

3.3.2 Do the HIPAA regulations impact modifying data? (Slide 14)

- Correcting data is not covered under the HIPAA rules. M+C organizations may use any data collection format to request data for the purpose of correcting or clarifying original information.

3.3.3 What is the best data collection strategy for Fair House Health Plan? (Slide 15)

- While the HIPAA transaction regulations have been extended until October 2003, risk adjustment rules state that if M+C organizations collect claims data, regardless of the claims format utilized (paper or electronic), the claims data must be used as the primary source for risk adjustment data.

The risk adjustment instructions can be found in the resource guide.

- According to risk adjustment rules, if a provider/physician has already submitted data, Fair House Health Plan cannot request the same data be resubmitted in another format. Additionally, since 50 percent of their providers are in a fee-for-service contracting arrangement, the RAPS format is not a suitable submission option. Although they are not required to collect full claims data from their capitated and staff model providers, they should consider using a full claims format for all providers.

MODULE 4 – CODING WORKSHOP

Purpose (Slide 2)

The accuracy of medical record documentation and coding support risk adjusted payments to M+C organizations. Educating providers and physicians on general coding guidelines is key to the success of collecting appropriate and accurate data from providers and physicians. The purpose of this module is for participants to gain an understanding of standard medical record documentation and coding guidelines and how those apply to risk adjustment. Topics to be discussed include medical record documentation and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding.

Learning Objectives (Slide 3)

Through the analysis of case studies and exercises presented in this module, participants will learn:

- The importance of medical record documentation for risk adjustment
- ICD-9-CM coding guidelines and common coding issues that apply to risk adjustment

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

4.1 Documentation (Slides 4-7)

Medical record documentation is important because quality documentation leads to correct code specificity and accurate risk adjusted payment. Since CMS makes payments based on the diagnostic data submitted by M+C organizations, CMS validates the data by matching the diagnostic data submitted with the documentation in a patient's medical record. The validation process will be discussed in more detail in Module 12.

Medical record guidelines for risk adjustment do not conflict with any State regulations or requirements for medical record documentation.

M+C organizations must submit risk adjustment data that are substantiated by the patient's medical record. There are five standard elements of quality medical record documentation. Documentation should be:

- Clear
- Concise
- Consistent
- Complete
- Legible

The medical record serves as a means to identify the patient, justify the treatment, support diagnoses, document the patient's progress and results of treatment, and promote continuity of care among healthcare providers. Therefore documentation from any source should identify the:

- Patient
- Date(s) of service
- Provider/physician-all participants in the care and treatment
- Reason for the encounter, visit, or admission
- Care rendered
- Conclusion and response to treatment, if applicable
- Diagnoses
- Follow-up plan, if applicable

One common method of documenting medical record progress notes that contain all the necessary elements is called the SOAP note. Each letter in SOAP stands for a section of the progress notes as follows:

- **S**ubjective: How the patient describes what is wrong.
- **O**bjective: Data obtained by the exam, lab results, vital signs, etc.
- **A**ssessment: Listing of the patient's current condition and status of all chronic conditions. How the objective data relates to the patient's acute problem.
- **P**lan: Next steps in diagnosing the problem further, such as prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

4.2 Case Study – 1 Quality of Documentation (Slide 8)

Evermore Health Plan received several claims for the same beneficiary. Each claim reported the same diagnoses. The claims were received from hospital inpatient, hospital swing bed/skilled nursing facility (SNF) unit, hospital outpatient, home health facility, and primary care physician.

Guiding Questions

4.2.1 Is there a difference in the standard of documentation between provider service types? (Slide 9)

Typically, the quality and type of documentation is different depending on the type of provider. Table 4A illustrates some of the key differences in the standard of documentation. Understanding the differences allows the M+C organization to develop outreach efforts that will meet the needs of the provider/physician regarding documentation practices. Ultimately, quality documentation leads to quality coding.

DOCUMENTATION SOURCE	DOCUMENTATION PRACTICES
Hospital Inpatient	• Generally meets most documentation requirements due to regulatory and certification requirements. • Records are typically arranged in sections, such as progress notes, orders, labs, operative episodes, medications, and nursing notes. • Discharge summaries, history, physicals, consultations, and procedure reports are usually transcribed, which is extremely helpful for legibility. • The most regulated and consistent in storage and retention standards. Retention and destruction of record standards vary from State to State. In the absence of State regulations, it is generally recommended that adult medical records are kept for at least 7 years to allow for the legal statute of limitations. Current technology in record reproduction makes it possible for hospitals to retain the records for much longer in a fraction of the space required for paper records. • The codes submitted by hospitals have most likely been through some level of code edits to assure that the code is, at a minimum, a current, valid, ICD-9-CM code. • Most hospitals also require certified coding staff and maintain coding compliance programs.
Hospital Outpatient	• Typically, records supporting hospital-based outpatient claims are clear and concise. • Documentation includes the patient identification, the procedure or test performed, and emergency room records or clinic progress notes. • Since they are hospital records, many of the same regulations for inpatient records documentation and retention apply.
Physician Offices	• Physician office documentation standards are generally not as rigorous as hospital regulated record standards. • Physician offices range from single practitioners with few office staff to large groups of physicians with a high level of office support and technology. Therefore, their documentation practices vary widely. • The variety of physician documentation includes hand written progress notes, pre-printed check-off forms, transcribed and typed letters, or output from electronic medical records. • Typically, the core source of physician record documentation is hand-written notes. These may require additional analysis by coders and reviewers to accurately extract the information necessary for complete coding. • It is important to determine the author(s) of physician office notes. In addition to a signature, other means of identification of the physician documenting the note may be necessary.

TABLE 4A – COMMON DOCUMENTATION PRACTICES

4.3 Introduction to ICD-9-CM Diagnosis Coding (Slide 10)

One of the many uses of quality medical record documentation is to confirm and validate the diagnosis codes that are reported for risk adjustment. This section will address how the coding process works and why clear, concise, consistent, complete, and legible documentation of diagnoses is so important. Appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis coding is important for risk adjustment because:

- The Medicare program recognizes ICD-9-CM as the official diagnosis code set for all providers.
- The CMS-HCC model utilizes ICD-9-CM codes for risk payment calculation.
- Organizations are required to submit, at a minimum, all relevant ICD-9-CM diagnoses that are in the CMS-HCC model for risk adjusted payment.

Official ICD-9-CM guidelines are available through the CDC web site: www.cdc.gov/nchs/data/icd9/icdguide.pdf.

The most recent official guideline revision is also published in *Coding Clinic for ICD-9-CM*, second quarter, 2002. The AMA Central Office on ICD-9-CM publishes quarterly official code advice in *Coding Clinic for ICD-9-CM*.

The Coding Clinic for ICD-9-CM is the approved resource to update and clarify official coding guidelines. The small volumes (typically about 20 pages) include clarifications of previous advice and guidelines or new information on a specific diagnosis coding practice by means of articles and a question and answer section.

ICD-9-CM Coordination and Maintenance Committee updates the ICD-9-CM. A transcript of the diagnosis part of the committee meetings is available on NCHS' website at http://www.cdc.gov/nchs/icd9.htm.

The ICD-9-CM updates are effective October 1st each year with a 90-day grace period for providers and M+C Organizations to submit either the old or new codes while making changes to their internal forms and systems.

4.3.1 ICD-9-CM Basic Steps and Guidelines (Slides 11-12)

A basic understanding of the ICD-9-CM process can assist the organizations in:

- Determining possible causes of ICD-9-CM coding errors
- Communicating diagnosis related collection issues to provider staff
- Developing and maintaining information systems that meet the clinical data collection needs of the organization
- Understanding and communicating with beneficiaries on clinical issues important to them
- Planning for future services

Example 1:

Using the steps in the Quick Facts ICD-9-CM Coding Process determine how the provider in the following example selected the codes.

A diagnosis of ***spontaneous compression fracture of the vertebrae*** was collected from a hospital outpatient facility department.

Step 1 Find the term that most broadly describes the disease or injury in the ICD-9-CM **Alphabetic Index.**

Definition: **Alphabetic Index** is also known as Volume II of ICD-9-CM. It is an index of all diseases and injuries categorized in ICD-9-CM. When a code is listed after the description, it means to look up that code in the Tabular Index to determine if that is the most specific code to describe the encounter.

Main term: *fracture*

Step 2 Determine if any other terms in the diagnosis are **non-essential modifiers,** located in the parentheses next to the main term.

Non-essential modifiers: *(compression)*

Definition: **Non-essential modifiers** are descriptors located in parentheses next to the main term. The presence or absence of these terms does not affect the coding of the main term.

Step 3 Determine if **subterms** are indented below the main term. Follow all cross reference instructions such as "*see*……..". The indented subterms describe the increasing levels of specificity. In this example the code for fracture, 805.8 is not correct and should not be reported because a more specific subterm is described in the documentation.

Definition: **subterms** are words that are related to the main term.

Subterms : spontaneous- *see* Fracture, pathologic

Pathologic	733.10
Vertebra	733.13
Vertebra	805.8
pathologic	733.13

The correct code can be found no matter which subterm is referenced first.

Step 4 Find the subterm code (733.13) in the **Tabular Index** and read all notes and references provided as well the description of codes in the same category.

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

Step 5 Determine the final diagnosis code for spontaneous compression fracture of the vertebrae.

Final code 733.13

When determining the correct code for a diagnosis there may be a notation of **NOS**, Not Otherwise Specified in the Tabular Index. Unspecified means that there were no other descriptions in the medical documentation to be able to assign a specific code. Do not use a code or term labeled with NOS where there is a more specific term in the same category.

Another common term found in the tabular index is **NEC**, Not Elsewhere Classified. This differs from NOS in that there is a more specific description in the medical documentation, but ICD-9-CM does not have a code appropriate for the level of specificity.

Other coding conventions are located in the front of the ICD-9-CM coding manual. Manuals are available from various publishers. The actual codes, conventions, and basic format are identical across publishers. Areas where they differ are in the level of detail on medical definitions, illustrations, and resource references. In addition to coding conventions, it is important to understand some of the various guidelines regarding coding in general.

4.4 Case Study 2 - Reporting Diagnoses (Slides 13-14)

Rosemount Health Plan requested several medical records from providers due to questions that arose after reviewing the claims of one of their enrollees. They wanted to determine if the diagnoses were reported correctly. Based on the medical record documentation of the first hospital inpatient claim, the chief complaint was a cough, code 786.2. The final diagnosis on the hospital inpatient medical record was simple bronchitis, code 491.0 and a history of lung cancer, code V10.11. The plan also requested documentation from a hospital outpatient facility to support the submitted diagnosis of AIDS, code 042. The documentation indicated that the patient was HIV positive and AIDS was suspected. Finally, the plan questioned a physician office bill that had abnormal findings of the lung, code 793.1, but the radiology report received stated "rule out recurrent lung cancer". Rosemount submits all diagnoses they collect (not only the ones in the CMS-HCC model). The compliance manager is unsure if the diagnoses submitted for this enrollee were accurately coded.

Guiding Questions

4.4.1 What diagnoses should be coded and reported?

All diagnoses that impact the patient's care should be documented in a medical record. This includes the main reason for the episode of care and all co-existing, acute or chronic conditions, and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded.

4.4.2 Do the codes have to be reported in a certain order?

Hospital inpatient codes have to be reported with the principal discharge diagnosis listed first. For hospital inpatient data, secondary codes are then listed in a basic order of importance with those impacting reimbursement listed higher than those not impacting reimbursement.

Principal diagnosis is that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

Hospital outpatient and physician coding guidelines do not have a designated principal diagnosis, but it is recommended that providers use the same logic in reporting the codes. The term "first listed diagnosis" is synonymous with principal diagnosis in that it should be the reason "chiefly responsible for the services provided" followed by other conditions that impact care and risk adjustment. These guidelines for reporting outpatient and physician diagnoses are included in the above referenced official guidelines *Coding Clinic for ICD-9-CM*, second quarter, 2002 beginning on page 68. These do not conflict with risk adjustment instructions concerning reporting of all relevant diagnoses.

4.4.3 Should providers/physicians report a diagnosis if it has not been established at the conclusion of the visit? (Slides 15-17)

The coding guidelines differ for inpatient and outpatient reporting regarding this question. Hospital inpatient claims can report diagnoses that are still under investigation. These may be documented in the final diagnostic statements with descriptors such as "rule out", "suspected", or "probable" and then coded as if the diagnosis was confirmed. The one exception to this rule is in the case of AIDS. Unconfirmed cases of AIDS should not be reported as AIDS. Other codes such as HIV+ (code V08) may be indicated.

Hospital outpatient and physician claims, however, must report the diagnoses to the highest degree of certainty known at the time of the visit. Outpatient facilities and physician offices should not report unconfirmed conditions. Instead, the patient's chief complaint described as a symptom or abnormal test result would be the reported diagnosis.

4.4.4 Do V codes and E codes need to be reported? (Slide 18)

It is recommended that providers and physicians report all diagnoses to the M+C organization. This includes V codes and E Codes. Some V codes and E codes are included in the risk adjustment model, so it is important that those codes are captured and submitted to CMS.

The list of V codes and E codes pertinent for risk adjustment can be found in the Resource Guide.

V codes pertain to a section of ICD-9-CM diagnosis codes that represent factors that influence health status or describe contact with health services. They are used to describe those circumstances or reasons for an encounter other than for disease or injury. For example, code V55.0, attention to gastrostomy, would be reported for a patient admitted only to have a gastrostomy tube changed.

E codes are a supplemental classification included in ICD-9-CM used for reporting external causes of injury and poisonings. The CMS-HCC model includes codes E950-E959 describing suicide or self-inflicted injuries.

4.4.5 Are the claims coded accurately?

Claim 1 – The chief complaint on the physician record was a cough 786.2 and the final diagnosis was simple chronic bronchitis, code 491.0. The documentation supports that there has been a history of lung cancer, code V10.11. It is appropriate to code the chronic bronchitis. The cough, however, is a common symptom of bronchitis, so it should not be reported. The history of lung cancer could potentially impact the treatment of the current problem, so it should be coded.

Claim 2 – The medical record indicates that AIDS was suspected, but not confirmed by the hospital outpatient facility, therefore the 042 cannot be reported. The plan should request a correction from the provider to reflect the correct code V08. While the suspected AIDS diagnosis cannot be reported, the confirmed HIV positive should be reported. While all V codes are not included in the CMS-HCC model, VO8 is included.

Claim 3 – The abnormal lab findings can be reported since the claim was received from a physician. "Rule out" conditions are not to be coded for physician visits.

4.5 ICD-9-CM Codes and Risk Adjustment

As previously stated in Module 1, the CMS-HCC model utilizes ICD-9-CM diagnosis codes. Short-term acute conditions, while costly in the year in which they occur, are not typically included in the predictive model. For example, fractures requiring long term follow up and potential for re-injury such as the skull, hip, and vertebrae are in the model, but other acute fractures are not.

4.5.1 Level of Code Specificity

CMS recommends that organizations collect all diagnoses from all applicable provider types. In all cases, coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model. If the organization collects data using an encounter or claim format, the codes should already be at the highest level of specificity.

Note that any transaction covered by the Health Insurance Portability and Accountability Act (HIPAA) standards must only contain valid ICD-9-CM codes. HIPAA also requires coding to the highest level of specificity.

At a minimum, submitted ICD-9 codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. In all cases, a medical record must substantiate all diagnostic information provided to CMS.

4.5.2 Clinical Specificity (Slide 19)

Specificity in documentation impacts both coding and risk adjustment. One area in which this is particularly true is in the coding of cancer codes. There are 4 HCC's relating to cancer representing over 600 ICD-9-CM codes in the new model. These include:

- HCC 7 Metastatic Cancer and Acute Leukemia
- HCC 8 Lung, Upper Digestive Tract, and other Severe Cancers
- HCC 9 Lymphatic, Head and Neck Cancers
- HCC 10 Breast, Prostate, Colorectal and other Cancers and Tumors

There are very specific guidelines for cancer coding. Cancer codes are located in Chapter 2 of the ICD-9-CM Tabular Index. Three factors must be taken into consideration when determining the correct code.

1. Behavior of the neoplasm—This factor describes whether the cancer is malignant, benign, or of uncertain or unspecified behavior. Often the most common behavior of a specific histological type of cancer can be located in the index. For example, the entry under *Adenoma* states "see neoplasm by site, benign." The entry under *Adenocarcinoma* states "see neoplasm by site, malignant."

2. Site of the neoplasm—If the cancer is malignant, it should be described as a primary site or secondary (metastatic) site. If only one site is mentioned, it is assumed to be primary in most cases. Documentation should also specify if metastasis is to a site or from a site. For example, the term "Metastatic Lung Cancer" is translated as primary cancer in the lung, metastatic to another site for coding purposes. The term "Lung Mets" is translated as secondary cancer in the lung from a primary cancer in another site. The original site may have already been removed or eradicated.

3. Reason for admission or visit—The third factor is to determine the thrust of treatment. This is particularly important in the coding of hospital inpatient claims in which the designation of a principal diagnosis is required. Treatment can be addressing the primary or metastatic site, or both. The encounter may also be for a related adjunct therapy (chemotherapy or radiation) or for cancer-related complications such as anemia or dehydration.

The ICD-9-CM alphabetic index contains a table of neoplasms divided by these factors. The next step in coding a cancer diagnosis, after looking under the histological type of cancer in the index, is to reference this table alphabetically by anatomical site. Finally, confirm the diagnosis selected in the Tabular Index.

Example 2

Using the following neoplasm table section (Table 4B), locate the correct code for Lower Esophageal Adenocarcinoma.

Neoplasm	Malignant			Benign	Uncertain Behavior	Unspecified
	Primary	Secondary	Ca Insitu			
Esophagus	150.9	197.8	230.1	211.0	235.5	239.0
Abdominal	150.2	197.8	230.1	211.0	235.5	239.0
Cervical	150.0	197.8	230.1	211.0	235.5	239.0
Contiguous site	150.8	-	-	-	-	-
Distal (third)	150.5	197.8	230.1	211.0	235.5	239.0
Lower (third)	150.5	197.8	230.1	211.0	235.5	239.0
Middle (third)	150.4	197.8	230.1	211.0	235.5	239.0
Proximal (third)	150.3	197.8	230.1	211.0	235.5	239.0
Specified part NEC	150.8	197.8	230.1	211.0	235.5	239.0
Thoracic	150.1	197.8	230.1	211.0	235.5	239.0
Upper (third)	150.3	197.8	230.1	211.0	235.5	239.0

4B – NEOPLASM TABLE

A list of the neoplasm guidelines from the Official ICD-9-CM Guidelines is located in the Resource Guide and at www.cdc.gov/nchs/data/icd9/icdguide.pdf.

4.5.3 Identifying and Communicating Documentation Needs to Physician Offices (Slide 22)

Communication between the M+C organization and the physician office may need more information than the diagnosis code, if it appears that additional specificity is needed. There will be instances where the M+C organization needs to request more information, clarification, or corrected data. Understanding the basics of the documentation and coding process helps the organization identify potential sources of errors and therefore offer solutions that will improve the accuracy and completeness of the data collected. Two common sources of error are described below.

1. Lack of clinical specificity—This is one area that may indicate a problem in translating medical record documentation to the appropriate diagnosis code. Example 3 illustrates this point.

Example 3 (Slide 21)

Physician office visit billing form states:

Diagnosis: "Ovarian Cancer" status post oophorectomy 1997
Procedure: CAT scan of the chest
Plan: refer to oncologist.

Using the neoplasm guidelines as a reference, how should the physician office staff proceed with coding and reporting this encounter?

Given only this information, the only code that would be appropriate is V10.43 history of ovarian cancer. The secondary site may be suspected but cannot be coded at this point. The patient was referred to an oncologist and has had a CAT scan. If the results of the CAT scan and referral were now available in the record, the physician may have documented a more specific diagnosis.

The office staff needs to determine if the physician notes truly reflect the diagnosis that was reported to the M+C or does a correction need to be submitted.

2. Incorrect use of the ICD-9-CM manual—Coding errors may occur when the full ICD-9-CM manual is not used. Many physician office staffs rely on preprinted charge forms to match diagnosis narrative to codes. In many situations, these forms should only be used as a link to the ICD-9-CM manual in order to report the most specific code to the organization. The organization can assist physicians in identifying common areas of undercoding and encourage them to communicate the full narrative of the diagnosis to their office staff for complete coding. This, of course, also means that the office staff needs to be more fully trained in ICD-9-CM and know when to request additional information or clarification regarding collected data.

4.6 Medical Record and Documentation Tips

The following tips should be shared with providers/physicians:

- Verify that all diagnosis codes reported can be supported by source medical records
- Communicate the full description of the diagnoses on the claim/reporting form
- Document all secondary diagnoses that impact clinical evaluation, management, and treatment
- Use the current version of ICD-9-CM
- Use codes to the highest level of specificity
- Train office staff in ICD-9-CM basics

MODULE 5 – DATA COLLECTION STRATEGIES

Purpose

Risk adjustment training has been a combination of theory and practice. The purpose of this module is to take the text even further—"out of the classroom"—and into real practice at the M+C organization level. Presenters from M+C organizations will share risk adjustment implementation challenges and solutions during this interactive module.

Learning Objectives

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

- Identify unique challenges to RAPS implementation and data collection
- Recognize key elements that M+C organizations have used to facilitate implementation
- Identify other recommendations that can be used to further enhance data collection

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

5.1 Blue Shield of California

Blue Shield is a non-profit health plan with an M+C membership of over 70,000. They have been involved with Medicare+Choice since 1998. They have a stable staff of five systems analysts and one shared administrative person. They attribute stability to cross-training and the ability of staff to serve in more than one position.

- **Successes**
  - Industry Collaboration Effort (ICE) - Collaboration of health plans, providers, and regulatory agencies seeking to improve and simplify the regulation of the industry. Collegial exchange of information, suggestions along with provider education tools.
  - Provider education – Identifying under-reporting providers and making in-person or phone contact to improve reporting. Establishing corrective plans.
  - System modifications to accept data from providers.

- **Lessons Learned**
  - Difficulty obtaining sufficient data from sub-capitated providers.
  - Global fee payment, where visits subsequent to procedure are included in the fee paid, so encounters aren't necessarily reported.
  - Inexperienced coders assigned to coding for M+C patients. They have involved the ICE team to improve this situation.

- Designated Providers (unique to California) – responsible to pay claims on the M+C organization's behalf, but may not store and report clinical data.

5.2 Health Alliance Plan (HAP), Michigan

HAP is located in southeastern Michigan and serves 500,000 members overall. Currently 15,238 are senior HMO members.

- **Success – CMS onsite visit identified decrease in data submissions.** HAP worked with CMS to correct the problem of decrease in data submissions, ultimately resulting in increase in premium levels for 2003 and additional premiums for 2002.
  - Identified the data extract had a logic error and by fixing the program and sending in missing admissions, were able to obtain the increase in premium levels.

- **Success – Proactively planned for RAPS**
  - Created new position with overall responsibility for Risk Adjustment/Data Submission process.
  - Created team to rewrite production jobs for data extraction, submission to CMS, development of model to store data, retrieve results, create reports, etc.
  - Worked with major provider to insure capturing of encounter data.
  - Created model for storing monthly submission data, identifying rejected records, correcting and resubmitting records.

5.3 Elder Health Maryland HMO

Elder Health has operated as an HMO since January 2001. As an HMO, Medicare is their only line of business. They have 3,000 members who are medically and socially frail and focus is on those dually-eligible for Medicare and Medicaid. Seventy percent of members live in the community and 30% live in nursing homes.

- **Challenges**
  - How to obtain data from practitioners paid on a capitation basis?
  - How to assure that encounters accurately and completely capture the chronic disease burden of care?

- **Solution- Obtaining data**
  - Tried to include encounter data in contracts, but collection remained variable.
  - Decided to change contracts to FFS arrangements, allowing M+C organization to obtain full claims data, since the payment is dependent on submission. This in turn would also provide adequate encounter data.
  - Enlisted support and commitment from all levels of organization and spoke with providers in advance of initiating change.

- **Solution-Capturing chronic disease burden**
  - Tied ICD-9 coding to reimbursement.
  - Connected diagnoses and co-morbidities to ability to be reimbursed at level 4 and level 5 visits.

5.4 Community Care Organization (CCO), Inc. PACE and Wisconsin Partnership Programs (WPP)

CCO/WPP is a PACE plan providing specialized managed care for frail elderly. Members, numbering approximately 725, receive services in six different sites. Most services – including primary care, some urgent care services, long-term care, and community-based social services-are provided in the member's home. CCO has its own transportation system for members needing services outside the home.

- **Challenge – Data Collection**
  - They use different methods of data collection from the varying providers but have developed a Participant Medical Problem List for primary care providers.
  - System is manual, time-consuming, and utilizes a consultant for coding.

- **Solution – Electronic Medical Record system**
  - Captures data more efficiently.
  - The impact on data submission is still to be determined.

MODULE 6 – DATA SUBMISSION

Purpose (Slide 2, 2)

M+C organizations submit accurate diagnostic data when submitting risk adjustment data. This module will describe the file layout for risk adjustment process submissions.

Learning Objectives (Slide 3, 3)

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

- Understand the RAPS file layout
- Identify the data elements required to submit risk adjustment data
- Locate and describe the diagnosis clusters in the new RAPS format
- Obtain an overview of the Direct Data Entry (DDE) process

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

6.1 Submission Process Requirements

- M+C organizations must have completed an Electronic Data Interchange (EDI) agreement with CMS and submitted the agreement to the Customer Service and Support Center (CSSC) prior to submitting risk adjustment data. The EDI agreement is a contract between the M+C organization and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the M+C organization must sign the document.

- Special arrangements must be made in order to utilize a third party Submitter. If the Submitter will be an entity other than an M+C organization, the Submitter must complete the Submitter ID Application form and the M+C organization must complete the EDI Agreement. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. Regardless who submits the data, CMS holds the M+C organization accountable for the content of the submission.

6.2 Connectivity Options (Slide 5)

The connectivity options are listed in Table 6A, below:

NDM Network Data Mover	• Mainframe-to-mainframe connection • Large data sets • Next day receipt of front end response
FTP File Transfer Protocol	• Modem-to-modem connection • Excellent for medium sized data sets • Requires password and phone line • Same day receipt of front end response
Secure Website	• Extranet site hosted by Palmetto GBA • Ideal for small sized data sets • Point and click features • Same day receipt of front end response • Direct Data Entry is a connection via a Secure Website

TABLE 6A – CONNECTIVITY

6.3 Relevant Diagnosis (Slide 8, 4)

M+C organizations must submit each relevant diagnosis at least once during a report period (currently July 1 – June 30 of each year) for each enrolled beneficiary. A relevant diagnosis must meet the following criteria:

- The diagnosis is included in the CMS+HCC risk adjustment model.
- The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.
- The diagnosis must be collected according to the risk adjustment data collection instructions.

M+C organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that diagnosis was recorded based on a face-to-face visit with one of the three provider types covered under risk adjustment. M+C organizations may submit any diagnoses received from the three covered provider types, including diagnoses that are not in the CMS-HCC risk adjustment model. Diagnoses that are in the model but that were not collected from one of the three provider types shall not be submitted as risk adjustment data.

6.4 Submission Formats

M+C organizations must submit data electronically using one of five formats.

- RAPS Format (for all provider types)
- NSF (physician only)
- UB-92 (hospital inpatient and hospital outpatient)
- ANSI (all provider types)
- Direct Data Entry Screen (all provider types)

6.5 Submission File Layout Logic (Slide 6, 7)

Submissions are organized into three levels of data.

- File-level information—identifies the submitter
- Batch-level information—identifies the M+C organization
- Detail-level information—identifies the beneficiary

A summary of the RAPS file structure follows as Figure 6A.

RT AAA – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BBB.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

RT BBB – BATCH HEADER (M+C Organizations Info)
Must follow RT AAA or RT YYY and must be followed by RT CCC.

- Record ID
- Sequence Number
- Plan Number
- Filler

RT CCC – DETAIL RECORD (Beneficiary Info)
Must follow RT BBB or RT CCC and may be followed by another RT CCC.

- Record ID
- Sequence Number
- Sequence Number Error
- Patient Control Number (optional)
- HIC Number
- HIC Error Code
- Patient Date of Birth (optional)
- Date of Birth Error Code
- Diagnosis Cluster (10 Occurrences)
  - Provider Type
  - From Date
  - Through Date
  - Delete Indicator
  - Diagnosis Code
  - Diagnosis Code – Filler
  - Diagnosis Cluster – Error 1
  - Diagnosis Cluster – Error 2
- Corrected HIC Number
- Filler

RT YYY – BATCH TRAILER
Must follow RT CCC and may be followed by another RT BBB or RT ZZZ.

- Record ID
- Sequence Number
- Plan Number
- CCC Record Total
- Filler

RT ZZZ – FILE TRANSFER
Must follow RT YYY, and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- BBB Record Total
- Filler

DETAIL LEVEL
BATCH LEVEL
FILE LEVEL

Figure 6A – RAPS File Summary

6.6 Diagnosis Cluster (Slide 7, 8)

The diagnosis cluster contains the core information used to calculate a risk adjustment factor. The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- Diagnosis Code

A maximum of 10 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above.

6.7 Provider Type (Slide 9)

Risk adjustment data must be submitted for hospital inpatient, hospital outpatient, and physician services. All provider types may be submitted in the same CCC record. The provider type must be coded accurately. There is one provider type per diagnosis cluster. Table 6B illustrates the code for each provider type.

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

TABLE 6B – PROVIDER TYPES

- All records submitted in the NSF format are considered to be physician records and will automatically be translated to the 20 provider type. M+C organizations must submit only those data that qualify as physician data when using the NSF.

- All records submitted on the UB-92 must include a type of bill so that the correct provider type can be translated. Bill types are illustrated in Table 6C.

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

TABLE 6C – BILL TYPES

6.8 From and Through Dates (Slide 10)

- Format should always be "CCYYMMDD".
- "Through Date" determines the date of service.

From and Through Dates for each provider type are illustrated in Table 6D.

PROVIDER TYPE	FROM DATE	THROUGH DATE
Hospital Inpatient	Admission Date	Must have a through date and must be the discharge date
Hospital Outpatient	Exact date of patient visit or the first date service began for a series of services	Exact date of patient visit or the last date of service for a series of services
Physician		

TABLE 6D – FROM AND THROUGH DATES

Example 1

June 30, 2002 should be submitted as 20020630.

When a submitter submits a "from date" and no "through date" for physician or hospital outpatient services, RAPS will automatically copy the "from date" into the "through date" field.

Interim bills (112, 113, & 114 bill types) are no longer accepted. If an M+C organization receives interim bills, then submit the hospital inpatient diagnoses upon the receipt of the final interim bill (114). This means the appropriate discharge diagnoses, rather than the admission diagnoses, will be submitted for risk adjustment.

6.9 Diagnosis Code (Slide 11)

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

6.10 RAPS Format

- Each field of the RAPS file layout is described below in Table 6E.
- The shaded fields represent where new information will be provided on the RAPS Return File after data is processed through RAPS.
- There are two diagnosis cluster error fields because M+C organizations normally can receive up to two errors on any diagnosis cluster.

RAPS RECORD AAA – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	File-Level information that identifies the submitter. This field should always be populated with "AAA".
2	4-9	Required	Submitter ID	Identifies the submitter and should be populated with the six-digit alphanumeric SH# assigned by the CSSC.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. This file name may not be repeated within a 12-month period.
4	20-27	Required	Transaction Date	Specifies the date that the file was submitted to Palmetto and should be formatted as CCYYMMDD.
5	28-31	Required	Production Test Indicator	Must be populated with "PROD" or "TEST". Submission test data will proceed through the entire process.
6	32-512	Spaces	Filler	Must be populated with 481 spaces. The filler field allows for additional fields in the future.

RAPS RECORD BBB – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Batch-level information that identifies the M+C organization. This field should always be populated with "BBB".
2	4-10	Required	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one. This is a numeric field.
3	11-15	Required	Plan Number	Identifies the M+C organization and should be populated with the five-digit alphanumeric H# assigned by CMS.
4	16-512	Spaces	Filler	Must be populated with 497 spaces. The filler field allows for additional fields in the future.

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Detail-level information that identifies the beneficiary information. This field should always be populated with "CCC".
2	4-10	Required	Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return this field will be populated with an error code if RAPS finds an error in the sequence number or will remain blank if no errors were detected in the sequence number.
4	14-53	Optional	Patient Control Number	This optional field may be used by the M+C organization to identify the claim submitted. The field allows up to 40 alphanumeric characters.
5	54-78	Required	HICN	The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces not zeros in unused spaces.
6	79-81	RAPS RETURN	HICN Error Code	This should be submitted with spaces. Upon return this field will be populated with an error code if RAPS finds an error in the HIC number or remain blank if no errors were detected in the HIC number.
7	82-89	Optional	Patient DOB	This optional field may be populated with the patient's date of birth and used to verify that the correct beneficiary was submitted. If the field is populated it must be formatted as CCYYMMDD. If this field is populated, CMS will edit this field against the information on file at the MBD. If no DOB is submitted, then fill with spaces.
8	90-92	RAPS RETURN	DOB Error Code	This field must be submitted with spaces. Upon return this field will be populated with an error code if RAPS finds an error with DOB or remain blank if no errors were detected in the DOB.

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
	93-412	DIAGNOSIS-CLUSTER (10 occurrences)		The following 8 fields (9.0-9.7) may be repeated 10 times in the same 'CCC' record with one diagnosis per cluster. Each diagnosis cluster must contain 32 characters or spaces. If there are more than 10 diagnoses, a new 'CCC' record must be established.
9.0		Required	Provider Type	This two-digit alphanumeric field identifies the site of service provided (01,02,10,20).
9.1		Required	From Date	For hospital inpatient this describes the admission date. For physician and hospital outpatient this field describes the date of service. Must be formatted as CCYYMMDD.
9.2		Required	Through Date	For hospital inpatient this describes the discharge date. For physician and hospital outpatient this field may be left blank and the system will fill with the From Date. Must be formatted as CCYYMMDD.
9.3		Conditional	Delete Indicator	This field allows the M+C organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS Database. Enter a "D" or space.
9.4		Required	Diagnosis Code	This field is populated with the three to five-digit ICD-9-CM diagnosis code. The decimal is implied and should not be included (e.g., 42732).
9.5		SPACE	Diagnosis Code Filler	This field is designed to allow space for future ICD-10-CM codes and any other growth in the diagnosis cluster. This field must be populated with spaces.
9.6		RAPS RETURN	Diagnosis Cluster Error 1	This field must be submitted with spaces. Upon return, this field will be populated with one error code if RAPS finds an error in the diagnosis cluster, or remain blank if no errors were detected in the diagnosis cluster.
9.7		RAPS RETURN	Diagnosis Cluster Error 2	This field must be submitted with spaces. Upon return this field will be populated with one error code if RAPS finds an error in the diagnosis cluster or remain blank if no errors were detected in the diagnosis cluster.
19	413-437	RAPS RETURN	Corrected HICN	This must be submitted with spaces. If the M+C organization has submitted an outdated HIC, upon return this field will be populated with the most current HICN and the HIC error field will contain an information error code.
20	438-512	Spaces	Filler	Must be populated with 75 spaces. The filler field allows for additional fields in the future.

RAPS RECORD YYY – BATCH TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Batch Trailer Information should be populated with "YYY".
2	4-10	Required	Sequence Number	7-digit numeric character identifying the batch submitted. Must match the **BBB** record.
3	11-15	Required	Plan Number	H# assigned by CMS to identify the M+C organization. Must match the H# in the corresponding BBB record (i.e., the BBB record with the same sequence number).
4	16-22	Required	CCC Record Total	This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001).
5	23-512	Spaces	Filler	Must be populated with 490 spaces. The filler field allows for additional fields in the future.

RAPS RECORD ZZZ – FILE TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	File Trailer Information should be populated with "**ZZZ**".
2	4-9	Required	Submitter ID	Identifies the submitter and must match the 6-digit alphanumeric SH# in the AAA records.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. Must match the File ID in the **AAA** record.
4	20-26	Required	BBB Record Total	This field should total the number of batches in the file. This field is numeric and should be filled with leading zeroes (e.g., 0000001).
5	27-512	Required	Filler	Must be populated with 486 spaces. The filler field allows for additional fields in the future.

TABLE 6E – RAPS FILE LAYOUT

6.11 Modifying Risk Adjustment Data (Slide 13)

Now that the RAPS system is operational, effective October 1, 2002, the new system allows for correction of risk adjustment data via the deletion process. All deletions are related to the diagnosis cluster only.

Duplicate checking is not performed by the new processing system. That is, there are no duplicate-checking edits in FERAS or RAPS.

6.12 Deleting Diagnosis Clusters (Slide 12, 13)

Each diagnosis cluster (provider type, from date, through date and provider type) will be stored separately as a unique cluster associated with a beneficiary's HIC number. If a diagnosis was submitted in error and needs to be corrected, the original diagnosis cluster must be resubmitted with a delete indicator in the appropriate field. **Delete transactions may only be submitted using the RAPS format or the DDE function.** When a delete record is received, CMS will maintain the original diagnosis cluster on file and add to it a delete indicator and the date of the deletion.

6.12.1 Reason to Delete a Diagnosis Cluster (Slide 15)

There are three reasons to delete a diagnosis cluster:

- Diagnosis cluster is submitted erroneously; e.g., data from an interim bill was submitted for hospital inpatient
- Incorrect HIC number was used for submission of a beneficiary's diagnostic information
- Any error in a diagnosis cluster field (i.e., provider type, dates of services, diagnosis code)

Deletions may be submitted within a file, batch, or record containing previously submitted risk adjustment data.

6.12.2 Steps for Deleting a Diagnosis Cluster (Slide 16)

Before deleting an error, verify that the diagnosis cluster appears on the RAPS Return File. Only diagnosis clusters accepted by RAPS and stored in the RAPS Database may be deleted.

There are two methods for deleting diagnosis clusters:

1. Submit **RAPS** format using normal submission process with appropriate HIC number included.
2. Enter information in the diagnosis cluster fields (9.0, 9.1, 9.2, 9.4, 9.5) exactly as it appeared in the original submission.
3. In field 9.3 enter a **"D"** for delete.
4. Enter the appropriate information in all other records to ensure the submission file is complete.
5. Transmit the file to **FERAS**.

OR

1. Enter information via **Direct Data Entry (DDE)** screens available through Palmetto (detailed information about the DDE process is located in Section 6.16).
2. Enter information exactly as it appeared in the original submission.
3. In the **DDE "CCC"** record screen, hit the down arrow key and select **"D"**.
4. Proceed with entering all appropriate information.
5. Submit file via **DDE** to **FERAS**.

6.12.3 M+C Organization Responsibilities Regarding Deletions

- M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS Database.
- If a diagnosis cluster is deleted for the purpose of correcting data, the M+C organization is responsible for submitting the correct diagnosis cluster. Conversely, if the M+C organization submits corrected data, the M+C organization must submit the appropriate deletion records. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same CCC record as the deletion (do not exceed 10 diagnosis clusters per CCC record).
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

6.12.4 2003 Reconciliation Data

After September 27, 2002, payment year 2003 reconciliation hospital inpatient data (discharge dates: July 1, 2001 through June 30, 2002) must be submitted as a 111 or 11Z bill type. The most recent information will be stored. This is similar to the overlay process used prior to the automated *encounter data* adjustment process described above. The "From" and "Through" dates will be checked to identify duplicate transactions and determine which of the duplicate transactions was submitted most recently. The latest version will be utilized in the risk adjustment model, and the remaining submissions will be discarded.

6.13 National Standard Format (NSF)

- NSF format is used to submit physician data.
- Table 6F below describes the minimum data set required for NSF submission. This format is translated into the necessary RAPS data set in FERAS prior to applying the editing process. In order to protect the integrity of the file, the data must be located in the correct position in the flat file format.
- Files processed by FERAS must be submitted with Payor ID C80883 (NSF RT AA0 17.0).

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

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

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

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

TABLE 6F – NSF MINIMUM REQUIRED FIELDS

- All NSF submissions will be translated to Provider Type 20 in CCC 9.0. Only physician data will be accepted via the NSF format.
- CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.
- Record Identifiers DA0 1.0, EA0 1.0, and FA0 1.0 must be populated. These are not optional fields when submitting via NSF.

6.14 UB-92

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

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

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

RECORD TYPE/ FIELD NO	UB-92 POSITION	UB-92 FIELD NAME	UB-92 EXPLANATION	RAPS FIELD	RAPS CROSSWALK EXPLANATION
30 7.0	35-53	HICN	HIC Number	CCC 5	The HIC number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first 9 characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces.
31 15.0	178-182	CONTRACTOR NUMBER	Contractor Number (HMO)	BBB 3 YYY 3	The plan number indicates the unique H number of the M+C organization assigned by CMS.
40 4.0	25-27	TYPE OF BILL	Type of Bill. Must be 11Z or 111 for inpatient, 131, 13Z, 141, or 14Z for outpatient.	CCC 9.0	If 111 or 11Z, this field indicates the provider type for all diagnoses on this encounter will be inpatient. The principal diagnosis on this UB-92 will translate to provider type 01, all other diagnoses to 02. If 131, 13Z, 141, 14Z, this field indicates that all diagnoses will be outpatient.

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

TABLE 6G – UB-92 REQUIRED FIELDS

- CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.
- Record Identifiers 30.1, 40.1, and 70.1 must be populated. These are not optional fields when submitting via UB-92.

6.15 ANSI 837

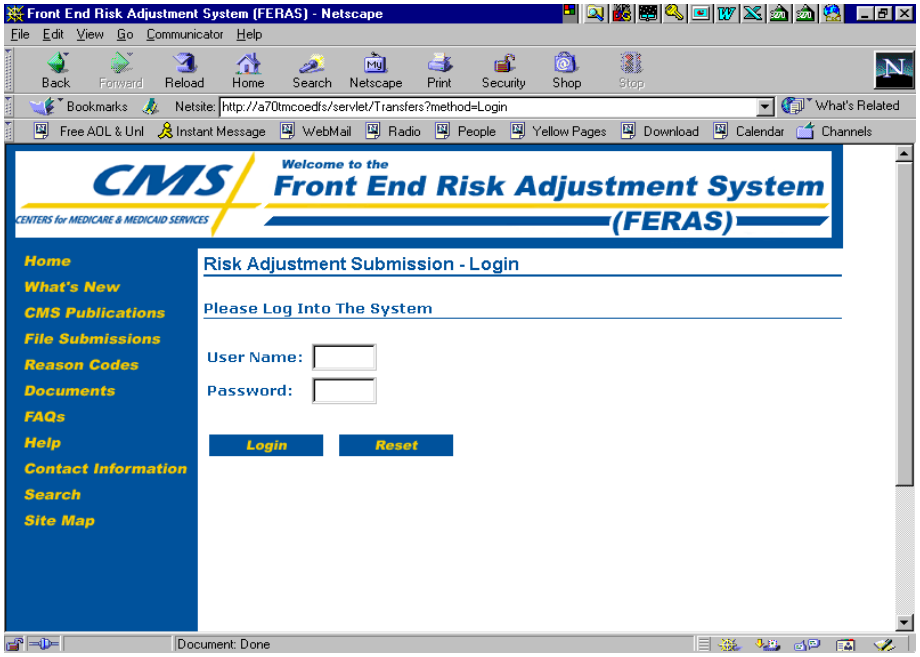
- ANSI 837 is the HIPAA compliant American National Standard Institute electronic format that can be used for data collection.
- This is an optional transmission format for submitting to RAPS.
- Risk adjustment data submitted to CMS is not covered under the HIPAA requirements to use ANSI 837.

See Resource Guide for ANSI crosswalk.

6.16 Direct Data Entry (Slide 14)

M+C organizations have the option of manually entering diagnostic information via the Direct Data Entry (DDE) application offered by Palmetto GBA. Screen shots below provide proposed instructions. DDE is available via the Medicare Data Communications Network (MDCN).

- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 6B through 6G, will automatically prevent the placement of incorrect data characters; e.g., alpha characters will not be accepted in the From or Through Date fields.
- After all screens of the DDE entry have been completed, a message will be generated indicating that the submission has been accepted.
- Similar to all other forms of submission, all DDE submissions will be reported on the Front-End Response Report found in the M+C organization's electronic mailbox.



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

Figure 6B – DDE 1

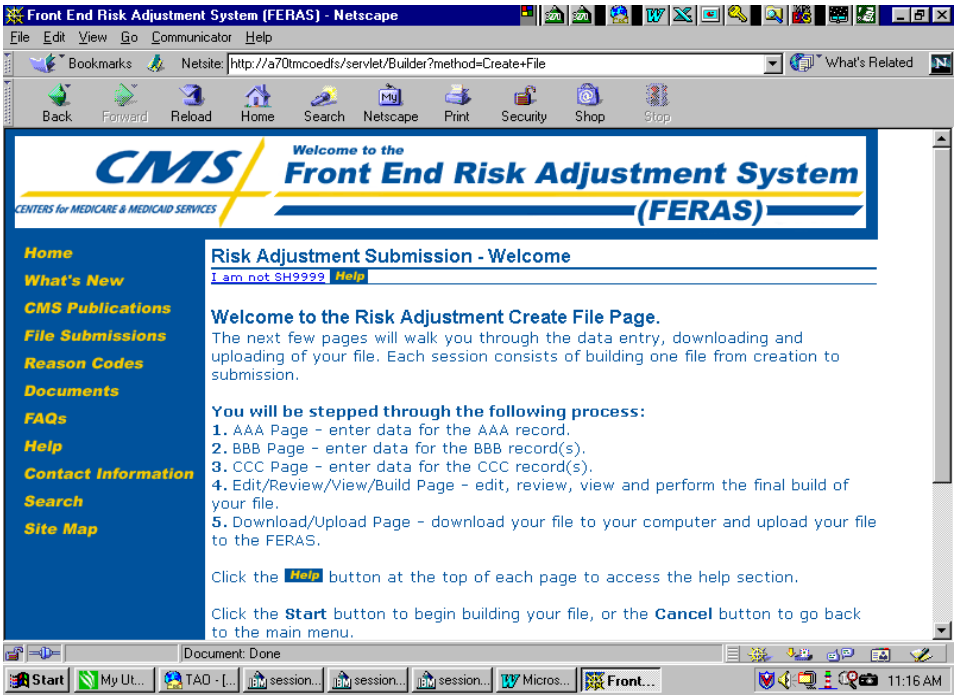
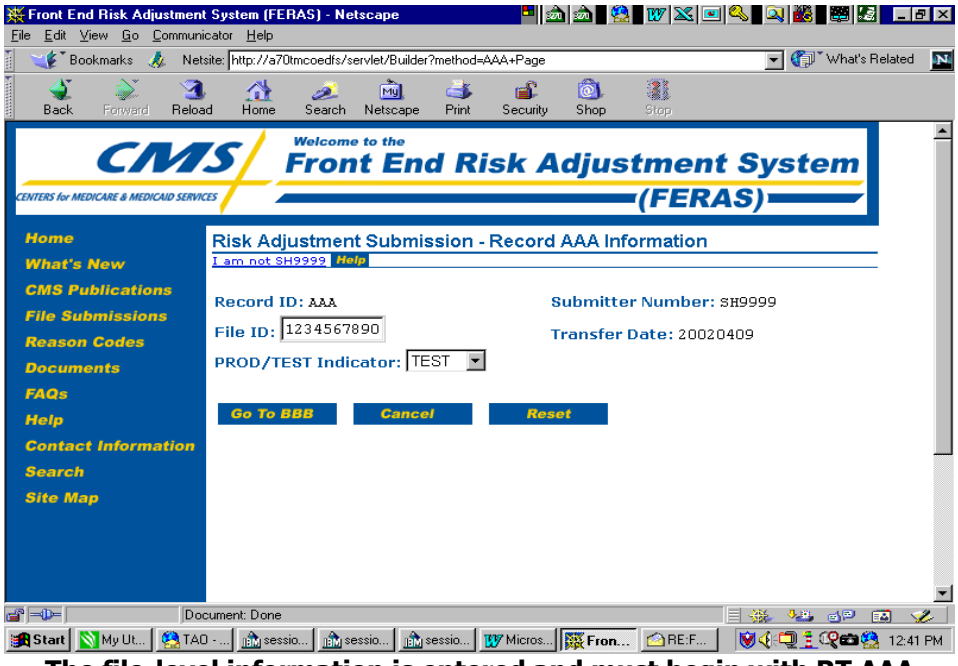
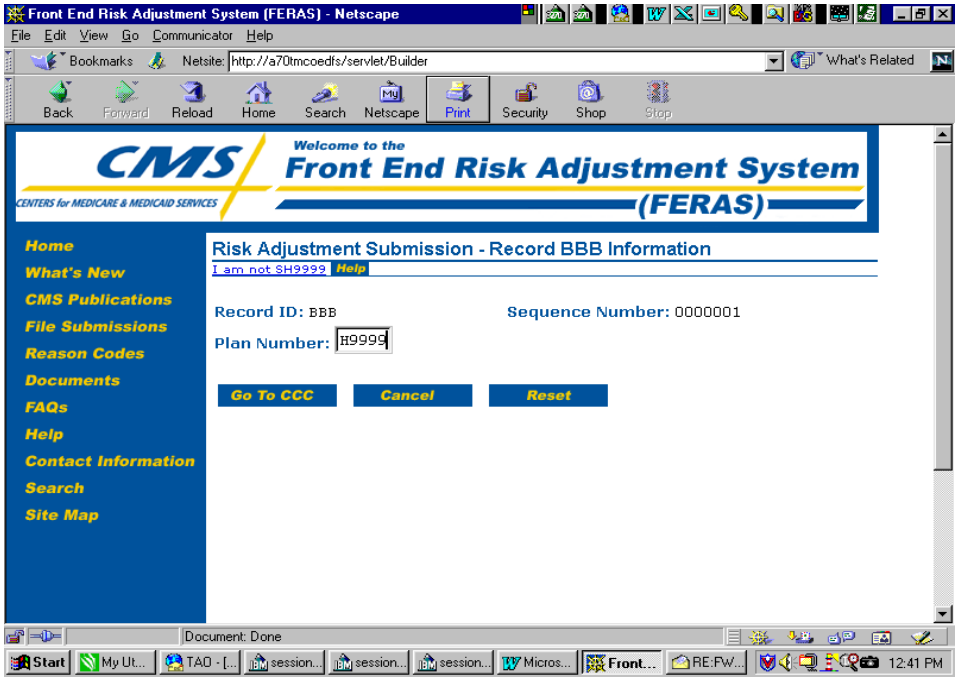


Figure 6C – DDE 2



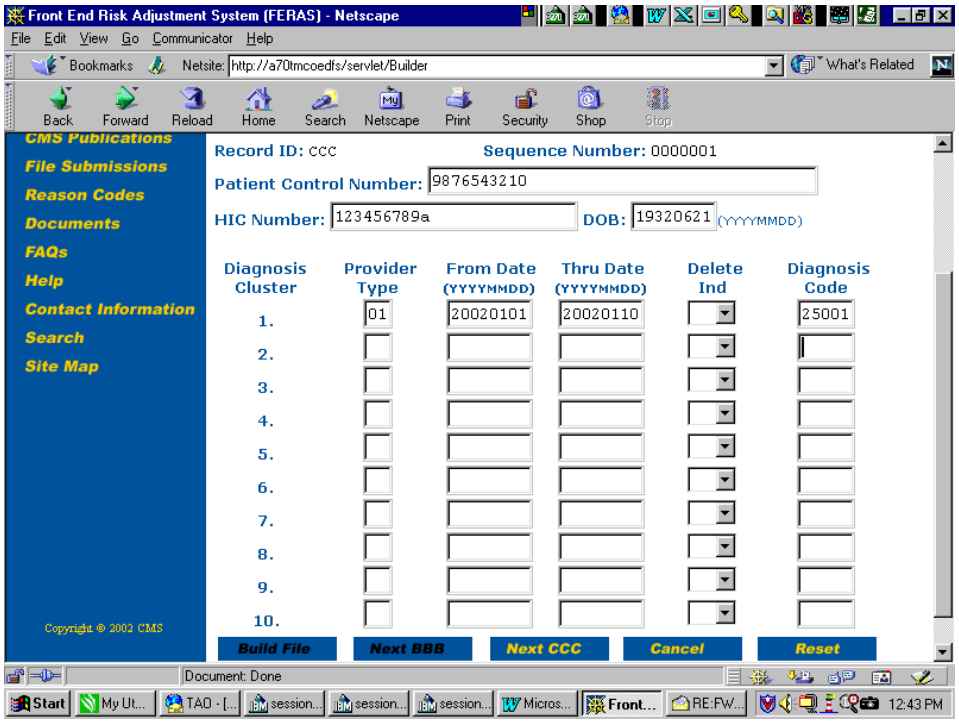
The file-level information is entered and must begin with RT AAA.

Figure 6D – DDE 3



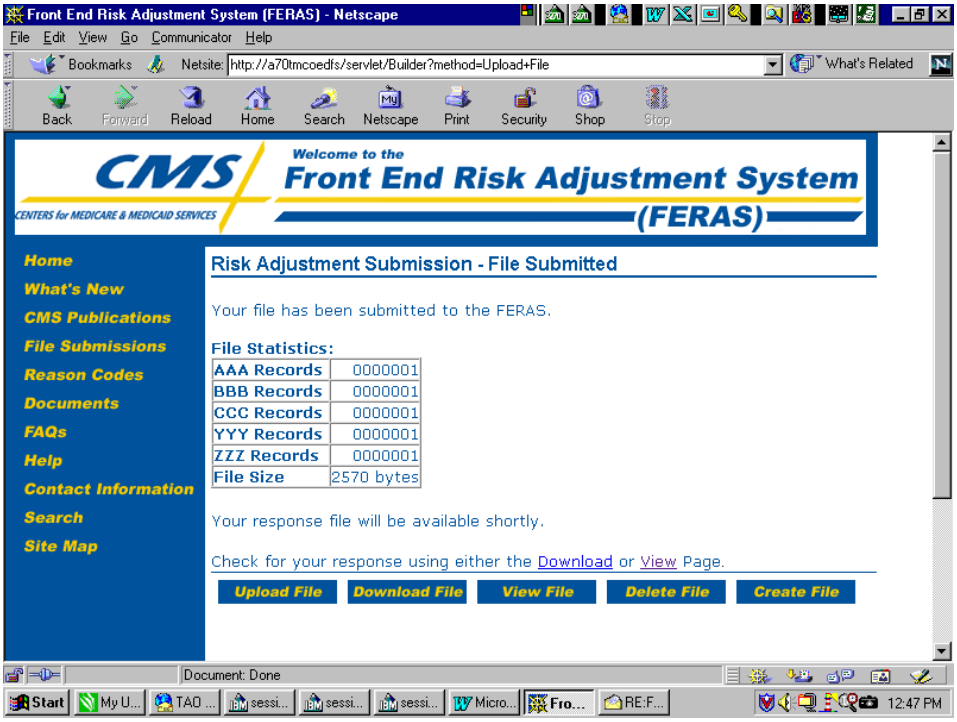
The batch-level information is entered and must begin with RT BBB.

Figure 6E – DDE 4



The CCC Record allows up to 10 diagnostic clusters.

Figure 6F – DDE 5



The file has been uploaded to FERAS.

Figure 6G – DDE 6

MODULE 7 – RISK ADJUSTMENT DATA EDITS

Purpose (Slide 2)

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation. When M+C organizations understand common errors and steps to prevent such errors, the efficiency of the risk adjustment process is increased. This module describes the common edits and assists M+C organizations with the required steps to prevent errors in the future.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

- Identify the top ten common errors
- Interpret steps required to prevent and correct the common errors

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

7.1 Data Flow (Slide 4)

Once data is submitted to Palmetto, the Front-End Risk Adjustment System (FERAS) performs format and integrity checks on the file and batch levels as well as on the first and last detail (CCC) record. Once the data pass the checks they are sent to RAPS for complete editing of all detail records. The flow of edits is illustrated in Figure 7A.

FERAS performs a check on the first and last C records to reduce the number of rejections from FERAS, which exists solely to verify appropriate formats. If the first and last C records pass FERAS checks, then the Risk Adjustment Processing Systems (RAPS) will accept and edit the file. If spacing is incorrect on the first and last C record, it is safe to assume that all records may be aligned incorrectly, and the complete file will reject.

All data submitted via UB-92, NSF, and ANSI formats will be translated by Palmetto to the RAPS format prior to applying any FERAS checks or RAPS edits.

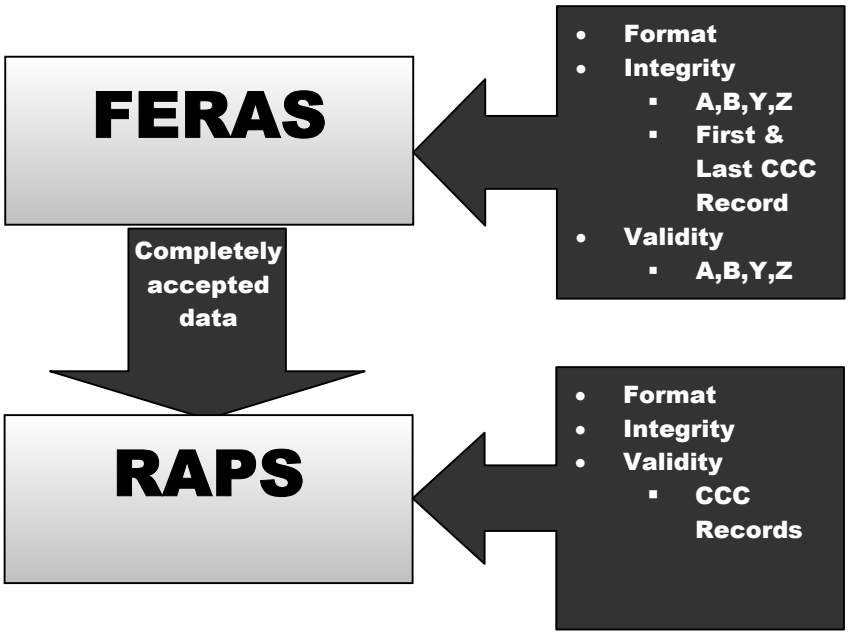


Figure 7A – Risk Adjustment Edits Flow

7.2 FERAS Error Code Logic

When a FERAS check fails, an associated error code will be created. Table 7A describes the error code logic. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all checks are completed.

SERIES	EXPLANATION
100	File-level errors on the AAA or ZZZ records.
200	Batch-level errors on the BBB or YYY records.
300-400	Check performed on first and last CCC records.

TABLE 7A – FERAS ERROR CODE LOGIC

- The 100 and 200 series error codes have been assigned based on the level of checks that are performed as well as the location of the edit.
- The entire file will be returned to the submitter.

Error code ranges are explained in Table 7B.

SERIES	EXPLANATION
100	A 100 error code indicates that the system could not determine the record type; all editing stopped at that point.
101-109	Indicates a failure of a face-validity edit on the AAA record (file-level header). The last digit indicates the specific field in which the error was found. For example, the 101 error code refers to an error found in field 1 on the AAA record.
111-149	Indicates a failure of a cross-reference edit between a field on the AAA (file-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific AAA field against which the cross-check was performed. For example, 112 indicates that the submitter ID in field 2 did not appear on a look-up table of valid submitter IDs.
151-159	Indicates a failure of a face-validity edit on the ZZZ record (first-level trailer). The last digit indicates the specific field in which the error was found. For example, the 151 error code refers to an error found in field 1 on the ZZZ record.
161-189	Indicates a failure of a cross-reference edit between a field on the ZZZ (file-level trailer) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific ZZZ field against which the cross-check was performed. For example, the 162 error code indicates that the Submitter ID, field 2 in ZZZ record, does not match the Submitter ID on the AAA record.
201-209	Indicates a failure of a face-validity edit on the BBB (batch-level header) record. The last digit indicates the specific field in which the error was found. For example, the 201 error code refers to an error found in field 1 on the BBB record.
211-249	Indicates a failure of a cross-reference edit between a field on the BBB (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific BBB field against which the cross-check was performed. For example, the 162 error code indicates that the Submitter ID, field 2 in ZZZ record, does not match the Submitter ID on the AAA record.
251-259	Indicates a failure of a face-validity edit on the YYY (batch-level trailer) record. The last digit indicates the specific field in which the error was found. For example, the 251 error code refers to an error found in field 1 in the YYY record.
261-299	Indicates a failure of a cross-reference edit between a field on the YYY (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific YYY field against which the cross-check was performed. For example, the 262 error code indicates that the Sequence Number in the YYY record field 2 does not match the Sequence Number in field 2.
301-489	Indicates a format problem with the first or last CCC record. The problem is either with the face validity of the data in specific fields or the presence of data in fields that are required to be blank. In either circumstance, the basic CCC record format is assumed to be in error and the entire file is rejected.

TABLE 7B – ERROR CODE RANGES

NOTE: FERAS will check the validity and format of an individual field before performing checks between fields. For example, the system will first check that there is a valid Submitter ID on the AAA record before it checks that the Submitter ID reported in the YYY record is identical. FERAS file-level, batch-level, and detail-level error codes are described in Table 7C.

FILE-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
100	AAA	INVALID RECORD TYPE
101	AAA	AAA RECORD MISSING FROM TRANSACTION
102	AAA	MISSING / INVALID SUBMITER-ID ON AAA RECORD
103	AAA	MISSING FILE-ID ON AAA RECORD
104	AAA	MISSING / INVALID TRANSACTION DATE ON AAA RECORD
105	AAA	MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD
112	AAA	SUBMITTER ID NOT ON FILE
113	AAA	FILE NAME DUPLICATES ANOTHER FILE ACCPETED WITHIN LAST 12 MONTHS
114	AAA	TRANSACTION DATE IS GREATER THAN CURRENT DATE
151	ZZZ	ZZZ RECORD MISSING FROM TRANSACTION
152	ZZZ	MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD
153	ZZZ	MISSING / INVALID FILE-ID ON ZZZ RECORD
154	ZZZ	MISSING / INVALID BBB-RECORD-TOTAL
162	ZZZ	ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD
163	ZZZ	FILE ID DOES NOT MATCH FILE ID ON AAA RECORD
164	ZZZ	ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS

BATCH-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
201	BBB	BBB RECORD MISSING FROM TRANSACTION
202	BBB	MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD
203	BBB	MISSING / INVALID PLAN NUMBER ON BBB RECORD
212	BBB	SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE
213	BBB	SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID
251	YYY	YYY RECORD MISSING FROM TRANSACTION
252	YYY	MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD
253	YYY	MISSING / INVALID PLAN NUMBER ON YYY RECORD
254	YYY	MISSING / INVALID CCC-RECORD-TOTAL
262	YYY	LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS
263	YYY	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD
264	YYY	YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS
272	YYY	SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE

DETAIL-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQ-NO ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
310	CCC	MISSING / INVALID HIC-NO ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST BE BLANK OR EQUAL TO "D"
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
400	CCC	MISSING / INVALID PROVIDER-TYPE ON CCC RECORD
401	CCC	INVALID FROM-DATE ON CCC RECORD
402	CCC	INVALID THRU-DATE ON CCC RECORD

TABLE 7C – FERAS ERROR CODES

7.3 RAPS Edits

- Once data passes the FERAS checks, the file is sent via Network Data Mover (NDM) to the CMS data center for RAPS processing.
- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from Palmetto prior to editing data.
- The RAPS system performs editing primarily on the CCC transactions.
- The data elements edited include HIC Number, Provider Type, Diagnosis Code, From Date, and Through Date.
- If Date of Birth is submitted, RAPS will perform an edit on that field.

7.4 RAPS Editing Rules

The RAPS editing process takes place in four logical stages.

Stage 1 – Field Validity and Integrity

RAPS performs format and integrity checks on all CCC level fields as a first level of editing. If there are data in the error code or filler fields the entire detail record will reject with no further editing performed. If a record fails this stage of editing, it is assumed that the data are corrupt.

The dates are also checked at this stage. If the dates within a diagnosis cluster are not valid dates, then the editing process for that diagnosis cluster is stopped, because all other date edits within a diagnosis cluster depend on the validity of the dates.

Stage 2 – Field-to-Field Editing

Once format and integrity are checked, the field-to-field editing takes place.

- RAPS ensures that the From Date is equal to or prior to the Through Date.
- RAPS also checks all diagnosis clusters for hospital outpatient and physician provider types to ensure compliance with the 31-day span rule.
- RAPS will check all 2003 inpatient data (dates of service July 1, 2001 through June 30, 2002) to ensure that the reconciliation data are properly submitted.

Stage 3 – Medicare Beneficiary Database Edits

The next stage of editing cross-checks the appropriate fields against the Medicare Beneficiary Database (MBD). In this process the HIC Number, Date of Birth, and Medicare Entitlement are checked. For example, in Stage 1 editing, the system ensures that a valid HIC Number is present in field 5 of the CCC record. In Stage 3 editing, the system ensures that the HIC Number exists on the MBD.

Stage 4 – Diagnosis Code Editing

Once the integrity of the individual fields are edited and the HIC Number and eligibility are validated, the diagnosis code is edited against the Diagnosis Lookup Table in RAPS. In this stage, the system first ensures that each diagnosis code is valid. Then the system checks each diagnosis code against service dates and gender. If any of these edits fail, the diagnosis cluster will not be stored in the RAPS Database. The edits at this stage also include an edit to check if the diagnosis code is in the risk adjustment model. If the diagnosis is not in the model, an information error will be returned. The diagnosis cluster will be stored if an information-only error is returned and no further action by the M+C organization is required.

Explanations of error codes and their consequences, RAPS error codes, and informational edits are presented in Tables 7D, 7E, and 7F, respectively.

SERIES	EXPLANATION OF ERROR AND CONSEQUENCES
300-349	Record level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
400-489	Diagnosis cluster error. All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error. Diagnosis was not deleted.
500-599	Informational message. All edits were performed and diagnosis cluster was stored, unless some other error is noted.

TABLE 7D – EXPLANATION OF ERROR AND CONSEQUENCES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NUMBER ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED FOR TRANSACTION
313	CCC	DELETE-INDICATOR MUST EQUAL SPACE OR "D" FOR DELETE
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
351	CCC	FIRST DIAGNOSIS CLUSTER MUST BE A PRINICPAL DIAGNOSIS; PROVIDER TYPE MUST EQUAL "01"; THIS CODE ONLY APPLIES TO HOSPITAL INPATIENT DIAGNOSES FOR DATES OF SERVICE PRIOR TO 7/1/02
353	CCC	HIC NUMBER DOES NOT EXIST ON MBD
354	CCC	PATIENT DOB DOES NOT MATCH WITH MBD DOB
400	CCC	MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD
401	CCC	INVALID SERVICE FROM-DATE ON CCC RECORD
402	CCC	INVALID SERVICE THROUGH-DATE ON CCC RECORD
403	CCC	SERVICE THROUGH DATE MUST BE GREATER THAN 12/31/2000
404	CCC	SERVICE FROM DATE MUST BE LESS THAN OR EQUAL TO THRU DATE
405	CCC	DOB IS GREATER THAN SERVICE FROM DATE
406	CCC	SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
407	CCC	SERVICE THROUGH DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
408	CCC	SERVICE FROM DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD
409	CCC	SERVICE THROUGH DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD
410	CCC	BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM DATE
411	CCC	SERVICE THROUGH DATE IS GREATER THAN DATE OF DEATH
412	CCC	SERVICE FROM DATE GREATER THAN TRANSACTION DATE
413	CCC	SERVICE THROUGH DATE GREATER THAN TRANSACTION DATE
450	CCC	DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH DATE
451	CCC	SERVICE THROUGH DATE IS GREATER THAN DIAGNOSIS END DATE
453	CCC	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX
454	CCC	DIAGNOSIS CODE IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING
460	CCC	SERVICE FROM AND THROUGH DATE SPAN IS GREATER THAN 31 DAYS

TABLE 7E – RAPS ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
490	CCC	COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD
491	CCC	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED
492	CCC	DIAGNOSIS CLUSTER WAS NOT SUCCESSFULLY DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE.

TABLE 7E – RAPS ERROR CODES (CONTINUED)

ERROR CODE	RECORD ID	ERROR DESCRIPTION
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS
501	CCC	VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIANGOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE.

TABLE 7F – INFORMATIONAL EDITS

7.5 Top 10 Common Error Codes (Slide 5)

CMS began accepting risk adjustment data in FERAS and processing the data through RAPS in October 2002. By the end of April more than 64 million CCC records were processed. While the error rate is less than 1 percent, there are several errors that represent the majority of the common errors seen.

In an effort to prevent the common errors, the next sections describe the errors and steps that M+C organizations may take to minimize the occurrence of these common errors.

7.5.1 File Name Duplicates Another File Accepted Within Last 12 Months (Slide 6)

In order to identify the unique file that has been accepted, CMS requires that all files include a ten-digit alpha-numeric file ID. The file ID is required when submitting test or production data. Once a file ID has been submitted and accepted in test or production, the same file ID should not be submitted on any other files within 12 months.

If a File ID was accepted in encounter data processing prior to October 2002, the file-ID should not be used for Risk Adjustment processing within 12 months. The NSF and UB-92 formats support a 10-digit file number, while the RAPS format requires a 6-digit format. FERAS performs an edit of the last six digits, so submitters should ensure that those digits are unique.

Example 1

Evergreen Health Plan submitted an encounter data hospital inpatient production file in August 2002, and an encounter data physician test file in August 2002. The plan cannot submit those files with the same file ID until September 2003.

Prevention

Submitters should consider establishing an automated system that assigns a file sequence number during the process of establishing the data file.

Correction

When a submitter receives a 113-error code, "File name duplicates another file accepted within the last 12 months", the following steps should be taken:

- Since this is a 100 level error code message, the submitter will refer to the AAA record.
- The error code 11**3**, describes the field within the A record that must be corrected.
- The submitter must enter a valid 10-digit file ID in AAA 3.
- Resubmit following correction.

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

7.5.2 Missing/Invalid Sequence Number on BBB Record (Slide 8)

As batches are created, the sequence of the batches must be identified and sequenced in numerical order. The sequence number is seven digits initialized with zeros and incremented by 1. This sequence number is required regardless of the submission format (RAPS, NSF, UB-92, ANSI).

Prevention

The DDE submission format establishes a batch sequence number during the creation of the batch; therefore, DDE submitters will not receive this error code message. Organizations using other submission formats should consider establishing automated systems that incorporate a batch number sequencing feature. Establishing this in the M+C organization's front-end process will prevent this error on the back-end.

Correction

When a submitter receives a 202-error code, "Missing/Invalid sequence number on the BBB record", the following steps should be taken:

- Since this is a 200 level error code message, the submitter will refer to the BBB record.
- The error code 20**2**, describes the field within the B record that must be corrected.
- The submitter must enter a valid 6-digit batch sequence number in BBB 2.
- Resubmit following correction.

7.5.3 Error Code Not Equal to Spaces (Slide 10)

The error code fields were designed to provide space for CMS to communicate errors to the submitter. The file should always be submitted with spaces, not zeros, in the error code fields.

When data is populated in error code filler fields, the system assumes that the entire file is corrupt. These errors will cause the system to discontinue editing and no cluster will be stored. The error code filler fields are summarized in Table 7G.

FIELD NUMBER	FIELD NAME	ERROR CODES
3	SEQUENCE NUMBER ERROR CODE	303
6	HIC NUMBER ERROR CODE	304
8	DOB ERROR CODE	305
9.6	DIAGNOSIS CLUSTER ERROR 1	307
9.7	DIAGNOSIS CLUSTER ERROR 2	308
19	CORRECTED HIC NUMBER	309

TABLE 7G – ERROR CODE FILLER SUMMARY

Prevention

If possible, organizations should lock the fields that are designed as error code communication fields. If organizations are unable to program a lock on the fields, a final check of the file format should be a requirement. This will allow the submitter to ensure that data have not been entered into this field.

Correction

When a submitter receives any error code in Table 7G, "File not equal to spaces", the following steps should be taken:

- Since these are 300 level error code messages, the submitter will refer to the CCC record.
- These error codes indicate a face validity error.
- The submitter must enter three spaces in CCC 8.
- Resubmit following correction.

If this occurs on the first or last C record, the file will be rejected on the front-end prior to sending the data to RAPS. If this occurred on any other C record in the batch, the record will be bypassed, and all editing will be discontinued. No diagnosis clusters from this record will be stored.

7.5.4 Patient DOB Does Not Match With MBD DOB (Slide 12)

The date of birth is an optional field. However, if the field is populated it will undergo a series of edits. During the processing of data, RAPS performs a crosscheck against the MBD to ensure beneficiary eligibility. If entered, the DOB in the record must match the DOB that is stored in MBD.

Prevention

CMS encourages all submitters to gain access to the MBD. Access instructions and features of the database are described in Module 10 of this participant guide. Historical trends show that M+C DOB and CMS DOB disagree for up to 4 percent of all beneficiaries. Initial errors with respect to DOB are difficult to avoid. Submitters may avoid errors associated with the DOB by either filling the DOB field with blanks or by updating internal files to reflect the CMS DOB after the initial error has occurred. This will minimize the number of errors received regarding enrollment information.

Correction

When a submitter receives a 354-error code, "Patient DOB does not match with MBD DOB", the following steps should be taken:

- Since this is a 354 level error code message, the submitter will refer to the CCC record.
- The submitter must either enter the correct DOB in CCC 7 or delete the DOB and replace with spaces.
- Regardless of which correction the submitter elects to make, resubmit following correction.
- Submitters that choose to correct the DOB should update their internal reference files with the corrected DOB.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

7.5.5 Missing/Invalid Provider Type Code on CCC Record (Slide 14)

The submitter must identify the source of the risk adjustment data within each diagnosis cluster submitted. The provider type field must be populated with valid provider type codes:

- 01 Hospital Inpatient Principal
- 02 Hospital Inpatient Other
- 10 Hospital Outpatient
- 20 Physician

Prevention

The DDE format will not accept diagnosis clusters with invalid or missing provider types, therefore DDE submitters will not receive this error code. Those organizations using the NSF, UB-92, or ANSI formats do not submit the provider type, as this information is automatically populated during the translation process. Those submitting using the RAPS format should incorporate a final QC process prior to submitting the data to ensure that a valid provider type was entered for each diagnosis cluster.

Correction

When a submitter receives a 400-error code, "Missing/Invalid provider type code on CCC record", the following steps should be taken:

- Since this is a 400 level error code message, the submitter will refer to the CCC diagnosis cluster.
- The submitter must enter the correct two-digit provider type in CCC 9.0.
- Resubmit following correction.

If this error occurs on the first or last CCC record, FERAS will reject the file prior to sending the data to RAPS. If this occurs on any other CCC record, RAPS will perform the editing process. All possible diagnosis cluster edits will be performed, but the diagnosis cluster will not be stored.

7.5.6 Service From Date Is Not Within M+C Organization Enrollment (Slide 16)

The beneficiary receiving services under the Medicare+Choice program must be enrolled in Medicare during the service period. The dates of service reported in the diagnosis clusters must be within the enrollment dates that are posted in the MBD. RAPS cross-references MBD to verify that the beneficiary was covered during the identified from and through dates of service. Prior to March 2003, M+C organizations received the 408 and 409 error codes due to data inconsistencies between various CMS systems. In early March, the MBD and Group Health Plan (GHP) database were synchronized, which eliminated much of the problem.

The 408 error code occurs with all data. The 409 error code occurs only with hospital outpatient and physician data.

Prevention

Submitters should check the from and through dates of service against internal enrollment records. Remember that for hospital outpatient and physician data, both the from and through dates must be within M+C enrollment periods. For hospital inpatient data, only the from dates must be within M+C enrollment periods. Performing these pre-edits will minimize the number of errors received regarding enrollment information.

Correction

As a result of the MBD and GHP synchronization, the number of diagnosis clusters returned with 408 and 409 error codes were significantly reduced. When a submitter receives a 408-error code, "Service from date is not within M+C organization enrollment period", or a 409-error code, "Service through date is not within M+C organization enrollment period", the following steps should be taken:

- Since this is a 400 level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter must ensure that the correct service through date was entered in CCC 9.2.
- The submitter should check these dates against the plan enrollment dates.
- If there are concerns on the enrollment date, contact CSSC.
- Resubmit following correction.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

7.5.7 Beneficiary Is Not Enrolled In Plan On Or After Service From Date (Slide 18)

In March 2003, CMS synchronized the data that is stored in the GHP with information in MBD. This provided the most current and accurate information regarding Medicare beneficiary enrollment information. Beneficiaries must be enrolled in the plan on or after the date of the service provided.

Prevention

Using information from the monthly membership report and internal enrollment files, submitters should be knowledgeable regarding the enrollment and eligibility of their beneficiaries. Establishing a systematic beneficiary enrollment tracking system will reduce the number of errors associated with this edit.

The 408 and 409 error code messages indicate that the service occurred while the beneficiary was not participating in any M+C program. The 410 error code message indicates that the service occurred while the beneficiary was not enrolled in your organization.

Correction

When a submitter receives a 410-error code, "Beneficiary is not enrolled in plan on or after service from date", the following steps should be taken:

- Since this is a 400 level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter should check the service from date against the plan enrollment dates to ensure that the beneficiary was enrolled in this plan on or after the from date.
- If there are concerns on the enrollment date, contact CSSC.
- Resubmit following correction.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

7.5.8 Service From And Service Through Date Span is Greater Than 31 Days (Slide 20)

The date span rule applies to hospital outpatient and physician data, but not hospital inpatient data. The date span for inpatient data should never be greater than the length of the inpatient stay. This error is primarily seen with physical therapy claims. Based on estimator data submitted, this accounts for approximately two hundred errors per 1 million diagnosis clusters submitted.

Prevention

The submitter should break the diagnosis into the appropriate 31-day span. This will prevent receiving this error code message.

Correction

When a submitter receives a 460-error code, "Service from and through date span is greater than 31 days", the following steps should be taken:

- Since this is a 400 level error code message, the submitter will refer to the diagnosis cluster.
- The submitter should separate the diagnosis into 31-day span if appropriate.
- Modify information in CCC 9.2.
- Resubmit following correction.

All possible diagnosis cluster edits will be performed, but the cluster will not be stored.

7.5.9 Diagnosis Code Is Not Appropriate For Patient Sex (Slide 22)

RAPS performs a crosscheck between the patient sex and the diagnosis code. Submitters will receive an error if the diagnosis is not appropriate for the patient sex. CMS has published a list of gender specific diagnosis codes on the www.mcoservice.com. This list is provided in a text and html format, and includes diagnoses that are in and out of the CMS-HCC model.

Prevention

CMS encourages submitters to access and download the database. Organizations may consider incorporating the database into their internal editing system. This will prevent the number of errors associated with gender-specific diagnosis codes.

Correction

When a submitter receives a 453-error code, "Diagnosis code is not appropriate for patient sex", the following steps should be taken:

- Since this is a 400 level error code message, the submitter will refer to the diagnosis cluster.
- The submitter should verify the patient sex and the diagnosis code.
- If the diagnosis code was entered incorrectly, the submitter should correct CCC 9.4.
- If the patient sex is in question, the submitter should contact CMS.
- Resubmit following correction.

7.5.10 Valid Diagnosis But Not Relevant Diagnosis For Risk Adjustment During This Service Period (Slide 24)

The new risk adjustment process allows the M+C organization the flexibility to decide the format of submission and the amount of data to submit. Submitters may decide to submit only the diagnosis codes included in the risk adjustment model, or to submit all valid ICD-9-CM codes. When submitting all diagnosis codes, users will receive a 501-error code message. This is an informational message, and does not require any action by the submitter.

MODULE 8 – REPORTS

Purpose (Slide 2, 2)

CMS communicates errors and the status of diagnosis clusters to submitters on reports. It is essential that the appropriate staff at the M+C organization understand how to read and resolve issues identified on the report. This module will provide insight on the appropriate use of the reports developed for the risk adjustment process.

Learning Objectives (Slide 3, 3)

At the completion of this module, participants will:

- Identify the purpose of each of the risk adjustment reports
- Determine the best uses for each of the reports

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

8.1 Accessing Risk Adjustment Processing Reports (Slide 4, 4)

The reports designed to support the risk adjustment process can be accessed through three methods:

- Secured Website
- File Transfer Protocol (FTP)
- Network Data Mover (NDM)

Direct Data Entry (DDE) and FTP users will receive reports generated by the Front-End Risk Adjustment System (FERAS) generally within 15 minutes of submission. NDM users will receive reports the following day. If the submission is received after 5:00p.m. ET, the NDM user will receive the report 2 days after submission.

The reports are sent to the submitter's mailbox, and will remain there for 14 days. The reports are automatically deleted from the mailbox after 14 days, but remain available through the Customer Service and Support Center for 7 years. Reports are sent to the mailbox identified on the submitter application. Since the reports are generated out of the processing systems at CMS and sent to Palmetto for distribution, the reports are not duplicated and sent to multiple mailboxes.

M+C organizations may request that reports are sent to them in a zip format. To avoid difficulties opening the zip reports, users should:

- Rename the file with the abbreviation .zip extension.
- When using the FTP command line, change the command to binary.

8.2 Printing Reports

All risk adjustment reports are delivered as text reports, with the exception of the Risk Adjustment Processing System (RAPS) Return File. Organizations may download the reports in Note Pad and change the print orientation to landscape to ensure that all of the data is printed on one page. Users should avoid opening the report in Word to prevent the default programming that occurs. When the reports are opened in Note Pad, the report is printed with the automatic page breaks incorporated.

8.3 Report Overview (Slide 5, 5)

Reports are summarized in Figure 8A.

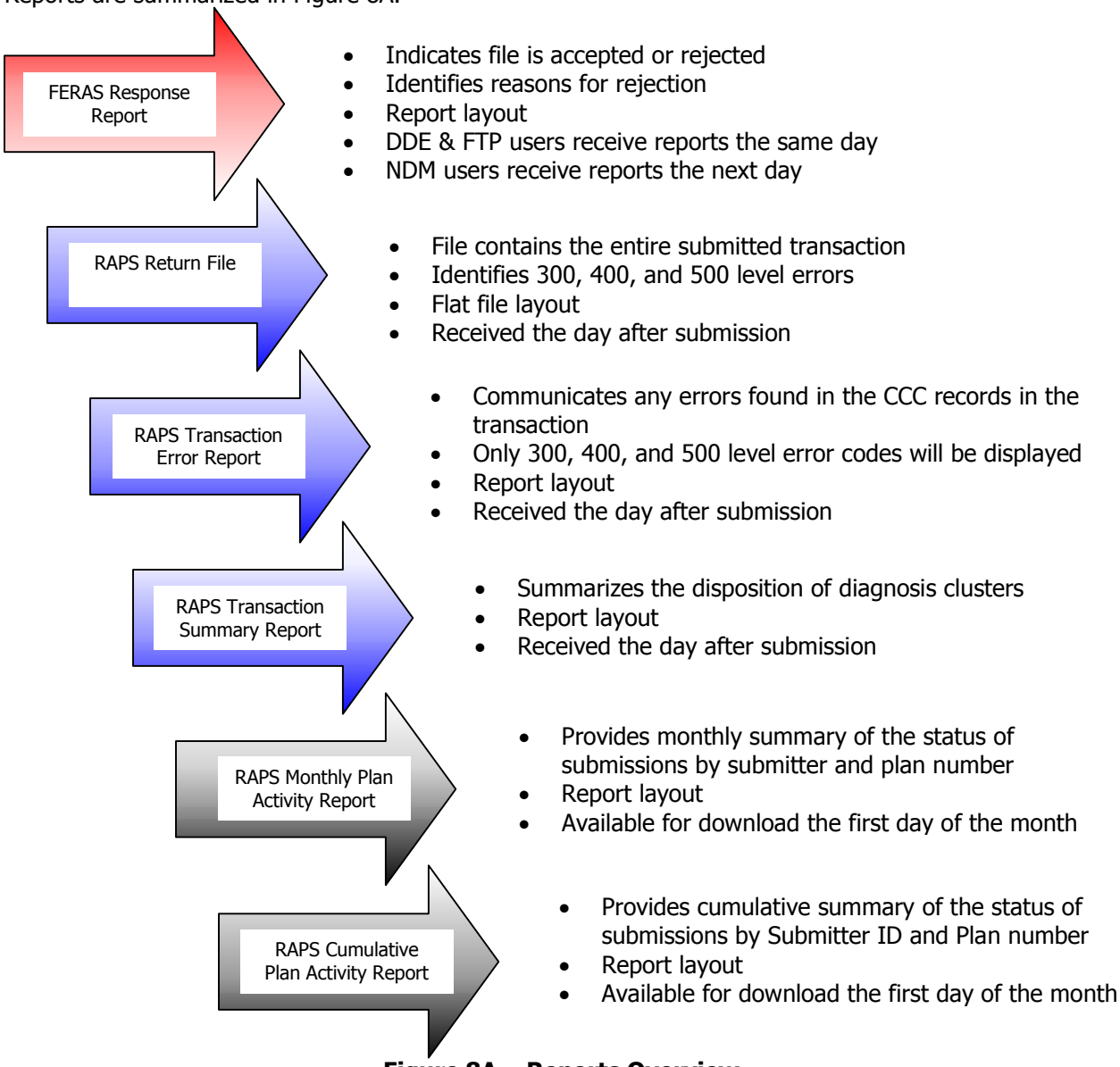


Figure 8A – Reports Overview

8.4 Using the Reports

Section 7.5.1 in the Edits module described one of the ten most common errors, "Duplicate file ID's within the last 12 months". Communicating that error on the FERAS and RAPS reports is described in the next section.

Example 1 (Slide 6, 6)

The Rosemount Health Plan, SH7777, submitted a file 0000001. This was not the first file submitted for the year. The file included one batch with three C records. The first C record was for HIC number 113334567A. The date of birth (DOB) on the claim was 19350305. This did not match the date of birth in MBD. What reports would be generated for this submission?

Initially, the M+C organization would receive a FERAS Response Report as illustrated in Figure 8B.

```
REPORT: FERAS-RESP      FRONT END RISK ADJUSTMENT SYSTEM
RUN DATE: 20030407          FERAS RESPONSE REPORT

SUBMITTER ID: SH7777
FILE ID: 0000001       REJECTED  PROD

RECORD  SEQ     ERROR
 TYPE   NO      CODE    ERROR DESCRIPTION
 AAA  0000001  113 DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS
 END OF REPORT
```

Figure 8B – Rejected FERAS Response Report

FTP and DDE submitters will receive this report generally within 15 minutes of submission. NDM users will receive the report the next day.

The plan will research the file ID and enter a new file ID in AAA 3. After submitting the file, the M+C organization will receive a new FERAS Response Report. As illustrated in Figure 8C, the file is accepted by the front-end system.

```
REPORT: FERAS-RESP      FRONT END RISK ADJUSTMENT SYSTEM
RUN DATE: 20030407          FERAS RESPONSE REPORT

SUBMITTER ID: SH7777
FILE ID: 0000005       ACCEPTED  PROD

 END OF REPORT
```

Figure 8C – Accepted FERAS Response Report

The front-end system performed all format and integrity checks for the A, B, Y, and Z and first and last C records, and the validity checks on the A, B, Y, and Z records. The data is now sent to the RAPS system for editing.

Users should be aware of the record number displayed on the FERAS reports. FERAS indicates the logical record number on the FERAS Response Report. While the submitter may identify the first batch in the file as sequence 0000001, the logical record number for the first batch is 0000002, as illustrated in Table 8-1. The logical record number for the first CCC record is 0000003. Users must crosswalk that information to the sequence number identified in their file.

Example 2

In the scenario presented in Example 1, RAPS determined a discrepancy between the DOB submitted on the file and what was stored in MBD. The submitter received a RAPS Return File. Figure 8D illustrates the portion of the RAPS Return File that identifies the incorrect DOB.

```
AAASH777700000000000120030411PROD

BBB0000001H9999

CCC0000001   7321430                    123456789A        1935030535401200303142003031 8
YYY0000001H99990000003

 ZZZSH9999    0411010000001
```

Figure 8D – RAPS Return File

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

The M+C organization will also receive a RAPS Transaction Error Report as described in Figure 8E. The RAPS Transaction Summary Report displays all records where an error occurred. The report also displays all of the clusters that were included in the record. When a fatal error occurs, all clusters will appear on the report. All clusters following the cluster with the fatal error will not have an error code displayed. This does not mean that there is not an error associated with the cluster. The system discontinued the editing after the fatal error occurred.

1REPORT : RAPS002 RISK ADJUSTMENT PROCESSING SYSTEM PAGE: 1
RUN DATE : 20030411 TRANSACTION ERROR REPORT TRANS DATE: 20030411
0SUBMITTER ID SH7777 FILE ID: 0000005 PLAN ID: H7777 BATCH NUMBER: 0000001

0SEQ NUM	SEQ ERR	PATIENT CONTROL NUM	HIC	HIC ERR	DOB	DOB ERR	PVDR TYPE	FROM DATE	THRU DATE	DEL IND	DGNS CODE	DGNS ERR1	DGNS ERR2	CORRECTED HIC
0000002			123456789A		19350305	354	01	20030314	20030318		4359	501		123456768788

END OF FILE

Figure 8E – RAPS Transaction Error Report

In March 2003, CMS reconfigured the programming of the 501 error code, "Diagnosis not in model". The 501 error code will not appear on the RAPS Transaction Error Report, unless there is another error associated with the record. Figure 8E illustrates this point. Since there was a Date of Birth error, error code 354, the system also reported the 501 error code.

The submitter also receives a RAPS Transaction Summary Report. This report summarizes the disposition of all diagnosis clusters that were present in the submitted file. In Figure 8F the report is displayed inclusive of all clusters submitted.

1REPORT : RAPS001 RISK ADJUSTMENT PROCESSING SYSTEM
RUN DATE : 20030412 TRANSACTION SUMMARY REPORT TRANS DATE:20030411
0
SUBMITTER ID SH7777 PLAN ID: H7777 FILE ID: 0000005

PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL
TOTAL SUBMITTED	207	1,213	0	0	0	1,420
TOTAL REJECTED	9	49	0	0	0	58
TOTAL ACCEPTED	198	1,164	0	0	0	1,362
TOTAL STORED	189	1,099	0	0	0	1,288
TOTAL MODEL STORED	103	368	0	0	0	471
TOTAL DELETE ACPTD	0	0	0	0	0	0
TOTAL DELETE RJCTD	0	0	0	0	0	0

Figure 8F – RAPS Transaction Summary Report

Based on the information displayed in Figure 8F, the organization can come to the following conclusions:

- Less than 5 percent of the clusters were rejected due to error.
- There were several duplicates submitted in the batch.
- Approximately a third of the diagnoses submitted were in the model.

The sum of Total Rejected, Total Accepted, Total Deletes Accepted, and Total Deletes Rejected will equal Total Submitted. The difference between the Total Stored and the Total Accepted is the number of duplicated clusters submitted. The difference between the Total Stored and the Total Model Stored indicates the number of non-model diagnoses submitted. The Total Model Stored will always be less than or equal to the Total Stored.

8.4.1 Management Reports

CMS developed two management reports that provide the organization with details on the amount of data submitted and stored for each provider type. The reports are delivered to the User on the first Monday of the month.

RAPS Monthly Plan Activity Report (Slide 14, 14)

- The RAPS Monthly Plan Activity Report identifies a monthly summary of the status of all submissions by the Submitter ID and Plan.
- The report will allow submitters to validate the diagnoses submitted for a 1-month period.
- The report is arrayed by provider type and month (determined by through date of service).
- Information is reported by Submitter ID and H#.
- Each page of the report will display 6 months of data.

Example 3

Management can determine how effectively the organization has submitted data by reviewing the number of clusters submitted and stored on a monthly basis. Figure 8G illustrates that there is a high rate of data rejected. There is a 27 percent error rate in the hospital outpatient submission. The rejection rate with Hospital inpatient appears to be approximately 26 percent, while there is a 5 percent rejection rate in physician data. The through dates of service range from July 2002 – March 2003.

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20030501 RAPS MONTHLY PLAN ACTIVITY REPORT SERVICE YEAR: 2002

SUBMITTER ID: SH8888 FOR THE MONTH OF APRIL, 2003
PLAN NO: H8888

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	19	25	28	73	404	1704	2253
TOTAL REJECTED	10	7	11	19	106	426	579
TOTAL ACCEPTED	9	18	17	54	298	1278	1674
TOTAL STORED	9	18	17	54	298	1278	1674
TOTAL MODEL STORED	5	8	12	27	158	646	856
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	103	113	143	407	2447	10561	13774
TOTAL REJECTED	49	44	55	112	638	2634	3532
TOTAL ACCEPTED	54	69	88	295	1809	7927	10242
TOTAL STORED	54	69	88	295	1809	7927	10242
TOTAL MODEL STORED	18	24	26	95	575	2574	3312
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	329	490	761	1691	9526	33693	46490
TOTAL REJECTED	115	179	219	531	2523	8769	12336
TOTAL ACCEPTED	214	311	542	1160	7003	24924	34154
TOTAL STORED	214	311	542	1160	7003	24924	34154
TOTAL MODEL STORED	35	82	135	244	1779	5305	7580
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	2450	3221	4812	12429	31573	130564	185049
TOTAL REJECTED	224	206	527	928	2039	6026	9950
TOTAL ACCEPTED	2226	3015	4285	11501	29534	124538	175099
TOTAL STORED	2226	3015	4284	11492	29533	124538	175088
TOTAL MODEL STORED	608	721	1116	2797	7462	29413	42117
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 2
RUN DATE: 20030501 RAPS MONTHLY PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH8888 FOR THE MONTH OF APRIL, 2003
PLAN NO: H8888

PROVIDER TYPE/TOTALS	JANUARY	FEBUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1754	1490	755	0	0	0	3999
TOTAL REJECTED	452	417	210	0	0	0	1079
TOTAL ACCEPTED	1302	1073	545	0	0	0	2920
TOTAL STORED	1302	1073	545	0	0	0	2920
TOTAL MODEL STORED	681	563	273	0	0	0	1517
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	10972	9519	4828	0	0	0	25319
TOTAL REJECTED	2868	2644	1360	0	0	0	6872
TOTAL ACCEPTED	8104	6875	3468	0	0	0	18447
TOTAL STORED	8104	6875	3468	0	0	0	18447
TOTAL MODEL STORED	2749	2289	1122	0	0	0	6160
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	30499	27099	12632	0	0	0	70230
TOTAL REJECTED	8243	7439	3615	0	0	0	19297
TOTAL ACCEPTED	22256	19660	9017	0	0	0	50933
TOTAL STORED	22256	19660	9017	0	0	0	50933
TOTAL MODEL STORED	4947	4330	1790	0	0	0	11067
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	143978	117932	63002	0	0	0	324912
TOTAL REJECTED	7397	6191	2838	0	0	0	16426
TOTAL ACCEPTED	136581	111741	60164	0	0	0	308486
TOTAL STORED	136581	111741	60164	0	0	0	308486
TOTAL MODEL STORED	33746	27414	13557	0	0	0	74717
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 8G – RAPS Monthly Plan Activity Report

RAPS Cumulative Plan Activity Report

- The RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions.
- The report allows submitters to compare their accepted diagnosis clusters to benchmarks.
- The report is arrayed by provider type and month (determined by through date of service).
- Information is reported by Submitter ID and H#.

Example 4

Using the RAPS Cumulative Plan Activity Report, the organization can effectively monitor the quantity of data submitted for each provider type. The report in Figure 8H reflects a low rate of physician and hospital outpatient submission.

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 2
RUN REPORT: DATE: 20030203 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2001

SUBMITTER ID: SH1111 FOR PERIOD ENDING JANUARY 31, 2003
PLAN NO: H1111

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	22	25	40	29	39	61	216
TOTAL REJECTED	0	0	2	0	3	1	6
TOTAL ACCEPTED	22	25	38	29	36	60	210
TOTAL STORED	22	25	38	29	36	60	210
TOTAL MODEL STORED	18	24	26	23	33	44	168
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	56	92	157	108	99	178	690
TOTAL REJECTED	0	0	8	0	15	4	27
TOTAL ACCEPTED	56	92	149	108	84	174	663
TOTAL STORED	56	92	149	108	84	174	663
TOTAL MODEL STORED	29	67	66	58	51	104	375
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	7	4	3	19	8	16	57
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	7	4	3	19	8	16	57
TOTAL STORED	7	4	3	19	8	16	57
TOTAL MODEL STORED	7	4	3	19	8	16	57
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	14	28	14	13	37	16	122
TOTAL REJECTED	0	0	4	6	1	0	11
TOTAL ACCEPTED	14	28	10	7	36	16	111
TOTAL STORED	13	26	10	7	31	14	101
TOTAL MODEL STORED	13	26	10	7	31	14	101
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 2
RUN DATE: 20030203 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2002

SUBMITTER ID: SH1111 FOR PERIOD ENDING JANUARY 31, 2003
PLAN NO: H1111

PROVIDER TYPE/TOTALS	JANUARY	FEBUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	480	301	84	153	583	2241	3842
TOTAL REJECTED	0	0	2	0	0	0	2
TOTAL ACCEPTED	480	301	82	153	583	2241	3840
TOTAL STORED	480	301	82	153	583	2241	3840
TOTAL MODEL STORED	457	280	71	135	544	2218	3705
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	561	448	225	367	725	1637	3963
TOTAL REJECTED	0	0	9	0	0	0	9
TOTAL ACCEPTED	561	448	216	367	725	1637	3954
TOTAL STORED	561	448	216	367	725	1637	3954
TOTAL MODEL STORED	388	305	129	201	457	1491	2971
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	31	29	47	54	99	332	592
TOTAL REJECTED	0	2	1	1	2	3	9
TOTAL ACCEPTED	31	27	46	53	97	329	583
TOTAL STORED	31	27	40	52	95	327	572
TOTAL MODEL STORED	31	27	40	52	95	327	572
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	99	52	76	96	273	661	1257
TOTAL REJECTED	5	0	0	0	2	15	22
TOTAL ACCEPTED	94	52	76	96	271	646	1235
TOTAL STORED	70	50	69	89	236	575	1089
TOTAL MODEL STORED	70	50	69	89	236	575	1089
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 8H – RAPS Cumulative Plan Activity Report

8.4.2 Correcting Rejected Data (Slide 20, 20)

When submitters correct data that was submitted with errors, the number of rejected data will still be reflected on the cumulative totals for the appropriate month, and in the number of total rejections. Once a diagnosis cluster is counted as stored, it will always remain part of the stored count on the RAPS Cumulative Plan Activity Report even if it is later deleted. When submitters delete a cluster, the number will be included in the total stored as well as the total deleted.

Example 5

The January RAPS Cumulative Plan Activity Report (Figure 8I) displays a high reject rate in the data submitted with dates of service July – September. The plan corrected the previously submitted errors and began submitting data more accurately. The May Cumulative Report (Figure 8J) reflects that the rate of rejection (Total Rejected) remained high for July – September, but decreased for October – December.

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20030203 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2002

SUBMITTER ID: SH2222 FOR PERIOD ENDING JANUARY 31, 2003
PLAN NO: H2222

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	85	264	32	0	0	0	281
TOTAL REJECTED	64	234	28	0	0	0	226
TOTAL ACCEPTED	21	30	4	0	0	0	55
TOTAL STORED	14	30	4	0	0	0	48
TOTAL MODEL STORED	14	30	4	0	0	0	48
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	185	581	69	0	0	0	835
TOTAL REJECTED	138	531	67	0	0	0	736
TOTAL ACCEPTED	47	50	2	0	0	0	99
TOTAL STORED	33	50	2	0	0	0	85
TOTAL MODEL STORED	33	50	2	0	0	0	85
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	664	1420	202	0	0	0	2286
TOTAL REJECTED	571	1260	181	0	0	0	2012
TOTAL ACCEPTED	93	160	21	0	0	0	274
TOTAL STORED	64	160	21	0	0	0	245
TOTAL MODEL STORED	64	160	21	0	0	0	245
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	1678	5528	1293	0	0	0	8499
TOTAL REJECTED	1473	4810	1181	0	0	0	7464
TOTAL ACCEPTED	205	718	112	0	0	0	1035
TOTAL STORED	201	714	112	0	0	0	1027
TOTAL MODEL STORED	201	714	112	0	0	0	1027
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 8I – RAPS Cumulative Plan Activity Report

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20030601 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2002

SUBMITTER ID: SH2222 FOR PERIOD ENDING MAY 31, 2003
PLAN NO: H2222

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	85	264	32	36	40	34	391
TOTAL REJECTED	64	234	28	1	3	0	230
TOTAL ACCEPTED	21	30	4	35	37	34	161
TOTAL STORED	14	30	4	35	37	34	154
TOTAL MODEL STORED	14	30	4	35	37	34	154
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	185	581	135	72	81	67	835
TOTAL REJECTED	138	531	67	3	6	0	736
TOTAL ACCEPTED	47	50	68	69	75	67	99
TOTAL STORED	33	50	63	64	75	67	85
TOTAL MODEL STORED	33	50	63	64	75	67	85
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	774	1420	356	168	207	182	3107
TOTAL REJECTED	576	1260	184	4	3	9	2036
TOTAL ACCEPTED	198	160	172	164	204	171	1071
TOTAL STORED	165	160	172	164	163	171	997
TOTAL MODEL STORED	165	160	172	164	163	171	997
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	2229	5528	1919	728	755	759	11917
TOTAL REJECTED	1484	4810	1187	12	17	7	7517
TOTAL ACCEPTED	744	718	732	716	738	752	4400
TOTAL STORED	741	714	732	716	733	752	4388
TOTAL MODEL STORED	741	714	732	716	733	752	4388
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 8J – RAPS Cumulative Plan Activity Report

MODULE 9 – RAPS STRATEGIES

Purpose

Risk adjustment training has been a combination of theory and practice. The purpose of this module is to take the text even further— "out of the classroom"—and into real practice at the M+C organization level. Presenters from M+C organizations will share risk adjustment implementation challenges and solutions during this interactive module.

Learning Objectives

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

- Identify unique challenges to RAPS implementation
- Recognize key elements that M+C organizations have used to facilitate implementation
- Identify other recommendations that can be used to further enhance data submission

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

9.1 Blue Shield of California

Blue Shield is a non-profit health plan with an M+C member of about 70,000. There is a separate IT platform for Medicare patients. They have been involved with M+C since 1998, and were a Medicare Managed Care Plan for many years prior to that. The staff is stable, and consists of five systems analysts and one shared administrative personnel. Staff stability is attributed to cross training and operation responsibilities. This results in increased interest and commitment to the organization.

- **Successes**
  - Collaboration with other health plans, providers, and regulator agencies to facilitate consistence and consistent application of regulations.
  - Involvement of providers in development tools that meet their needs.
  - Refinement of internal systems to accommodate data collected from providers.

- **Lessons Learned**
  - Recognizing that data submitted directly from a provider is preferable to third party submissions.
  - Evaluating EDI vendors across several parameters.
  - Improving internal knowledge about processing system.
  - Maintaining a "sent history" that mirrors the format sent to CMS.

9.2 HIP Health Plan of New York

HIP is the largest HMO in the New York metropolitan area and has been in the Medicare Risk program since 1987. Current Medicare membership is 104,381. They began transmitting encounter data to Palmetto in 1998 using the UB92 format via NDM. They collect and submit all diagnoses more than once during a data collection period.

- **Success – Development of a Trigger File**
  - The Trigger File uses the RAPS return file and pulls out errors.
  - Uses the Patient Control Number, with its 40-character field to further designate the provider type.
  - Providing access to the trigger file allows business partners to participate in correction process.
  - Trigger File recycles claims until error is corrected and is also a storing mechanism.

9.3 Hopkins ElderPlus

Hopkins ElderPlus is a PACE plan located in an urban, campus-like setting. Maximum participants limited to 150; current census is 142, with 40 people on a waiting list. A 15-bed assisted living facility is scheduled to open in July 2003. Hospital inpatient data for the period 7/1/00-6/30/01 was submitted via PC-ACE and electronic submission of hospital inpatient, outpatient, and partial hospitalization began July 1, 2002.

- **Challenges**
  - Educating medical staff so they understand the payment methodology and the significance of diagnostic data to the process.
  - Establishing a process for submitting diagnostic data and responding to error codes.
  - Training a back-up person able to submit data.
  - Ongoing refinement of the payment methodology and process.
  - Participating in discussions unique to the PACE population.
  - Maximizing reimbursement based on the RA methodology.

- **Solutions**
  - Use of a PACE generated superbill for physician encounters, UB-92 and outside bills for inpatient and other outpatient charges.
  - Development of streamlined database for easy data entry. By providing name or Medicare number, HIC number is easily retrieved, thus minimizing errors.

9.4 Community Care HMO

Community Care is an M+C organization owned by two local hospitals in Tulsa, Oklahoma. Currently, there are 20,000 members participating in the senior health plan. Their total commercial membership is 67,000. They began submitting encounter data in Fall 2001. They receive all claims from providers and enter them into Amisys. Everything is coded in SAS and submission is through the RAPS format.

- **Successes**
  - Use of SAS to collect all data elements, identifying specific selection criteria.
  - Make clear distinctions among types of claims, e.g. inpatient, outpatient-non-inpatient hospital or DME, non-covered services, and physician-non-hospital with approved provider specialties.

- **Submission Tips**
  - Create hard-coded fields
  - Output data to a text file
  - Count total diagnosis clusters and total for each provider to compare to summary file
  - Read data from return file into SAS, and add to master submission file.

9.5 Ovations – A United Health Group Company

Ovations serves the health and well-being needs of retirees and seniors. It includes underwriting and services in support of AARP Health Care Options, the group insurance program of the American Association of Retired Persons (AARP), and EverCare®, which delivers medical care to frail elderly residents of nursing homes.

- **Success – Current Process Model**
  - Role delineation for business, operations, and IT
  - Establish Error Correction Team lead by the business project manager to prioritize, review, investigate and correct errors
  - Error Correction Team benefits all entities, business, operations, and IT, with a single consolidated team.

MODULE 10 – MEDICARE BENEFICIARY DATABASE

Purpose (Slide 2)

CMS has moved toward an information-centered approach in record keeping with an initial focus on beneficiary data. Preventing unnecessary errors when submitting data to the Risk Adjustment Processing System (RAPS) will provide a more streamlined risk adjustment process. This module provides instructions on accessing and using the Medicare Beneficiary Database (MBD).

Learning Objectives (Slide 3)

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

- Identify the purpose of the Medicare Beneficiary Database
- Interpret system access instructions
- Understand common risk adjustment uses of the database
- Contact appropriate resources

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

10.1 Medicare Beneficiary Database (Slide 4)

The MBD was created to provide CMS with a centralized database that is able to communicate with other systems while being able to view, manage, and update beneficiary information. The MBD is the authoritative source of beneficiary information. The MBD is used to support managed care enrollments and payments to M+C organizations. There are four categories of data stored in the MBD:

- **Beneficiary Profile**
  Provides the necessary information on personal characteristics to uniquely identify Medicare beneficiaries.

- **Entitlement**
  Provides the data necessary to determine an individual's entitlement to Medicare, and specifically, the periods of Part A and Part B enrollment coverage.

- **Coverage**
  Contains Beneficiary service delivery elections and other coverage choices.

- **Medicaid**
  Provides a profile of current and historical Medicaid eligibility periods.

10.2 Accessing MBD (Slide 9)

The M+C organization must complete and submit an MBD Access Application to their regional office contact. Table 10A identifies the regional office contacts. Users may download the application at http://cms.hhs.gov/mdcn/access.pdf. Users must submit completed applications to the regional office contacts and the CMS contract manager must approve the application. Users should allow 5 business days for processing.

The application should be completed when the user:

- Requires new access
- Changes names
- Changes access needs/job duties
- Seeks recertification
- Retires, resigns, or is removed from the organization

To gain access to the MBD, a user ID and password is required. Based on the information populated on the application, the user will be assigned the ability to update and view information at a level appropriate for their role. Restrictions to access include:

- M+C organizations will only have access to information for those beneficiaries currently enrolled in the organization.
- Viewing of enrollment information is limited to the contract numbers associated with the user ID logged on to the system.
- If a user does not have access to view a particular MBD element, asterisks (***) will display in that field.
- If the user does not have authority to update, add, or delete, the element will be protected.

Region	Point-of-Contact	Technical Support
Boston	Jackie Buise, 410-786-7607	Sarah Brown, 410-786-6358
New York	Juan Lopez, 410-786-7621	Sarah Brown, 410-786-6358
Philadelphia	James Dorsey, 410-786-1143	Sarah Brown, 410-786-6358
Atlanta	Brenda Hicks, 410-786-1159	Susan Hartmann, 410-786-6192
Chicago	Janice Bailey, 410-786-7603	Susan Hartmann, 410-786-6192
Dallas	Joanne Weller, 410-786-5111	Susan Hartmann, 410-786-6192
Kansas City	Gloria Webster, 410-786-7655	Sarah Brown, 410-786-6358
Denver	David Evans, 410-786-0412	Sue Mathis, 410-786-6938
San Francisco	Ed Howard, 410-786-6368 Jim Logan, 410-786-7625	Sue Mathis, 410-786-6938
Seattle	David Evans, 410-786-0412	Sue Mathis, 410-786-6938

TABLE 10A – REGIONAL OFFICE MBD CONTACTS

10.2.1 Connectivity

- Connection to the MBD is obtained through the Medicare Data Communications Network (MDCN), that is currently maintained by AT&T Global Networking Services (AGNS). The AGNS dialer software can be downloaded at ftp://ftp.attglobal.net/pub/Client/win32/setup.exe. The dialer is also available from the CMS Extranet at http:/158.73.207.36/attsetup.exe. If users are unable to access the Internet to download the dialer, contact CMS at 410-786-6008 or RemoteAccess@cms.hhs.gov.

- Users should contact their regional office contact to ensure that the AGNS ID has been added to the MBD group, which allows connection to the MBD production server. If a T1 connection is being used, send an email to MDCN@cms.hhs.gov to gain access to the MBD GUI production server (IP address 158.73.105.55) and web server (IP address 158.73.207.36).

- To avoid firewall problems, contact the IT support to ensure access to the production server (IP address 158.73.105.55) and the web server (IP address 158.73.207.36).

10.2.2 Installation

Users will receive a password and software from CMS once the system access application form is processed. Close attention must be given to following the detailed installation instructions to prevent future system errors.

- Double-click the self-extracting zip file MBD_Websphere Version 4.exe. The WinZip self-extractor pop-up window will display as illustrated in Figure 10-1. Click Unzip to install the files into a new directory, C:\Mbdtcpi, which is created automatically during the unzip process.

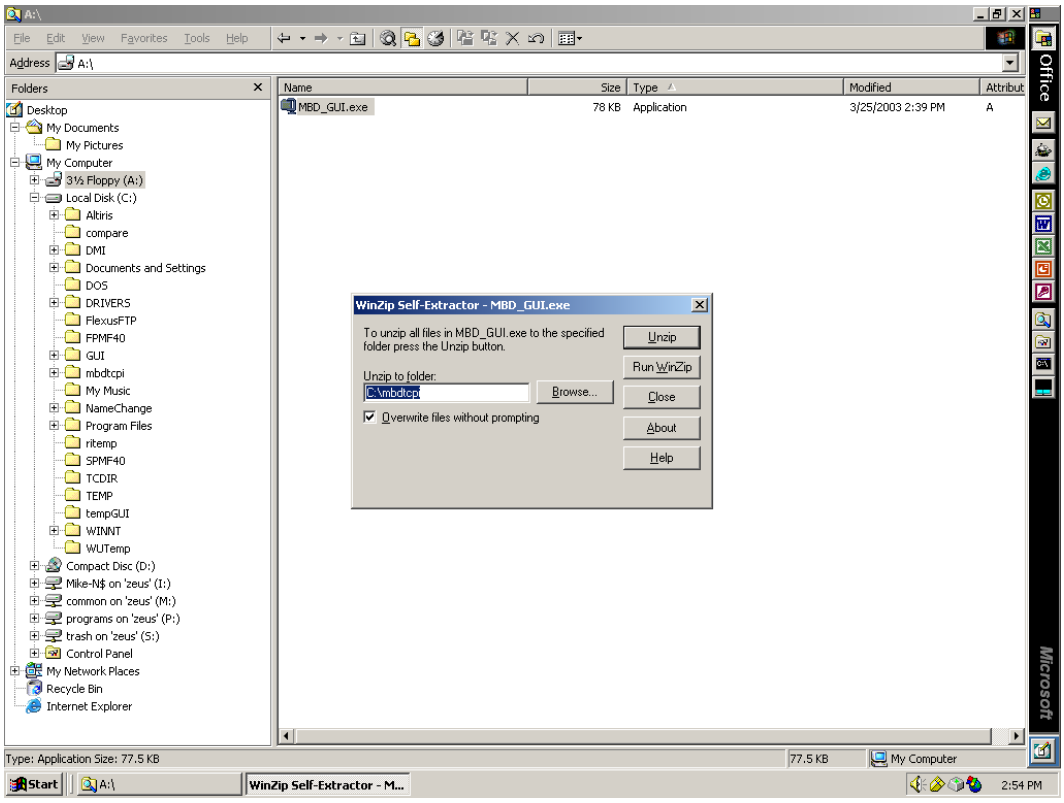


Figure 10A – Winzip Self-Extracting

- Access Windows Explorer by clicking Start, then Programs, then Windows Explorer.
- Click on the C:\Mbdtcpi folder to view its contents.
- If there is no connection to the CMS Data Center via an intranet, connect to the AGNS network via the AGNS dialer.
- Click on the MBD_X_0321.htm file.
- The browser will display the MBD web page, which should automatically launch the MBD GUI application. When prompted with a security warning to install and run the ActiveX control, click 'Yes'.

NOTE: When accessing MBD for the first time, users will experience a longer wait while the application files are downloaded to the computer. The client server picture and small window in the center of the computer screen indicates that the files are being downloaded as illustrated in Figure 10B. A "broken link" icon in the center of the page indicates that a connection has not been made. Contact CMS for assistance.

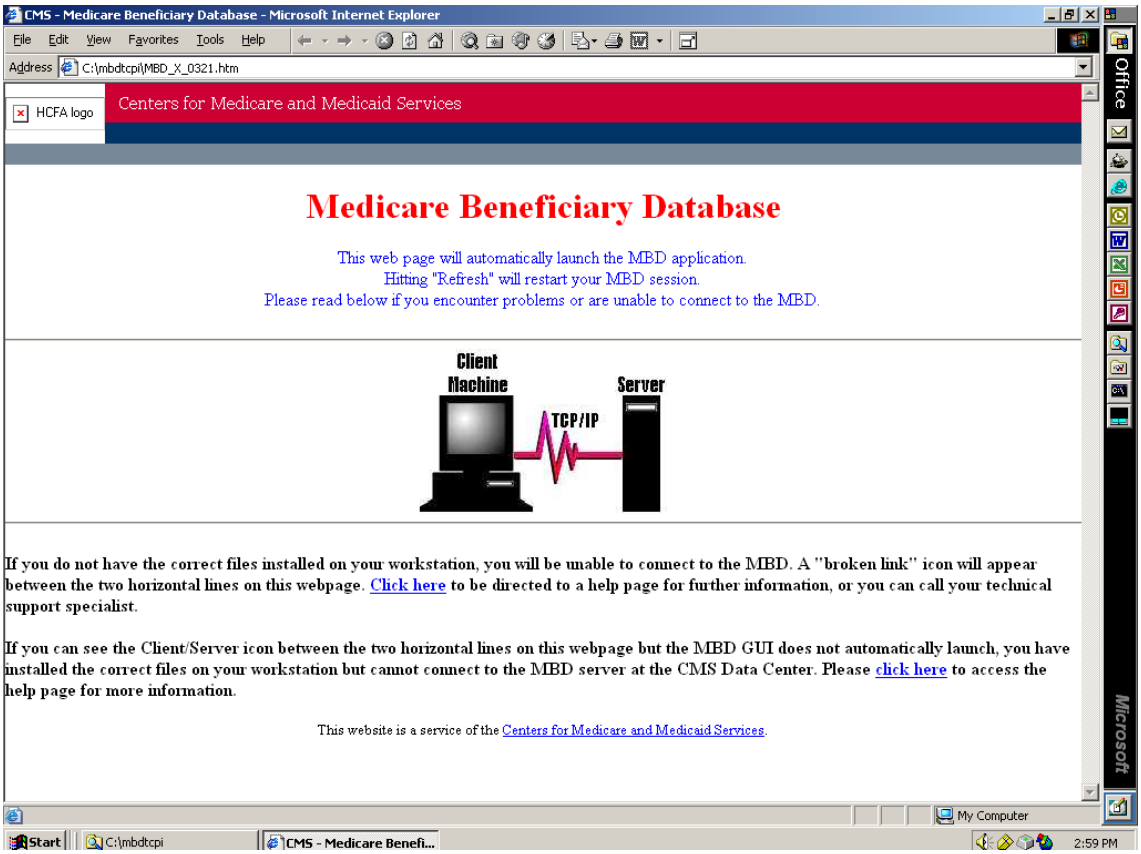


Figure 10B – MBD Connection Screen

- After a successful connection, the MBD_X_0321.htm and sp2tc.cab files may be deleted from the C:\mbdtcpi folder. Copy the WebSphere MBD shortcut to the desktop and use this to access the MBD. The WebSphere MBD shortcut will provide password maintenance and periodic informational messages to users.

- If the WebSphere MBD shortcut does not work, speak to your CMS contact to ensure that the AGNS account or T1 connection have the proper authority settings.

Figure 10C illustrates the User Logon Screen.

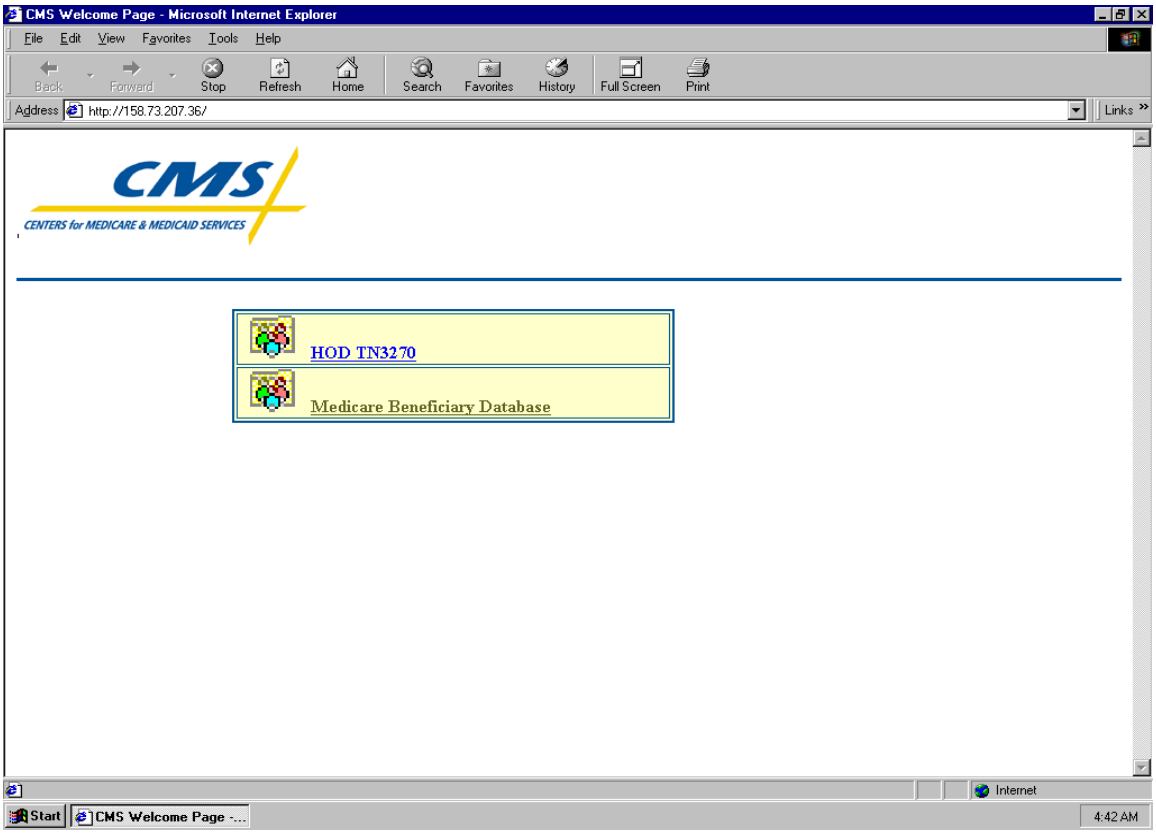


Figure 10C – User Logon Screen

The MBD User's Guide is located in the resource guide.

10.3 MBD Risk Adjustment Purpose (Slide 10)

During processing of the risk adjustment data, RAPS checks the eligibility of the Medicare beneficiary against the MBD. In March 2003, The Group Health Plan System (GHP) database was loaded to the MBD. This ensured that the MBD eligibility information was consistent with GHP, the sole system for Medicare enrollment information.

Figure 10D illustrates the flow of data from GHP to MBD and between MBD and RAPS.

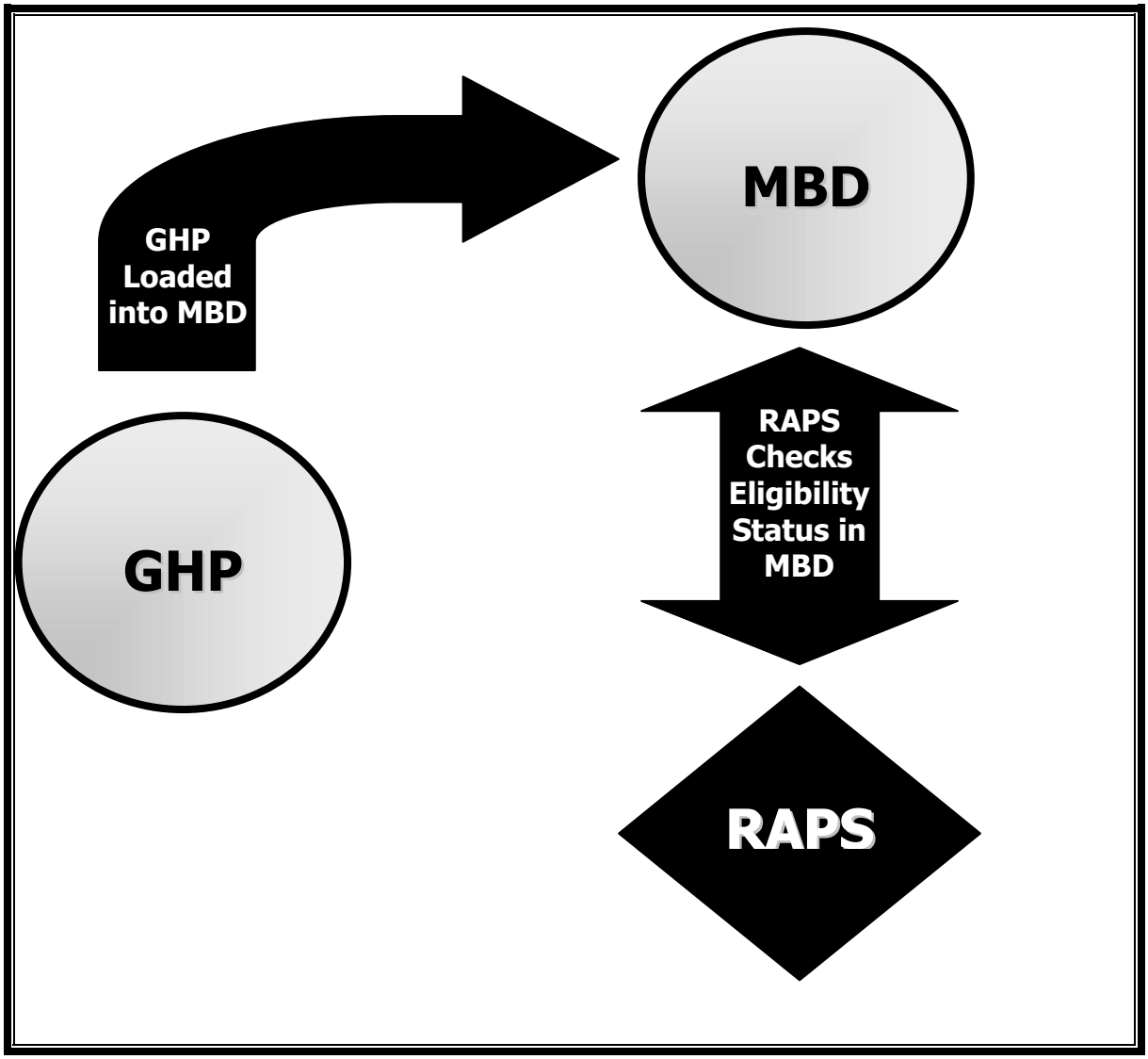


Figure 10D – MBD Flow of Data

10. 4 MBD Common Risk Adjustment Uses (Slide 11)

M+C organizations can reduce the numbers of errors that are returned due to invalid eligibility by accessing MBD to determine the eligibility and other demographic information. Implementing the following procedures in your organization will reduce the time spent on resolving errors.

- Develop a monthly validation process that verifies the eligibility of the M+C organization enrollees.
- Program the internal information systems to cross check the MBD before submitting the data to the Front-End Risk Adjustment System (FERAS).

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

- Date of Birth
- Date of Death
- Medicare Effective Date
- Medicare Termination Date

Example 1

The M+C organization includes the date of birth in their submission, but found that the majority of their errors were related to the date of birth. The organization implemented a system to reduce the number of errors returned for eligibility issues. Figures 10E, 10F, and 10G illustrate the process of researching the Date of Birth of a beneficiary.

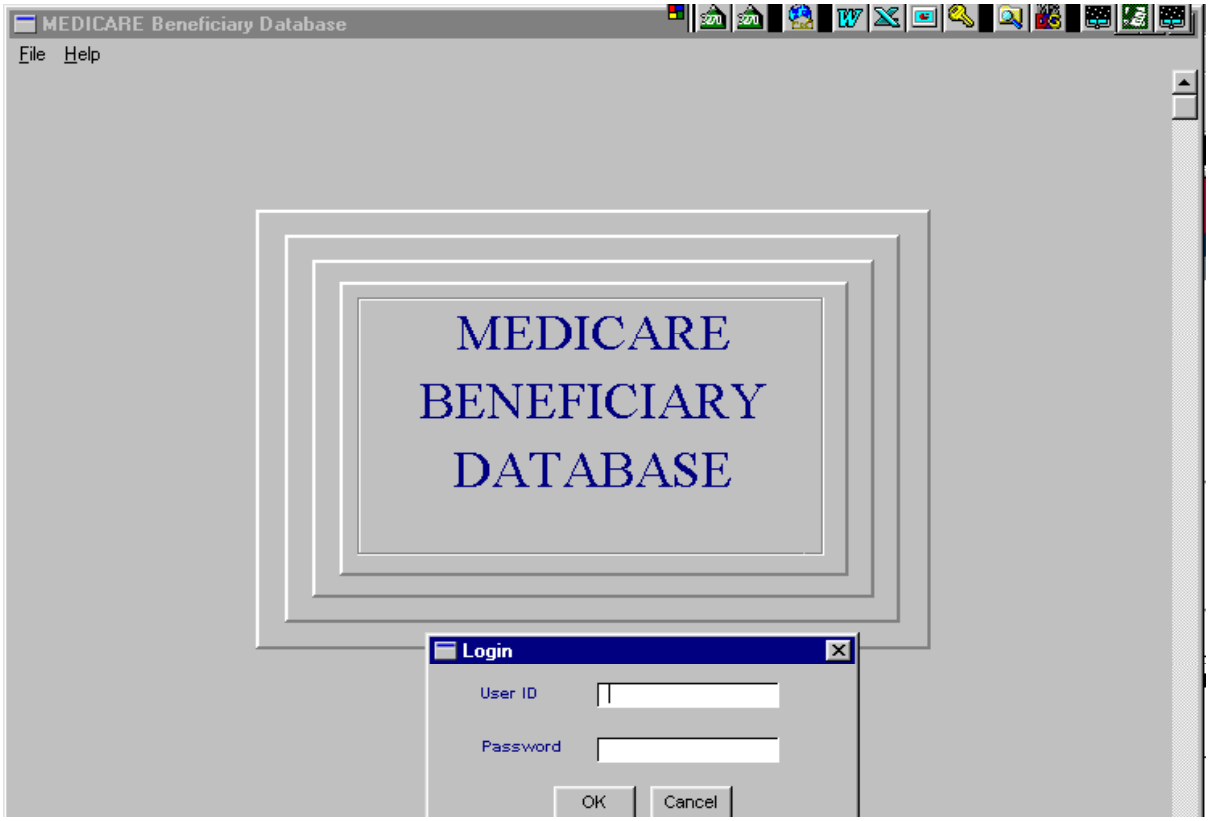


Figure 10E – Log In

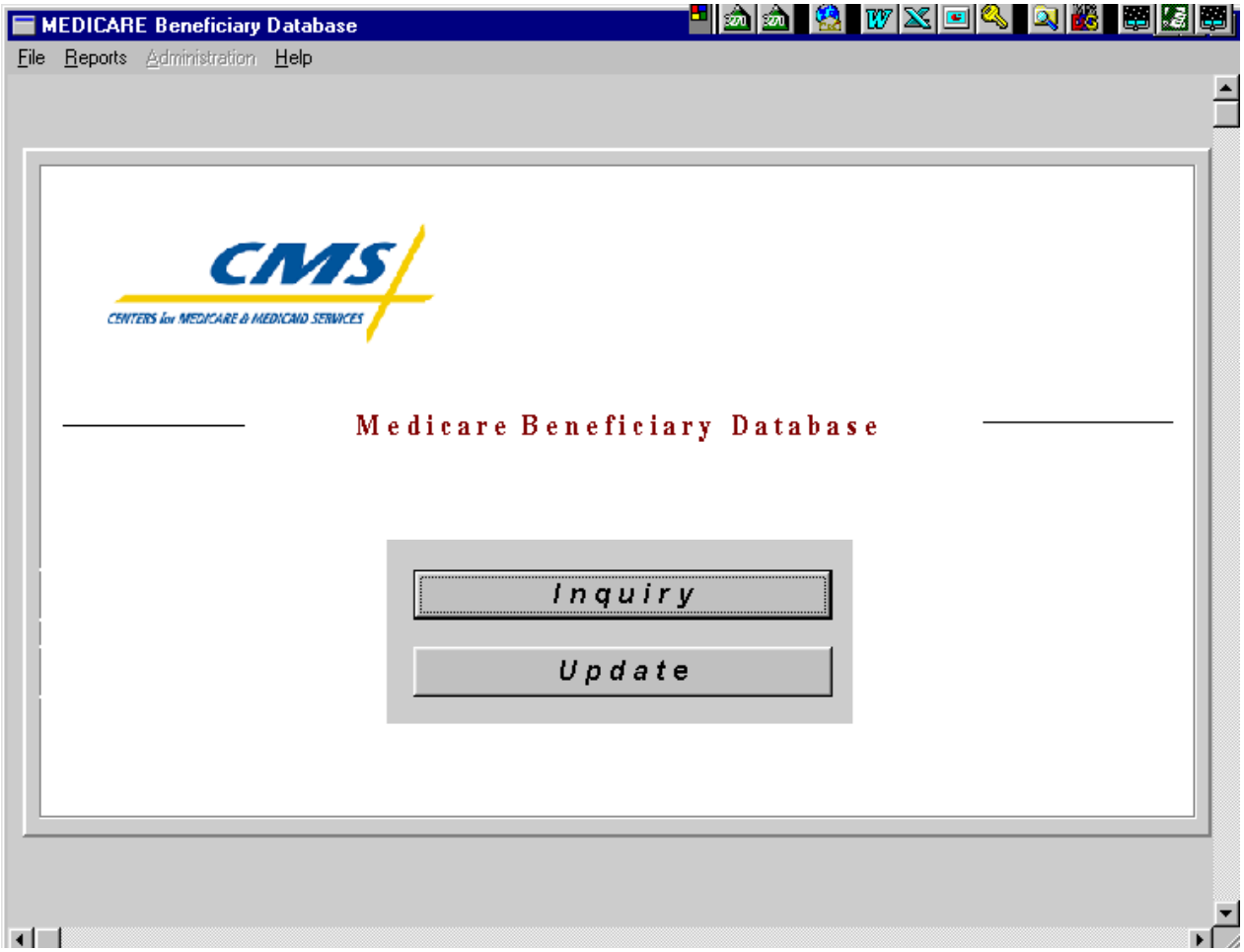


Figure 10F – Inquiry Screen

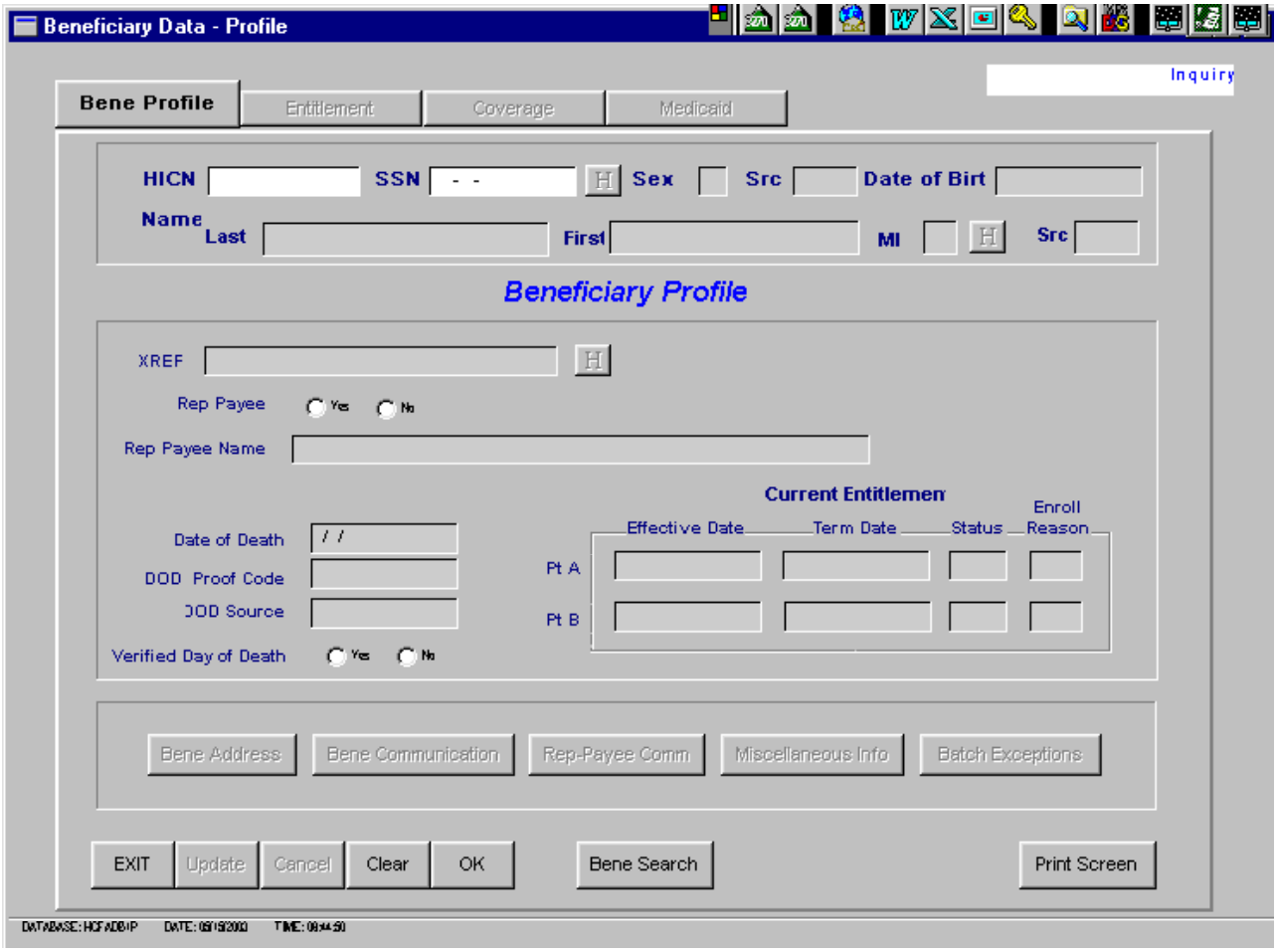


Figure 10G – Checking DOB

MODULE 11 – VERIFYING RISK SCORES

Purpose (Slide 2)

Successful collection and submission of risk adjustment data ensure accurate payment to the M+C organization. This module will identify the systems that are used to calculate risk scores and the reports that are available to verify risk scores.

Learning Objectives (Slide 3)

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

- Understand how to use reports to verify risk scores
- Identify data systems used to calculate risk scores
- Interpret the Impact Data Report
- Identify the changes in the Monthly Membership Report
- Understand how to interpret benchmarks

ICON KEY

Example

Reminder

Resource

IT/Systems Track:
Data Collection Track

11.1 Verification Tools

There are a number of tools available to M+C organizations to assist in verifying risk scores.

11.1.1 RAPS Management Reports (Slide 5)

The RAPS Monthly and Cumulative Plan Reports are available the first of each month. These reports assist in the confirmation of the total number of diagnoses stored in the CMS-HCC model.

11.1.2 Raps Return File (Slide 6)

M+C organizations can use the results of each Raps Return File to establish a record of every diagnosis that is stored in the CMS-HCC model for each enrollee.

11.1.3 Monthly Membership Report (MMR) (Slide 7)

The MMR is generated by the Group Health Plan (GHP) payment system and provides beneficiary-level information. The MMR is specific to the M+C organization and contains a list of all M+C enrollees for the given month of the report. The MMR provides all monthly payment amounts by beneficiary for the M+C organization. Additional beneficiary information includes: health status, risk factor amount paid, and any monetary payment adjustments. The report is downloaded via GROUCH at the CMS Data Center and is usually available the third week of every month.

Because the risk adjustment payment method is changing for 2004, CMS will apply the CMS-HCC model (instead of the PIP-DCG model) to calculate the risk adjustment factors. The CMS-HCC model produces a minimum of two risk scores—a community score and an institutional score. In addition, the blended payment percentages are changing to 70% demographic and 30% risk adjustment.

 See Attachments A & B for DRAFT MMR file layouts

NOTE: In order to reconcile risk scores properly it is important to track beneficiary level status, payment rate, and demographic payment information as full risk adjustment is phased in.

11.1.4 Risk Adjustment Model Output Report (Slide 9)

In addition to the MMR, plans also will receive the Risk Adjustment Model Output Report available through GROUCH. This report will supplement the MMR by reporting each HCC triggered for an individual, disease and demographic interactions, and other information used in making risk adjusted payments.

 See Attachment C for a DRAFT of the file layout

11.1.5 Run the CMS-HCC Model (Slide 10)

CMS will run the CMS-HCC model on an annual basis. M+C organizations may run the model using SAS software available at the CMS website to compare their risk scores against the risk scores reported by CMS in the MMR.

11.2 Calculation of the Risk Factors (Slide 11)

1. Each year CMS defines a cohort of beneficiaries for whom risk scores will be calculated and used for making payments beginning the following January. Under the PIP-DCG model, all Medicare beneficiaries were included in the cohort. In contrast, under the CMS-HCC model, only a subgroup of beneficiaries will be included in this group because of concerns over the extensive processing time necessary to include all beneficiaries in the calculation. For payments in 2004, this cohort initially will include only beneficiaries enrolled in M+C, PACE, and capitated demonstrations active for one or more months between July 2002 to June 2003.

2. For this cohort, we obtain their beneficiary specific information from Medicare's enrollment databases including the MBD. Beneficiary information includes the months of Part A and Part B enrollment, age,

sex, original reason for Medicare entitlement, etc. for each beneficiary in the cohort. Medicaid information is obtained from the third party payor file. Plan submitted Medicaid status information is also included. CMS ensures that all HIC numbers associated with each individual in the file have been identified. We use all of this information to create a beneficiary demographic input file.

3. Next, for this cohort, we extract assessments from the Minimum Data Set (MDS). We identify the beneficiaries who have resided in a long-term institution for the past 90 days or more and classify these individuals as long-term institutional beneficiaries. We hold the long-term institutional file until we reach the payment stage.

4. Next, we obtain all diagnostic information from Medicare data files for the cohort. These data include all diagnoses for the data collection period for the three types of data sources: physician services, hospital outpatient, and hospital inpatient. These diagnoses come from the RAPS database as well as Medicare fee-for-service files. From this data we create a beneficiary diagnosis input file.

5. The beneficiary demographic and beneficiary diagnosis input files are used to run the CMS-HCC model. The model determines a new enrollee factor for each individual who has less than 12 months of Part B enrollment during the data collection period. The model filters out diagnoses that are from excluded provider types and diagnoses that don't correlate, such as ovarian cancer in a male patient. For each individual with 12 months of Part B enrollment, the software produces two risk scores: one based on the community model and one on the institutional model. The software also shows which HCC group (as well as which demographics/interactions/etc.) is associated with the risk scores. Only the most severe disease classification within a hierarchy is shown in the output. Based on this information, an output file is created and sent to the payment system.

6. The output from the CMS-HCC model is provided to the Group Health Plan payment system (GHP) for use in making payments to plans in January. GHP will be replaced with the Medicare Managed Care System (MMCS) in 2004. In addition, the model output serves as the basis for the MMR reports provided to plans and the Risk Adjustment Model Output Report.

7. Plan level instructions also are provided to the GHP for use in determining which factor, community or institutional, should be used in actually making payments. For example, one list informs the payment system of those plans that should receive a frailty adjuster. Another list includes plans that have a large percentage of institutionalized enrollees. For these plans, the payment system will use the MDS long-term institutionalized indicator for an individual to determine whether to use the community risk factor or the institutional one in making payments.

8. GHP identifies individuals enrolled in an organization for a particular month, and then accesses the risk factor file to retrieve the appropriate risk factor for each individual. The GHP uses the individual's state and county code to determine the correct county capitation rate and then multiplies the risk factor by that rate. After calculating the correct demographic payment for the same individual, the GHP then calculates the correct payment by blending the appropriate proportion of risk and demographic payments. The working aged adjustment is applied as appropriate to each component. Then the demographic and risk adjusted amounts are totaled.

   NOTE: The reconciliation for a year redefines the cohort to include, for example, all Medicare beneficiaries. The process is repeated—updating the data used for the model to include new

diagnoses received for the data collection period, as well as changes in any of the demographic factors.

11.2.1 Calculation Process (Slide 14)

In 2004, the risk adjustment calculation process will include a variety of systems that will provide the components necessary for accurate risk adjustment. The systems include risk adjustment information, fee-for-service, and demographic data. The process is identified in figure 11-A and described below.

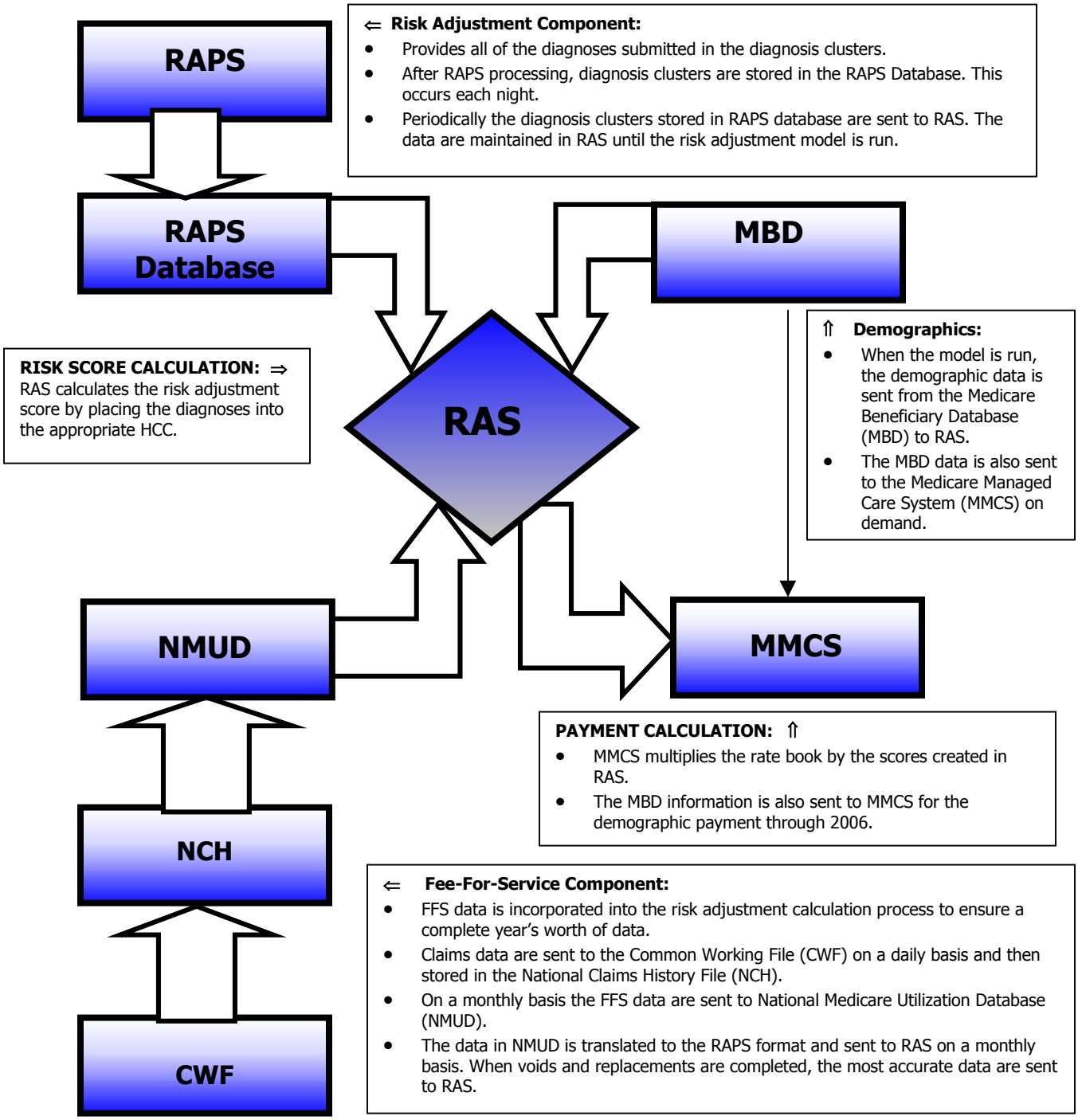


Figure 11A – Calculation Process

11.3 Impact Data Report (Slide 15)

As described in Module 1, individual plan impact reports based on estimate data will be posted in HPMS. The Impact Data Report provides the risk score and HCCs for a plan that submitted risk adjustment estimator data.

- The estimator data was based on dates of service July 1, 2001 – June 30, 2002.
- The impact data report is based on:
    - Hospital inpatient, hospital outpatient, and physician data
    - Estimator data submitted in the RAPS
    - Fee-For-Service claims data
    - M+C encounter data submitted prior to October 1, 2002
    - Enrollee in September 2002 Cohort during the 12-month period

Table 1 shows aggregate plan information, the estimated impact for the plan, the estimated risk factor for the plan, as well as the risk score for all M+C organizations and the estimated national payment change.

Table 2 shows the number and percentage of beneficiaries for an organization by the number of condition categories (HCCs) triggered. Each beneficiary is assigned to only one group in this table.

Table 3 shows the number and percentage of beneficiaries for an organization by the specific HCC category (categories) triggered. Only beneficiaries that triggered one or more condition categories (HCCs) are reflected in this table. An enrollee may be reflected in more than one table.

The information contained in Tables 2 and 3 will be updated based on current year data and appear in the Quarterly Diagnosis Counts Report posted in HPMS (in this report the tables will be labeled 1 and 2, respectively).

H7777 – SUNSHINE HEALTH PLAN

September 2002 Enrolled Beneficiaries: 3,452

Model using data from 7/1/2001 through 6/30/2002 (updated 03/31/2003)

Table 1: Projected Impact	
Variable	**Score**
Number of New Enrollees	1,000
Number of Institutional Beneficiaries	500
Number of Community Beneficiaries	250
Risk Score for H7777	1.36
Risk Score for all Managed Care Organizations	0.85
Estimated Percent Change in Payment for H7777	3.2
National Estimated Percent Change in Payment	-0.5

Table 2: Number of Beneficiaries per Number of Conditions		
Condition	**Number**	**Percent**
Number of beneficiaries with 0 conditions	629	83.87%
Number of beneficiaries with 1 condition	47	6.27%
Number of beneficiaries with 2 conditions	34	4.53%
Number of beneficiaries with 3 conditions	18	2.40%
Number of beneficiaries with 4 conditions	13	1.73%
Number of beneficiaries with 5 conditions	4	0.53%
Number of beneficiaries with 6 conditions	3	0.40%
Number of beneficiaries with 7 or more conditions	2	0.27%
Total Number of Beneficiaries in Risk Models	750	100%

Table 3: Number of Beneficiaries with Conditions in Model*			
Code	**Condition**	**Number**	**Percent**
HCC 1	HIV/AIDS	0	0.0%
HCC 2	Septicemia/Shock	17	0.5%
HCC 5	Opportunistic Infections	0	0.0%
HCC 7	Metastasis Cancer and Acute Leukemia	18	0.6%
HCC 174	Major Organ Transplant Status	5	0.2%
HCC 176	Artificial Openings for Feeding or Elimination	0	0.0%
HCC 177	Amputation Status, Lower Limb/Amputation Complications	2	0.1%

*Abbreviated report

Figure 11B – Sample Impact Data Report

11.4 Benchmarking (Slide 18)

M+C organizations have access to a number of sources of information that can be used to determine if sufficient diagnoses have been submitted to CMS. These sources include specific reports provided to the M+C organization through RAPS and HPMS.

For example, RAPS reports can inform the organization about the number of diagnoses submitted and accepted from each provider type for an organization or the number of relevant diagnoses accepted for a data collection period. Through HPMS, organizations will be provided with quarterly reports (beginning in November 2003) that profile the data submitted for a given data collection period. The data in HPMS will reflect non-duplicated diagnoses that trigger an HCC for a person. Using the RAPS reports and the HPMS tables, M+C organizations can compare their distributions to published benchmarks.

CMS plans to post (on its website) the distribution of HCCs for Medicare fee-for-service. These frequencies could be compared to a plan's distribution as reflected in HPMS.

For example, table 11A below is based on beneficiaries enrolled in M+C organizations that submitted sufficient data from the July 2001-June 2002 data collection period. These data were used to generate an estimate of the impacts of the CMS-HCC model for use in developing adjusted community rates (ACRs) for 2004. While the number of organizations reflected in these data is not necessarily representative of the entire M+C program, the distribution does reflect diagnostic data for over 3.4 million persons.

Condition	Number	Percent
Number of enrollees with 0 conditions	1,855,524	54.0%
Number of enrollees with 1 condition	844,722	24.6%
Number of enrollees with 2 conditions	372,525	10.8%
Number of enrollees with 3 conditions	175,556	5.1%
Number of enrollees with 4 conditions	89,798	2.6%
Number of enrollees with 5 conditions	47,108	1.4%
Number of enrollees with 6 conditions	24,996	0.7%
Number of enrollees with 7or more conditions	28,517	0.8%
Total number of (non-new) enrollees	3,438,746	100.0%

TABLE 11A – NUMBER OF ENROLLEES PER NUMBER OF CONDITIONS—DRAFT—NATIONAL ESTIMATES

Example: Suppose a plan had the following results for 2003: (Slide 19)

Condition	Number	Percent
Number of enrollees with 0 conditions	2,112	63.8%
Number of enrollees with 1-6 conditions	1,036	31.3%
Number of enrollees with 7 or more conditions	161	4.8%
Total number of (non-new) enrollees	3,309	100.0%

Compared to the data in the national estimate table, does the organization's data look complete? Why or why not?

What To Look For:

1. Does your data look like the data for the national average plan? Where does it differ?
2. Does the organization's data differ at the extremes? Do you have a significantly larger percentage of enrollees with 0 conditions? Do you have a lower percentage with 7 or more conditions?
3. If your distribution looks different, what information is available from the frequency by HCCs? How does this distribution look relative to the national FFS frequencies?
4. What specific HCCs are affected? Are there specific provider types or physicians associated with this HCC?

By comparing your plan results to the national benchmarks, plans can conduct further analysis to identify potential problems with data collection and data submission. The benchmarks also assist plans in identifying the relative "healthiness" of their enrollee population.

ATTACHMENT A – DRAFT MMR DATA FORMAT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
	Demographic Health Status Indicators:			
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD

#	Field Name	Len	Pos	Description
16	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
	Risk Adjuster Indicators:			
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
*22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**
***23**	**Default Indicator**	**1**	**71-71**	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD

#	Field Name	Len	Pos	Description
	Fields 26 - 30 applicable to both Demographic and Risk Adjuster:			
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-$$$$$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-$$$$$.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-$$$$$.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-$$$$$.99
35	Blended Paymt/Adjustmt Rate A	9	144-152	-$$$$$.99
36	Blended Paymt/Adjustmt Rate B	9	153-161	-$$$$$.99
37	Total Paymt/Adjustmt	9	162-170	-$$$$$.99
	Additional Risk Adjuster Indicators:			
*38	FILLER	1	171-171	SPACES

#	Field Name	Len	Pos	Description
39	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
40	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
41	FILLER	1	183-183	SPACES
42	FILLER	1	184-184	SPACES
43	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
44	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
*45	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community CP = Community Post-Graft (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) EP = New Enrollee Post-Graft (ESRD) G = Graft (ESRD) I = Institutional IP = Institutional Post-Graft (ESRD)
*46	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included

#	Field Name	Len	Pos	Description
*47	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
*48	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
*49	FILLER	7	194-200	SPACES

ATTACHMENT B – DRAFT MMR REPORT FORMAT

[EXISTING FORMAT]

```
|----+----1----+----2----+----3----+----4----+----5----+----6----+----7----+----8----+----9----+----0----+----1----+----2----+----3--

   RUN DATE:YYYYMMDD                          MONTHLY MEMBERSHIP REPORT                                    PAGE:         9
   PAYMENT MONTH:YYYYMM                     PLAN: H9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                                                                PAYMENT DATE   DEMOGRAPHIC PAYMENT
                                AGE                                M   C A D MTHS             START   END      PART A      PART B
                                GRP                          H E   I   C   H D E A B        ------------------------------------
                      S         ---        OUT             O S   N N A   F D F --- ADJ ***** RISK ADJUSTMENT PAYMENT *****
   CLAIM          F E DATE OF  DMG  STATE OF PART S R W S H I     O A PIP REA FCTR-A FCTR-B     PART A      PART B     TOTAL
   NUMBER   NAME  I X  BIRTH   RA   CNTY AREA A B P D A T C D     N U DCG CDE PBP-ID PRDIB                            AMOUNT
_____________________________________________________________________________________________________________________________
 ***[PAYMENT FORMAT]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC  Y  Y Y Y Y Y Y Y Y   Y Y Y 1 1     YYYYMM YYYYMM $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
                           9999                                    Y      99     9.9990 9.9990 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
                                                                   Y               999 9.9990 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
***[ADJUSTMENT FORMAT]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC  Y  Y Y XXXXXXXXXXXX    Y YZ9Z9  99 YYYYMM YYYYMM $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
                           9999                                        99     9.9990 9.9990 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
                                                                              9.9990 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99

***[NEW FORMAT A]***
|----+----1----+----2----+----3----+----4----+----5----+----6----+----7----+----8----+----9----+----0----+----1----+----2----+----3--

  RUN DATE:YYYYMMDD                          MONTHLY MEMBERSHIP REPORT                                        PAGE:         9
  PAYMENT MONTH:YYYYMM                     PLAN: H9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                                                                PAYMENT DATE       BLENDED PAYMENT
                                AGE  STATE O  P P          M  F P A D MTHS                   START   END
                                GRP  CNTY  U  A A H E   I  C  R R D E A B                    ---------------------------------------------
                      S         ---  ----- T  R R O S   N N A  A D D F --- ADJ              FCTR-A FCTR-B
   CLAIM          F E DATE OF  DMG  PBP  OF  T T S R W S H I  I I O A PIP REA              ---------------------------------------------
   NUMBER   NAME  I X  BIRTH   RA   ID  AREA A B P D A T C D  L B N U DCG CDE  LAG   FTYPE       PART A      PART B    TOTAL AMT
_____________________________________________________________________________________________________________________________
 ***[PAYMENT FORMAT]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y Y Y Y Y Y Y  Y Y Y Y 1 1      YYYYMM YYYYMM
                           9999 999                                        __      9.9990 9.9990
                                                                           Y       XX     $ZZZ,ZZ9.99 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
***[ADJUSTMENT FORMAT, POST-2003]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y XXXXXXXXXXXX Y Y Y YZ9Z9  99   YYYYMM YYYYMM
                           9999 ___                                        __      9.9990 9.9990
                                                                           Y       XX     $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
***[ADJUSTMENT FORMAT, PRE-2004]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y XXXXXXXXXXXX _ Y Y YZ9Z9  99   YYYYMM YYYYMM
                           9999 ___                                        99      9.9990 9.9990
                                                                           _       __     $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
```

MODULE 12 – RISK ADJUSTMENT DATA VALIDATION

Purpose (Slide 2)

To describe the data validation approach under the CMS-HCC model.

Objectives (Slides 3)

- Understand the risk adjustment data validation process and principles
- Identify the guidelines for medical record documentation
- Understand the risk adjustment data sampling approach
- Understand the medical record review process and data validation
- Identify risk adjustment data discrepancies
- Understand payment adjustments and appeals

ICON KEY

Example	
Reminder	
Resource	
IT/Systems Track	
Data Collection Track	

12.1 What is Risk Adjustment Data Validation? (Slides 5)

Data validation is the next step that occurs after data is collected and payment is made to the M+C organization.

In order to ensure the implementation of an accurate M+C payment system, CMS must:

- Identify risk adjustment data discrepancies
- Measure the accuracy of the risk adjustment data submitted by M+C organizations
- Communicate risk adjustment data validation findings to M+C organizations
- Implement steps to improve inaccurate data, for example, by providing technical assistance to plans with high discrepancy rates

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

Purpose: To ensure risk adjusted payment integrity and accuracy.

12.2 Risk Adjustment Data Validation Process and Principles (Slides 7)

The approach for data validation under the CMS-HCC model is based upon the validation process used under the PIP-DCG (Principal Inpatient Diagnostic Cost Group) model. That is:

- A sampling design is developed
- Medical records are requested from M+C organizations
- Medical records are submitted for review and checked by the validation contractor
- Medical record reviews are conducted
- Risk adjustment data discrepancies are identified
- Data discrepancies associated with inaccurate payment are subject to confirmation by a second independent review
- HCCs are assigned based on the confirmed findings and inaccurate payments are identified
- Plan specific and summary findings are shared with M+C organizations
- Payments may be adjusted to correct inaccurate payments
- Appeals of disputed findings associated with payment inaccuracies are allowed

New Components of Data Validation Under the CMS-HCC Model

- In addition to hospital inpatient data, physician and hospital outpatient data will be validated
- Because we have only limited information on a diagnosis for an enrollee, CMS can only provide limited information back to the M+C organization for them to use to track and locate supporting medical record documentation. Based upon the data posted at CMS, the medical record request will include the information provided in the diagnosis cluster as follows:
  - Provider type (hospital inpatient, hospital outpatient or physician)
  - HIC number (beneficiary identification number)
  - Service date(s)
  - ICD-9-CM diagnosis code

> **Guiding Principle:** 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. M+C organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.

- M+C organizations may submit a complete or less than a complete medical record for an enrollee as documentation.

- M+C organizations may identify any medical record, per the requirements outlined in the guiding principle, which supports the diagnosis under review. They are not limited to the medical record that supports the specific diagnosis cluster. That is, a different date (within the correct data collection period) or a different (but allowed) provider type could be substituted for the specific diagnosis cluster under review. For example, the identified diagnosis was associated with a hospital outpatient service, but instead the plan decides to send hospital inpatient documentation to support the diagnosis.

- Because the M+C organization may need to identify which medical record provides the most clear documentation of a diagnosis, CMS will attempt to increase the amount of time allowed for organizations to obtain and review these records.

- The appeals process will be conducted after payment adjustments have been implemented.

- Per similar Medicare fee-for-service practice, CMS will allow M+C organizations one additional opportunity to submit medical record documentation to support a diagnosis for confirmed discrepancies during the appeals process.

12.3 Guidelines for Medical Record Documentation (Slide 10)

Given that diagnosis codes are assigned based on medical record documentation, it is critical that documentation guidelines are followed and medical records are complete and accurate. Medical record documentation of diagnoses is the basis for validating the diagnoses submitted by the M+C organization. The new CMS-HCC model includes many more diagnoses from additional settings. Data from physician settings will comprise a large portion of the diagnoses submitted. This expansion means that accurate medical record documentation by physicians and other clinicians is a key component of accurate risk adjusted payments.

Below are general guidelines for ambulatory medical record documentation:

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medial record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education

An appropriately documented medical record may serve as a legal document to verify the care provided, if necessary.

Source: 1997 Documentation Guidelines for Evaluation and Management Services

The principles of documentation listed below are applicable to all types of medical and surgical services for all settings.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - Assessment, clinical impression or diagnosis;
   - Plan for care; and
   - Date and legible identity of the observer
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Source: 1997 Documentation Guidelines for Evaluation and Management Services

Remember, probable, suspected, questionable, rule out, or working diagnoses cannot be reported to CMS as valid diagnoses by a physician.

NOTES: All diagnoses, as well as information that supports the assigned diagnoses, must be documented during the correct data collection period in the medical record and must comply with ICD-9-CM coding guidelines.

As with other Medicare payment systems medical record documentation will be used to validate payments. Signed attestations or superbills will not be considered sufficient medical record documentation to support a diagnosis.

Acceptable Types of Documentation by Source (Slide 11)

Table 12.A below identifies some of the types of documentation that are acceptable and not acceptable for risk adjustment data validation. CMS will provide organizations with the option of submitting either a complete or less than a complete medical record to support a diagnosis being validated. We recognize that each M+C organization must judge what part of the medical record contains the most appropriate support for the diagnoses being validated; however, we wanted to give plans the flexibility to identify from within a medical record the best medical record documentation to support the diagnosis.

Physician	Hospital Inpatient	Hospital Outpatient
ACCEPTABLE		
• Dated and signed problem list • Diagnoses documented by the physician in the medical record as part of the treatment and evaluation of the enrollee with the date of the encounter. Note - it may be documented in different components of the medical record, e.g. progress notes or the history and physical, as long as that diagnosis is dated within the correct data collection period. • One record may provide support for more than one diagnosis. We have estimated that over 50% of the enrollees will have more than one HCC. There are generally 2 to 3 diagnoses per physician office medical record. • Documentation will be considered sufficient if a coder is able to identify the diagnosis assigned by a physician in a manner consistent with the ICD-9 coding guidelines.	• The average number of diagnoses on an inpatient hospital record is 5. • Coding generally done by professional coders • Considered to be most reliable source of accurate diagnostic coding	• Coding generally done by professional coders
NOT ACCEPTABLE		
• Superbills • Physician signed attestation • Alternative data sources • Incorrect physician extender type (e.g., nutritionist) • Documentation for dates of service outside of data collection period	• SNF records • Documentation for dates of service outside of data collection period	• Freestanding Ambulatory Surgical Center (ASC) medical records • Documentation for dates of service outside of data collection period

TABLE 12A – DOCUMENTATION BY SOURCE

Examples of different circumstances where plans may or may not submit diagnoses based on the medical record documentation.

Example 1: The patient has a broken leg and Congestive Heart Failure (CHF). The physician documents a diagnosis for the broken leg in the medical record, but does not reference the CHF in the medical record documentation on the date of service when he attended to the broken leg. In this case, the M+C organization cannot submit the code for CHF because the physician did not document the diagnosis of CHF on that date.

Example 2: The patient has a broken leg, CHF and Chronic Obstructive Pulmonary Disease (COPD). The physician documents a diagnosis for the broken leg for the patient, and also notes that the patient has CHF and COPD in the medical record documentation on the date of service when he is attending to the broken leg. The physician, however, fails to communicate the CHF or the COPD diagnoses to the plan for the submission of this data to CMS. The plan learns that that patient did have diagnoses of CHF and COPD assigned by the physician during the visit for the broken leg visit. In this case, because the physician has noted the diagnoses in the documentation, the plan may submit the CHF and COPD diagnoses as risk adjustment data, assuming the dates of service fall within the correct data collection period.

Example 3: The patient has diabetes with complications – ophthalmic manifestations. In this case, the physician submitted to the plan a diagnosis code of diabetes without mention of complications (code 250.0). However, in the medical record documentation the physician has noted on the date of the face-to-face encounter with the patient that the patient has a diagnosis of diabetes with ophthalmic complications (250.5). The plan is made aware of the diabetes diagnosis with the higher level of specificity in the medical record documentation. In this case, the plan may correct the risk adjustment data and change the diagnosis from 250.0 to 250.5.

12.4 CMS-HCC Risk Adjustment Data Sampling Approach (Slide 12)

Sampling will be conducted on an annual basis starting with data collected in CY 2003 for CY 2004 payments. The CMS-HCC risk adjustment data sampling approach will include both targeted and random components. The sampling is conducted in three stages. Organizations are sampled first, then beneficiaries are sampled and lastly, HCCs or specific diagnoses for those beneficiaries will be selected for medical record review.

Stage 1: In any one validation year M+C organizations are selected either at random or based upon targeting criteria. Targeting criteria includes patterns in the risk adjustment data that are suggestive of potential problems and also past performance in M+C validation activities. For example, a plan might be targeted for validation because the risk adjustment data submitted to CMS by that plan indicated a unique and disproportionately high number of higher scoring HCCs (that is, the risk score associated with that HCC is a large number). Alternatively, a plan might be reselected for medical record review as a result of a high CMS-HCC risk adjustment data discrepancy rate based on prior validation activities. Over time past performance may play a greater role in determining whether or not a plan will be reselected for validation. In the future, a targeted design may be applied to select either specific HCCs or specific diagnoses.

Stage 2: Once the sample of M+C organizations has been selected for validation, beneficiaries are then selected for medical record review. Beneficiaries may be sampled at random, or targeted as a result of their profile of HCCs. A profile of HCCs refers to all HCCs assigned to a beneficiary based on all the diagnoses reported that are included in the CMS-HCC model.

Stage 3: Once a beneficiary has been sampled for validation, all or specific HCCs assigned to that beneficiary and/or individual diagnoses will be selected for review. For each beneficiary sampled, medical record documentation will then be requested to support any combination of the following:

- the profile of HCCs (each of the HCCs) assigned to that beneficiary
- a subset of HCCs for that beneficiary
- one HCC for that beneficiary
- and/or
- specific diagnoses

Generally, if a diagnosis was submitted when a person was in Medicare fee-for-service, CMS will not review that diagnosis.

CMS-HCC Risk Adjustment Data Validation Sampling Stages		
Stage 1: M+C Organization	**Stage 2: Beneficiary**	**Stage 3:HCCs/Diagnoses**
Select M+C Organizations: • Random and Targeted • Targeting criteria based on profile of data submitted and past performance in validation • Approximately 30 to 50 organizations	Select beneficiaries: • Random and targeted based on the HCCs assigned • Approximately 50 to 400	Medical record request will be based on: • Entire profile of HCCs for the beneficiary, or a subset of HCCs or single HCC for that beneficiary or certain diagnoses assigned to a beneficiary • Approximately 50 to 600 HCCs and/or diagnoses

TABLE 12B – DATA VALIDATION SAMPLING STAGES

The actual sampling design for the CY 2004 validation will be developed once CMS has received the risk adjustment data for CY 2004. Because risk adjusted payments will be based on a non-lagged data collection period (which will not be calculated until mid-2004), the medical record request will be sent out no earlier than the spring of CY 2004.

For the CY 2004 validation, CMS anticipates selecting approximately one-third of the M+C organizations (both random and targeted). Between 50 and 400 beneficiaries will be selected for validation for the sampled plans, and medical record documentation to support 50 and 600 HCCs or diagnoses will be requested. We expect that a medical record for one individual will provide support for multiple diagnoses.

In subsequent years, it is likely that CMS will focus some of the validation activities on HCCs that seem to be more problematic than others and that only one HCC may be subject to validation for certain subsamples of beneficiaries.

12.5 Medical Record Review Process and Data Validation (Slides 13)

The request for medical record documentation may specify the requirement to submit documentation to support one or more individual HCCs or diagnoses for an enrollee.

M+C organizations must have data systems in place to track and locate the requested medical record documentation. CMS does not require or store provider identification numbers as a part of risk adjustment data. Therefore, the M+C organization should be able to link a specific diagnosis back to a specific provider.

The medical record request package will include for each beneficiary sampled a listing of all relevant diagnosis clusters submitted and the HCCs assigned to that enrollee. Organizations may submit any record listed or any other record from within the correct data collection period for the payment year being validated in order to support the assignment of an HCC for payment. In some cases, organizations will need to review available documentation to identify the medical record that provides the most appropriate documentation.

CMS will provide a letter to providers on CMS letterhead to encourage providers to respond to the medical record request. CMS will continue to distribute such a letter to organizations for use at their discretion. In this letter, CMS will address the collection and submission of medical records for M+C payment validation purposes in the context of HIPAA privacy regulations. Because CMS is validating payments, access to the medical record is allowed under HIPAA.

CMS will conduct the medical record reviews offsite – in a similar manner to the process implemented for the PIP-DCG model. Plans will be expected to collect and submit the requested medical record documentation to CMS (or its contractor) for review. We expect to reimburse M+C organizations at a flat rate of $10 per record submitted for CY 2004. Note this $10 flat rate may change from year-to-year.

Upon receipt of the medical record documentation, the CMS contractor will conduct a preliminary check to confirm that the correct record has been submitted. If it is not, CMS (or a contractor) will take steps to alert the M+C organization of the problem.

Example

Here is a draft example of how information in the medical record request may be presented:

Health Plan: H1234 **HIC #: 123456789A**			
HCC	**Diagnosis Code**	**Service Date(s)**	**Provider Type**
HCC2	038	1/27/03	Physician
HCC2	0384	4/8/03	Physician
HCC2	0388	2/3/03 through 2/21/03	Hospital Inpatient
HCC2	0388	5/1/03	Physician
HCC2	0381	6/1/03 through 6/4/03	Hospital Outpatient
HCC2	03849	6/6/03 through 6/9/03	Hospital Inpatient
HCC15	2504	1/27/03	Physician
HCC16	2507	5/20/03	Physician
HCC17	25082	6/5/03	Physician
HCC18	2505	4/1/03	Physician
HCC18	25050	4/21/03	Physician
No HCC	111	2/1/03	Hospital Outpatient
No HCC	222	2/2/03	Physician

This individual would have been paid on HCC2 (Septicemia/Shock) and HCC15 (Diabetes with Renal Manifestations). (HCC15, HCC16, HCC17, and HCC18 are in the diabetes hierarchy; therefore, the M+C organization will be paid on only the most severe HCC or HCC15.) The M+C organization may need to submit only one record. There are many options for supporting a diagnosis for HCC2. There is only one record that supports HCC15. (Note, if the organization cannot locate the documentation for HCC15, they should submit the documentation to support another HCC in this hierarchy.)

Responding to a Risk Adjustment Data Validation Medical Record Request (Slide 16)

When responding to a request for medical records, M+C organizations should:

1. Select one record that best supports each diagnosis or HCC specified in the medical record request. That is, if the HCC provided on the request is associated with more than one data source (hospital inpatient, hospital outpatient, physician), then the M+C organization has the option of selecting the specific medical record for validation.
2. Due to variations in physician office medical record documentation, CMS suggests that the M+C organization first select an institutional medical record (either hospital inpatient and hospital outpatient) when the choice of documentation is between an institutional record and a physician record.

3. CMS will consider receiving electronic medical record formats that have been transferred from the physician setting to the M+C organization and then to CMS. While there are a number of proprietary and "home-grown" software packages for electronic medical records, CMS would need to identify a uniform format for use in transmission. M+C organizations would then have to comply with our requirements. CMS would only accept electronic records via Federal Express or other bonded carrier, due to the confidentiality of the data. We will work on developing a uniform format within the next several months.

12.6 Data Discrepancies and CMS-HCC Risk Adjustment Discrepancies

The medical record review and validation process may result in the identification of data discrepancies in the diagnoses submitted by an organization to CMS for risk-adjusted payment. Data discrepancies will occur when the diagnostic data that was reported to CMS by an M+C organization does not match the supporting medical record documentation.

Data Discrepancies (Slide 17)

Data discrepancies include the following:

Coding Discrepancies, which occur when:
- The diagnosis code recorded in the risk adjustment record is not supported by the medical record documentation according to the ICD-9 Guidelines for Coding and Reporting.

Missing or Incomplete medical record discrepancies, which occur when:
- There is a no documentation
- There is insufficient documentation to support a diagnosis
- The dates of service are not within the correct data collection period

Invalid risk adjustment record discrepancies, which occur when:
- The medical record documentation is not provided by an appropriate provider type (hospital inpatient, hospital outpatient, physician) as defined in the CMS instructions for risk adjustment implementation, for example, a skilled nursing facility.

Risk Adjustment Discrepancies (Slides 18)

A risk adjustment discrepancy will be identified when one or more HCCs originally assigned to an enrollee differs from the HCC(s) assigned after medical record review and validation process. Such a discrepancy can either increase the risk score for an enrollee or decrease it. We will analyze changes in risk scores using the following dichotomy:

- *Upcoding* occurs where the final risk score calculated after the medical review is lower than the risk score calculated using the risk adjustment data. Upcoding is associated with overpayment.
- *Downcoding* occurs where the final risk score calculated after the medical review is higher than the risk score calculated using the risk adjustment data. Downcoding is associated with underpayment.

The identification of CMS-HCC risk adjustment discrepancies during the validation process may result in a payment adjustment to the risk portion of the payment for that enrollee.

Example of Coding Discrepancy

The reported diagnosis was 428.0 for congestive heart failure (HCC80). Upon review of medical record documentation the code 402.91 (HCC80) Hypertensive Heart Disease should have been coded. While this is a coding discrepancy, there is no change in the HCC assigned, no change in the risk score, and no change in payment.

Example of Coding Specificity Discrepancy

The risk adjustment data indicated a code of 250 (diabetes mellitus or HCC19). After medical record review, the correct code assigned was 250.1 (diabetes with ketoacidosis or HCC17). This coding discrepancy change would have resulted in a change in HCC (from HCC19 to HCC17), a change in risk score (an increase from .2 to .391), and a change in payment. (Note: this example is one of downcoding.)

Example of Upcoding

Reported Diagnostic Data: 428.0 Congestive Heart Failure (CHF) (HCC80)
Data Validation Findings: 427.31 Atrial Fibrillation (HCC92)

The medical record documentation supports the code 427.31 atrial fibrillation, not 428.0 CHF. It is an example of upcoding because the risk score associated with HCC80 is .417. The risk score associated with HCC92 (the final HCC) is less (.266). Thus, the original diagnosis was upcoded relative to the final diagnosis. This change would have resulted in a lower payment (if a payment adjustment were made).

Example of Downcoding

Reported Diagnostic Data: 428.0 Congestive Heart Failure (HCC80)
440.0 Atherosclerosis of Aorta (HCC105)

Data Validation Findings: 428.0 Congestive Heart Failure (HCC80)
440.23 Atherosclerosis of the Extremities with Ulceration (HCC104)

The medical record documentation supports the CHF finding, but did not confirm HCC105. This case is an example of downcoding because the risk score associated with HCC105 was .357 while the risk score associated with HCC104 (the final HCC) was higher (.677). Thus, the original diagnosis was downcoded relative to the final diagnosis. This change would have resulted in a higher payment (if a payment adjustment were made).

12.7 Second Independent Medical Record Review (Slide 22)

Data discrepancies identified during the validation process that are associated with a CMS-HCC risk adjustment discrepancy will be subject to a second independent medical record review. The purpose of this second independent medical record review is to confirm data discrepancies associated with inaccurate risk adjusted payment. Typically, the second review is done by a Quality Improvement Organizations (QIO) or other program integrity contractor.

12.8 Payment Adjustment & Appeals (Slides 23)

Payments to M+C organizations may be adjusted to reflect the outcomes of data validation. Based on the results of CY 2001 and 2002 data validation studies, CMS will develop criteria for adjusting payment to organizations that demonstrate consistent patterns of payment inaccuracies based on risk adjustment data discrepancies that have yielded overpayments to plans. Based on CY 2003 data validation findings, CMS reserves the right to adjust payment to organizations for all risk adjustment data discrepancies resulting in either over or underpayments. In 2004, CMS recognizes that M+C organizations will be submitting more data and from additional provider types. Any payment adjustments applied based on CY 2004 data will take into consideration that a new risk adjustment model, with different data requirements, has been implemented.

An appeals process will be available when a M+C organization disagrees with the payment adjustment. Consistent with fee-for-service, the M+C organization will have one opportunity to challenge a payment adjustment with additional medical record documentation. The appeals process will likely be conducted after payment adjustments have been made. It is at this point that an organization may appeal a finding that they believe results in an inaccurate payment. We currently expect to structure the appeals process to allow for **one** substitute record if the first set of medical record documentation submitted does not support the diagnosis.

12.9 Analysis and Findings (Slide 25)

A key goal of the validation process is to improve risk adjusted payment accuracy through identifying problems and sharing problematic findings. CMS will continue to provide organization specific and summary findings from medical record review and the validation process to M+C organizations. Under the PIP-DCG validation process, these findings were provided in detail at the discharge level in both electronic and hard copy formats. Upon analysis of the findings, CMS will develop a format for sharing a similar level of detail with organizations that have participated in the CMS-HCC risk adjustment data validation. CMS also expects to continue to provide technical assistance during onsite visits to organizations that appear to be experiencing difficulties with submitting accurate data.

CMS will work toward providing more timely feedback of the validation and medical record review findings. However, it will still be necessary to accommodate the long data collection period, which allows plans to submit late data and the second independent medical record review to confirm discrepancies. The provision of more timely findings may mean that CMS will share preliminary findings from the initial validation process prior to confirmation by the second independent review.

12.10 Pilot Test of CY2003 Estimator Data (Slides 26)

Prior to implementing the data validation approach for CY2004 risk adjustment data, CMS will pilot test the approach using the data reported for impact estimates (July 1, 2001 to June 30, 2002). The pilot test will consist of approximately ten plans of approximately 20 beneficiaries reviewed per plan. The selection of the ten plans will be on a volunteer basis. Volunteer M+C organizations will be reimbursed a flat rate of $10 per record submitted. The pilot test will occur in the Fall 2003 (October/November).

CMS hopes that organizations will view the pilot test as an excellent opportunity to identify problems with their data collection/submission process, their physicians' medical record documentation and potential coding issues before the CY 2004 validation occurs.

Such a test may cause organizations concern about CMS' response to the results of the pilot test. While CMS staff will know which organizations are participating, we intend to have the contractor responsible for conducting the studies "blind" the results to CMS staff. This "blinding" will prevent CMS staff from knowing which plan is associated with which discrepancy rate. In addition, CMS will not target organizations for review in the following year based on the results of the pilot test.

12.11 CY2004 Data Validation Timeline (Slide 28)

CY2004 data validation will be based on non-lagged data. That is, the data collection period for CY2004 data validation activities will be January 1 through December 31, 2003. The medical record request for the CY 2004 validation will be sent out in the spring of CY 2004.

12.12 Physician Training (Slide 29)

CMS recognizes that the CMS-HCC risk adjustment model may require additional education for physicians. To assist, CMS is in the process of producing a CD for training physicians. This CD should be available in September 2003 and we encourage plans to take advantage of this CD when working with their physicians. Plans may also want to use these training materials for physician education activities.

MODULE 3 – CODING WORKSHOP

Exercise 1

Based on the ICD-9-CM guidelines we have reviewed and the CMS-HCC code set in the Resource Guide, discuss situations below in which M+C organization staff should contact a physician or office staff for more information.
What is the problem: multiple possible codes, illegible documentation, "suspected" or "confirmed" diagnoses?
What information does the physician need to further research the situation?
Who should the request be addressed to?
How should it be made- written, fax, phone message, special form?
Is every situation different or can some "canned" statements be prepared to address common undercoding issues?
In what format does the M+C organization want the provider to respond with clarification, additional codes, or a statement that there is no further information available other than what was already submitted?

1a. Diagnostic narrative and code 1:

Office visit: Rule out diabetes 250, refer to ophthalmologist

Potential difference in HCC:

250	Diabetes (category code)	HCC 19	Diabetes without complication
250.50	Diabetes with ophthalmic manifestation	HCC 18	Diabetes with ophthalmic or unspecified manifestation

1b. Diagnostic narrative with no code indicated:

Final diagnosis: History of liver cancer [Possible codes include: History of liver cancer V10.07, Primary liver cancer 155.0, or metastatic liver cancer 197.7]

Potential difference in HCC:

V10.07	History of liver cancer	No HCC	
155.0	Primary liver cancer	HCC 8	Lung, upper digestive tract and other severe cancers
197.7	Secondary liver cancer	HCC 7	Metastatic cancer and acute leukemia

1c. Diagnostic narrative and code 3 with the following superbill diagnosis checked off:

☒ Fibrillation 427

Potential difference in HCC:

427.31	Atrial fibrillation	HCC 92	Specified heart arrythmias
427.41	Ventricular fibrillation	HCC 79	Cardio-respiratory failure and shock

MODULE 6 – DATA SUBMISSION

Exercise 1

Complete the bold portions of the diagnosis clusters in two CCC records for the following record. Assume the M+C organization submits all reported diagnoses from valid provider types. Begin a new CCC record for the hospital inpatient provider type. Indicate which diagnoses are in the CMS-HCC model.

1. Mr. Bouy was seen by his primary physician on 10/2/02 for ankle edema, weakness and shortness of breath. The diagnoses on the claim were listed as:

Congestive Heart Failure 428.0
Decreased peripheral pulses 785.9, Rule out DVT. 451.19
History of depression 311

He was referred for lower extremity venous testing at an Independent Diagnostic Testing Facility (IDTF).

2. The IDTF report on 10/3/02 stated:

Peripheral vascular disease (PVD) 443.9
No evidence of DVT

3. Mr. Bouy returned to the primary physician for increased pain and ulceration on his calf on 10/25/02. The diagnoses included:

Arteriosclerotic (AS) PVD with ulceration 440.23
CHF, compensated 428.0
Major Depression, mild 296.31

Mr. Bouy refused hospitalization.

4. On 11/15/02 Mr. Bouy was seen in the emergency room at Community Hospital. Due to the extensive ulceration and possible gangrene, he was transferred to University Hospital.

Community Hospital Emergency Room diagnoses:

Lower leg ASPVD with gangrene 440.24

5. Mr. Bouy was at University Hospital from 11/15/02-12/15/02. He underwent a below knee amputation for osteomyelitis with gangrene. His multiple diagnoses included:

Principal Diagnosis:
ASPVD with gangrene 440.24

Other Diagnoses:
Acute osteomyelitis lower leg 730.06
Atheroembolism of lower extremity 445.02
Acute on chronic systolic heart failure 428.33
Chronic atrial fibrillation 427.31
Major depressive disorder, recurrent NOS 296.30

6. Mr. Bouy was discharged to an intermediate level nursing facility for further recovery and not being able to care for himself at home.

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**
9.0		**10.0**		**11.0**		**12.0**		**13.0**		**14.0**	
9.1	**2002**	**10.1**	**2002**	**11.1**	**2002**	**12.1**	**2002**	**13.1**	**2002**	**14.1**	**2002**
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4		**10.4**		**11.4**		**12.4**		**13.4**		**14.4**	
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

CLUSTER 7		CLUSTER 8		CLUSTER 9		CLUSTER 10	
FIELD	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**	**FIELD**	**DATA**
15.0		**16.0**		**17.0**		**18.0**	
15.1	**2002**	**16.1**	**2002**	**17.1**	**2002**	**18.1**	**2002**
15.2		16.2		17.2		18.2	
15.3		16.3		17.3		18.3	
15.4		**16.4**		**17.4**		**18.4**	
15.5		16.5		17.5		18.5	
15.6		16.6		17.6		18.6	
15.7		16.7		17.7		18.7	

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0		**10.0**		**11.0**		**12.0**		**13.0**		**14.0**	
9.1	**2002**	**10.1**	**2002**	**11.1**	**2002**	**12.1**	**2002**	**13.1**	**2002**	**14.1**	**2002**
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4		**10.4**		**11.4**		**12.4**		**13.4**		**14.4**	
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

MODULE 6 – DATA SUBMISSION

Exercise 2

Complete the following bold portions of the diagnosis clusters for two CCC records. The first is the original submission and the second a corrected submission. Assume the M+C organization reports all diagnoses. Indicate those diagnoses that are in the CMS-HCC model.

1. Mrs. Davis relocated to the East Coast and enrolled with Senior Care Health Plan. She brought her medical history to her first visit with her new primary care physician, Dr. Jones. She described having pain in her hip following a hip replacement earlier in the year. He reviewed her history, completed a physical exam and renewed prn medications. His first claim for the 3/5/02 visit listed the following diagnoses:

Pain due to hip prosthesis, r/o displacement 996.77
Diabetic Cataracts 250.50, 366.41
Chronic bronchitis 491.9

2. He referred her to have X-rays performed at a Diagnostic Radiology Services (not hospital affiliated) and to an orthopedic surgeon once the x-rays were completed. Two claims were received for services on 3/10/02 at the outpatient radiology center: one for the radiologist and one for the center both with the following diagnoses:

Displacement of hip prosthesis 996.4

3. Mrs. Davis saw Dr. Manoman, the orthopedic surgeon on 3/12/02. Her final diagnosis for that visit was:

Displacement of hip prosthesis 996.4
Schedule for revision of hip replacement 3/13/02

4. From 3/13/02-3/17/02 Mrs. Davis was in Community Hospital for the hip replacement. Her final diagnosis:

Osteoarthritis of the hip 715.95
Transfer to Rehab Center for post op care and physical and occupational therapy.

5. Mrs. Davis was in the Shady Side Skilled Nursing Center from 3/17/02-3/29/02. While there she did experience some pain and fever which was diagnosed as mild postoperative infection by the house physician. The infection cleared without further hospitalization. Diagnoses during the Rehab visit included:

Shady Side Skilled Nursing Center claim:
Encounter for combined rehabilitation V57.89, attention to surgical dressings V58.3, osteoarthritis 715.95, postoperative infection 996.66, E878.1.

Dr. Manoman submitted a claim for a surgical follow up visit on 3/28/02 with the diagnoses: Surgical follow-up V67.09, osteoarthritis 715.95, wound care/staples removal V58.3.

6. Mrs. Davis had one home health claim on 3/30/02 for follow up, diabetes and anemia check and home instruction for safety. 715.95, 250.00, 285.9, V58.3, V65.43 (counseling for injury prevention).

7. On 4/20/02 Community Hospital submitted a corrected claim for the 3/13/02-3/17/02 hospitalization. The principal diagnosis was changed to 996.4.

Complete the following bold sections of the CCC record layout.

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0		**10.0**		**11.0**		**12.0**		**13.0**		**14.0**	
9.1	**2002**	**10.1**	**2002**	**11.1**	**2002**	**12.1**	**2002**	**13.1**	**2002**	**14.1**	**2002**
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4		**10.4**		**11.4**		**12.4**		**13.4**		**14.4**	
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

CLUSTER 7		CLUSTER 8		CLUSTER 9		CLUSTER 10	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
15.0		**16.0**		**17.0**		**18.0**	
15.1	**2002**	**16.1**	**2002**	**17.1**	**2002**	**18.1**	**2002**
15.2		16.2		17.2		18.2	
15.3		16.3		17.3		18.3	
15.4		**16.4**		**17.4**		**18.4**	
15.5		16.5		17.5		18.5	
15.6		16.6		17.6		18.6	
15.7		16.7		17.7		18.7	

New CCC Record-Corrected Data

CLUSTER 1		CLUSTER 2	
FIELD	**DATA**	**FIELD**	**DATA**
9.0		**10.0**	
9.1	**2002**	**10.1**	**2002**
9.2	**2002**	**10.2**	**2002**
9.3		**10.3**	
9.4		**10.4**	
9.5		10.5	
9.6		10.6	
9.7		10.7	

MODULE 3 – CODING WORKSHOP

Exercise 1

Based on the ICD-9-CM guidelines we have reviewed and the CMS-HCC code set in the Resource Guide, discuss situations below in which M+C organization staff should contact a physician or office staff for more information.

What is the problem: multiple possible codes, illegible documentation, "suspected" or "confirmed" diagnoses?
What information does the physician need to further research the situation?
Who should the request be addressed to?
How should it be made- written, fax, phone message, special form?
Is every situation different or can some "canned" statements be prepared to address common undercoding issues?
In what format does the M+C organization want the provider to respond with clarification, additional codes, or a statement that there is no further information available other than what was already submitted?

1a. Diagnostic narrative and code 1:

Office visit: Rule out diabetes 250, refer to ophthalmologist

Answer: *"Rule out" diagnoses should not be coded by outpatient services, including physician office visits. The physician staff should research the record and determine if the patient has diabetes. If he or she does, are there any associated ophthalmic or other complications (250.50) documented?*

Potential difference in HCC:

250	Diabetes (category code)	HCC 19	Diabetes without complication
250.50	Diabetes with ophthalmic manifestation	HCC 18	Diabetes with ophthalmic or unspecified manifestation

1b. Diagnostic narrative with no code indicated:

Final diagnosis: History of liver cancer [Possible codes include: History of liver cancer V10.07, Primary liver cancer 155.0, or metastatic liver cancer 197.7]

Answer: *The correct code assignment, given only this information, would be V10.07. Liver cancer (155.0 if primary) is typically a secondary/metastatic site (197.7). Ask the physician's staff to review the medical record to determine if it documents whether the patient currently has cancer or, if it has been removed, if the patient still under treatment. Also, determine if the liver is the primary site or secondary site.*

Potential difference in HCC:

V10.07	History of liver cancer	No HCC	
155.0	Primary liver cancer	HCC 8	Lung, upper digestive tract and other severe cancers
197.7	Secondary liver cancer	HCC 7	Metastatic cancer and acute leukemia

1c. Diagnostic narrative and code 3 with the following superbill diagnosis checked off:

☒ Fibrillation 427

Answer: *The issue in this example is in the lack of specificity at the fourth and fifth digit level of the diagnosis code. Fibrillation can be atrial 427.31, which is in HCC 92 or ventricular 427.41 which is in HCC 79. Since this physician uses a superbill, a method is needed to ensure the distinction between the two types of fibrillation.*

Potential difference in HCC:

427.31	Atrial fibrillation	HCC 92	Specified heart arrythmias
427.41	Ventricular fibrillation	HCC 79	Cardio-respiratory failure and shock

MODULE 6 – DATA SUBMISSION

Exercise 1

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0	**20**	**10.0**	**20**	**11.0**	**20**	**12.0**	**20**	**13.0**	**20**	**14.0**	**20**
9.1	**20021002**	**10.1**	**20021002**	**11.1**	**20021002**	**12.1**	**20021025**	**13.1**	**20021025**	**14.1**	**20021025**
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4	**4280**	**10.4**	**7859**	**11.4**	**311**	**12.4**	**44023**	**13.4**	**4280**	**14.4**	**29631**
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

CLUSTER 7		CLUSTER 8		CLUSTER 9		CLUSTER 10	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
15.0	**10**	**16.0**		**17.0**		**18.0**	
15.1	**20021115**	**16.1**		**17.1**		**18.1**	
15.2		16.2		17.2		18.2	
15.3		16.3		17.3		18.3	
15.4	**44024**	**16.4**		**17.4**		**18.4**	
15.5		16.5		17.5		18.5	
15.6		16.6		17.6		18.6	
15.7		16.7		17.7		18.7	

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0	**01**	**10.0**	**02**	**11.0**	**02**	**12.0**	**02**	**13.0**	**02**	**14.0**	**02**
9.1	**20021115**	**10.1**	**20021115**	**11.1**	**20021115**	**12.1**	**20021115**	**13.1**	**20021115**	**14.1**	**20021115**
9.2	**20021215**	**10.2**	**20021215**	**11.2**	**20021215**	**12.2**	**20021215**	**13.2**	**20021215**	**14.2**	**20021215**
9.3		10.3		11.3		12.3		13.3		14.3	
9.4	**44024**	**10.4**	**73006**	**11.4**	**44502**	**12.4**	**42833**	**13.4**	**42731**	**14.4**	**29630**
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

1. Provider type for physician is 20. Do not report "rule out" diagnoses (451.19 r/o DVT). Submit all other diagnoses. Code 428.0 is in the model
2. IDTF is not a valid provider type. Do not report
3. Provider type for physician is 20. All codes are in the model.
4. Emergency room is provider type 10. Code is in model.
5. Inpatient hospital principal diagnosis provider type is 01 code 440.24. All other diagnoses are provider type 02. All codes are in the model.
6. Intermediate care facilities are not valid provider types. Do not report.

MODULE 6 – DATA SUMISSION

Exercise 2

CLUSTER 1		CLUSTER 2		CLUSTER 3		CLUSTER 4		CLUSTER 5		CLUSTER 6	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
9.0	**20**	**10.0**	**20**	**11.0**	**20**	**12.0**	**20**	**13.0**	**20**	**14.0**	**20**
9.1	**20020305**	**10.1**	**20020305**	**11.1**	**20020305**	**12.1**	**20020305**	**13.1**	**20020310**	**14.1**	**20020312**
9.2		10.2		11.2		12.2		13.2		14.2	
9.3		10.3		11.3		12.3		13.3		14.3	
9.4	**99677**	**10.4**	**25050**	**11.4**	**36641**	**12.4**	**4919**	**13.4**	**9964**	**14.4**	**9964**
9.5		10.5		11.5		12.5		13.5		14.5	
9.6		10.6		11.6		12.6		13.6		14.6	
9.7		10.7		11.7		12.7		13.7		14.7	

CLUSTER 7		CLUSTER 8		CLUSTER 9		CLUSTER 10	
FIELD	DATA	FIELD	DATA	FIELD	DATA	FIELD	DATA
15.0	**01**	**16.0**	**20**	**17.0**	**20**	**18.0**	**20**
15.1	**20020313**	**16.1**	**20020328**	**17.1**	**20020328**	**18.1**	**20020328**
15.2	**20020317**	16.2		17.2		18.2	
15.3		16.3		17.3		18.3	
15.4	**71595**	**16.4**	**V6709**	**17.4**	**71595**	**18.4**	**V583**
15.5		16.5		17.5		18.5	
15.6		16.6		17.6		18.6	
15.7		16.7		17.7		18.7	

New CCC Record-Corrected Data

CLUSTER 1		CLUSTER 2	
FIELD	**DATA**	**FIELD**	**DATA**
9.0	**01**	**10.0**	**01**
9.1	**20020313**	**10.1**	**20020313**
9.2	**20020317**	**10.2**	**20020317**
9.3	**D**	**10.3**	
9.4	**71595**	**10.4**	**9964**
9.5		10.5	
9.6		10.6	
9.7		10.7	

1. Use provider type 20 for physician. Report all diagnoses since physician is reviewing and treating them all.
2. The outpatient radiology facility is not a valid provider type, however the physicians claim is reported under provider type 20.
3. Provider type 20.
4. Inpatient principal diagnosis provider type 01 for code 71595. There are no secondary diagnoses to report.
5. Rehab centers are typically skilled or intermediate nursing facilities and are there fore not valid provider types. However, the physician claim is provider type 20 and all codes can be reported. None of them are in the model.
6. Home health is not a valid provider type.
7. The complete cluster for the incorrect diagnosis needs to be deleted by resubmitting the exact cluster with a "D" in field 9.3. The correct diagnosis is then submitted by entering the inpatient hospital principal diagnosis provider type, dates of service and corrected code.

RISK ADJUSTMENT CALENDAR

June 2003 – May 2004 Dates to Remember!

JUNE

S	M	T	W	T	F	S
1	2	**3**	**4**	5	6	7
8	**9**	**10**	11	**12**	**13**	14
15	16	17	18	**19**	**20**	21
22	23	**24**	**25**	26	27	28
29	**30**					

JULY

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	**14**	**15**	**16**	**17**	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	**18**	**19**	**20**	**21**	22	23
24	**25**	26	27	28	29	30
31						

SEPTEMBER

S	M	T	W	T	F	S
	1	2	3	4	**5**	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	**22**	**23**	**24**	**25**	**26**	27
28	29	**30**				

OCTOBER

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	**20**	**21**	**22**	**23**	24	25
26	27	28	29	30	31	

NOVEMBER

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	**17**	**18**	**19**	**20**	21	22
23	24	25	26	27	28	29
30						

DECEMBER

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	**15**	**16**	**17**	**18**	19	20
21	22	23	24	25	26	27
28	29	30	**31**			

JANUARY

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

FEBRUARY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

MARCH

S	M	T	W	T	F	S
	1	2	3	4	**5**	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	**31**			

APRIL

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

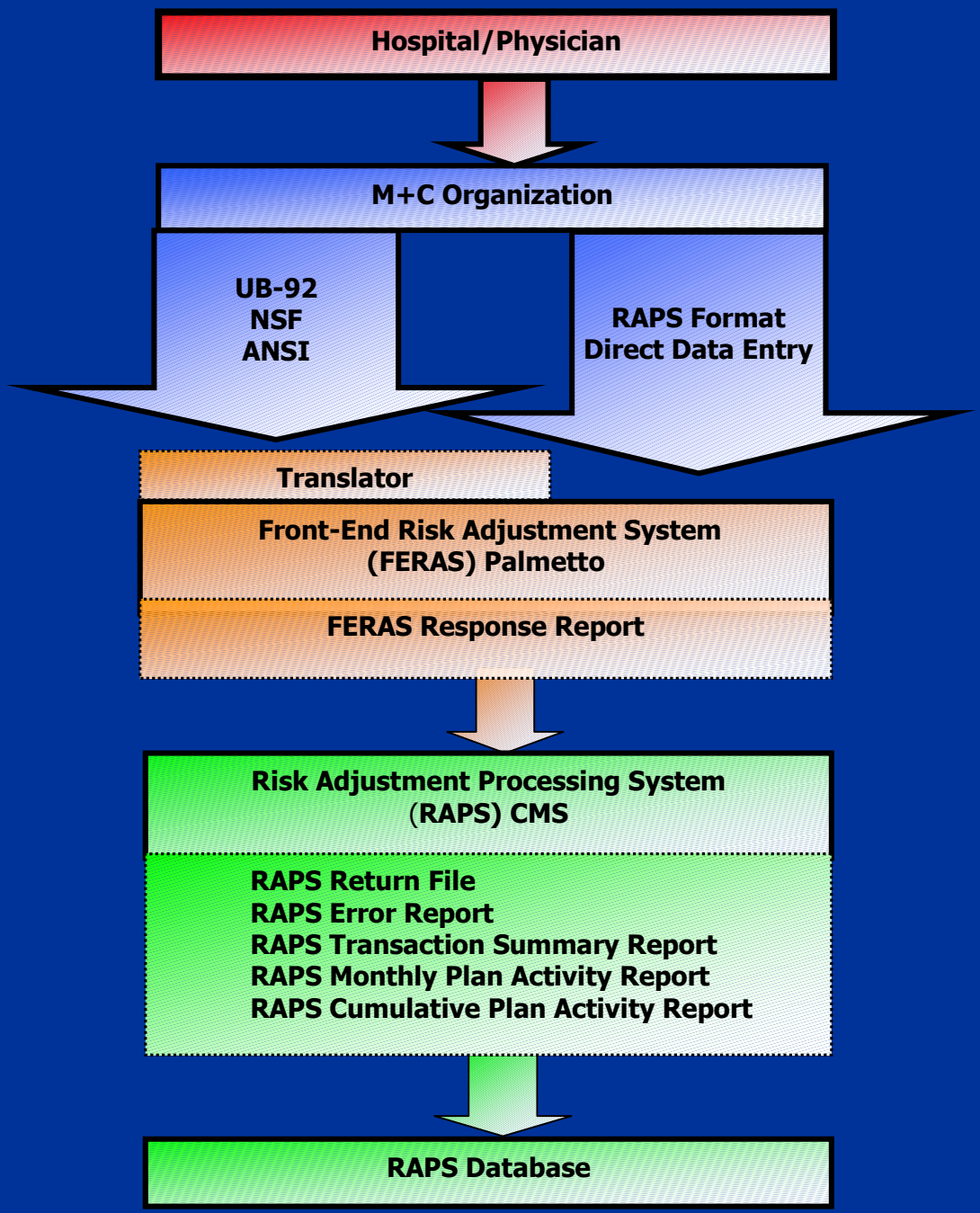
MAY

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

- Regional Training Dates
- Technical Assistance Workshop
- User Groups
- Quarterly Submission Deadline
- Initial Submission Deadlines
- Final Submission Deadline for CY2002

July 2003

2003 Risk Adjustment Dataflow



June 2003

RAPS Record Layout

AAA RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'AAA'
2	SUBMITTER-ID	4 – 9	X(6)	'Shnnnn'
3	FILE-ID	10 – 19	X(10)	
4	TRANSACTION-DATE	20 – 27	9(8)	'CCYYMMDD'
5	PROD-TEST-IND	28 – 31	X(4)	'PROD' Or 'TEST'
6	FILLER	32 - 512	X(481)	SPACES

BBB RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BBB'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	PLAN-NO	11 – 15	X(5)	'Hnnnn'
4	FILLER	16 – 512	X(497)	SPACES

CCC RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'CCC'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	SEQ-ERROR-CODE	11 – 13	X(3)	SPACES
4	PATIENT-CONTROL-NO	14 – 53	X(40)	Optional
5	HIC-NO	54 – 78	X(25)	
6	HIC-ERROR-CODE	79 – 81	X(3)	SPACES
7	PATIENT-DOB	82 – 89	9(8)	'CCYYMMDD'
8	DOB-ERROR-CODE	90 – 92	X(3)	SPACES
9 – 18	DIAGNOSIS-CLUSTER (10 OCCURRENCES)	93 – 412		
9.0	PROVIDER-TYPE		X(2)	HOSPITAL IP PRINCIPAL = 01 HOSPITAL IP OTHER = 02 HOSPITAL OP = 10 PHYSICIAN = 20
9.1	FROM-DATE		9(8)	'CCYYMMDD'
9.2	THRU-DATE		9(8)	'CCYYMMDD'
9.3	DELETE-IND		X(1)	SPACE or 'D'
9.4	DIAGNOSIS-CODE		X(5)	
9.5	DC-FILLER		X(2)	SPACES
9.6	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.7	DIAG-CLSTR-ERROR-2		X(3)	SPACES
19	CORRECTED-HIC-NO	413 – 437	X(25)	SPACES
20	FILLER	438 - 512	X(75)	SPACES

YYY RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'YYY'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	PLAN-NO	11 – 15	X(5)	'Hnnnn'
4	CCC-RECORD-TOTAL	16 – 22	9(7)	
5	FILLER	23 – 512	X(490)	SPACES

ZZZ RECORD

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

Submission Timetable

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2003	July 1, 2001 through June 30, 2002	September 6, 2002	January 1, 2003	September 26, 2003
2004	July 1, 2002 through June 30, 2003	September 5, 2003	January 1, 2004	NA*
2004	January 1, 2003 through December 31, 2003	March 5, 2004	July 1, 2004	March 31, 2005
2005	July 1, 2003 through June 30, 2004	September 3, 2004	January 1, 2005	NA*
2005	January 1, 2004 through December 31, 2004	March 4, 2005	July 1, 2005	March 31, 2006

* With elimination of the payment lag, the final submission deadline (reconciliation) changes to March 31st of each year. There is no September 30, 2004 deadline.

FERAS Error Codes

ERROR CODE LOGIC	
SERIES	**EXPLANATION**
100	File-level errors on the AAA or ZZZ records
200	Batch-level errors on the BBB or YYY records
300-400	Check performed on first and last CCC records

FILE LEVEL

ERROR CODE	RECORD ID	ERROR DESCRIPTION
100	AAA	INVALID RECORD TYPE
101	AAA	AAA RECORD MISSING FROM TRANSACTION
102	AAA	MISSING / INVALID SUBMITTER-ID ON AAA RECORD
103	AAA	MISSING FILE-ID ON AAA RECORD
104	AAA	MISSING / INVALID TRANSACTION DATE ON AAA RECORD
105	AAA	MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD
112	AAA	SUBMITTER ID NOT ON FILE
113	AAA	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
114	AAA	TRANSACTION DATE IS GREATER THAN CURRENT DATE
151	ZZZ	ZZZ RECORD MISSING FROM TRANSACTION
152	ZZZ	MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD
153	ZZZ	MISSING / INVALID FILE-ID ON ZZZ RECORD
154	ZZZ	MISSING / INVALID BBB-RECORD-TOTAL
162	ZZZ	ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD
163	ZZZ	FILE ID DOES NOT MATCH FILE ID ON AAA RECORD
164	ZZZ	ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS

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

FERAS Error Codes

BATCH LEVEL		
ERROR CODE	**RECORD ID**	**ERROR DESCRIPTION**
201	BBB	BBB RECORD MISSING FROM TRANSACTION
202	BBB	MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD
203	BBB	MISSING / INVALID PLAN NUMBER ON BBB RECORD
212	BBB	SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE
213	BBB	SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID
251	YYY	YYY RECORD MISSING FROM TRANSACTION
252	YYY	MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD
253	YYY	MISSING / INVALID PLAN NUMBER ON YYY RECORD
254	YYY	MISSING / INVALID CCC-RECORD-TOTAL
262	YYY	LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS
263	YYY	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD
264	YYY	YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS
272	YYY	SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE

DETAIL LEVEL		
ERROR CODE	**RECORD ID**	**ERROR DESCRIPTION**
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQUENCE NUMBER ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
310	CCC	MISSING / INVALID HIC-NO ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST BE BLANK OR EQUAL TO "D"
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
400	CCC	MISSING / INVALID PROVIDER-TYPE ON CCC RECORD
401	CCC	INVALID FROM-DATE ON CCC RECORD
402	CCC	INVALID THRU-DATE ON CCC RECORD

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

RAPS Error Codes

SERIES	EXPLANATION OF ERROR AND CONSEQUENCES
300-349	Record level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
400-489	Diagnosis cluster error. All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error, diagnosis was not deleted.
500-599	Informational message, all edits were performed; diagnosis cluster was stored unless some other error is noted.

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NUMBER ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST EQUAL SPACE OR "D" FOR DELETE
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
351	CCC	FIRST DIAGNOSIS CLUSTER MUST BE A PRINCIPAL DIAGNOSIS; PROVIDER TYPE MUST EQUAL "01"; THIS CODE ONLY APPLIES TO HOSPITAL INPATIENT DIAGNOSES FOR DATES OF SERVICE PRIOR TO 7/1/02
353	CCC	HIC NUMBER DOES NOT EXIST ON MBD
354	CCC	PATIENT DOB DOES NOT MATCH WITH MBD DOB

RAPS Error Codes

ERROR CODE	RECORD ID	ERROR DESCRIPTION
400	CCC	MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD
401	CCC	INVALID SERVICE FROM-DATE ON CCC RECORD
402	CCC	INVALID SERVICE THROUGH-DATE ON CCC RECORD
403	CCC	SERVICE THROUGH DATE MUST BE GREATER THAN 12/31/2000
404	CCC	SERVICE FROM DATE MUST BE LESS THAN OR EQUAL TO THROUGH DATE
405	CCC	DOB IS GREATER THAN SERVICE FROM DATE
406	CCC	SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
407	CCC	SERVICE THROUGH DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
408	CCC	SERVICE FROM DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD
409	CCC	SERVICE THROUGH DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD
410	CCC	BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM DATE
411	CCC	SERVICE THROUGH DATE IS GREATER THAN DATE OF DEATH
412	CCC	SERVICE FROM DATE GREATER THAN TRANSACTION DATE
413	CCC	SERVICE THROUGH DATE GREATER THAN TRANSACTION DATE
450	CCC	DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH DATE
451	CCC	SERVICE THROUGH DATE IS GREATER THAN DIAGNOSIS END DATE
453	CCC	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX
454	CCC	DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING
460	CCC	SERVICE FROM AND THROUGH DATE SPAN IS GREATER THAN 31 DAYS
490	CCC	COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD
491	CCC	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED
492	CCC	DIAGNOSIS CLUSTER WAS NOT SUCCESSFULLY DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE.

INFORMATIONAL EDITS

ERROR CODE	RECORD ID	ERROR DESCRIPTION
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS
501	CCC	VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE.

QUICK FACTS
SOAP Notes

One common method of documenting medical record progress notes (for all provider types) that contain all the necessary elements, is called the Problem Oriented Medical Record (POMR). POMR includes a problem list and SOAP notes. Each letter in SOAP stands for a section of the progress notes as follows:

Subjective

- How the patient describes what brings them to the facility/office for care, what medications they have taken, and any other relevant observations by the patient about their condition. This includes chief complaints and associated symptoms.

Objective

- Data obtained by the current problem focused exam, lab results, vital signs, and other observations made directly by the physician. A full history and physical is a separate document typically generated during the initial patient visit.

Assessment

- Listing and description of a patient's current diagnosis or symptom and status of all chronic conditions. This includes how the objective data relates to each of the patient's problems. Conditions are listed by problem number, referring back to the problem list.

Plan

- The plan includes four elements:
  - diagnostic plan- further diagnostic tests or consultation/referrals
  - therapeutic plan- medications and treatments such as physical therapy
  - patient education- instructions for care at home, expected outcomes, potential complications, side effects of medication etc.
  - follow-up - next scheduled appointment or conditions for return visit or phone call

Legible SOAP notes really clean up medical record documentation!

QUICK FACTS

Tips for Documentation:
The Problem Oriented Medical Record (POMR) Problem List

- The problem list is a numbered index of the patient's problems from identification to resolution.
- The list should be kept in the front of the physician office record, clinic record, or hospital progress note section.
- The problems should include acute or chronic diagnoses, symptoms not related to an established diagnosis, social issues, or any other condition that may impact the patients care and treatment.
- The problems are numbered and dated so they can be identified in ongoing SOAP notes (see side 2). The date the problem is resolved can be entered in a separate column.

Example Problem List

Patient Identification
Allergies: None known

Problem #1	10/4/02	Asthma, COPD	
Problem #2	10/4/02	History of smoking, quit 2 years ago	
Problem #3	12/30/02	Wife expired, no one to render care at home	
Problem #4	1/7/03	Broken toe	*resolved 3/3/03*
Problem #5	3/3/03	Depression, continued grief reaction	

Three of the most commonly used formats of the POMR SOAP notes include:
1) "Pure" POMR notes address each numbered problem with separate SOAP breakdown.

Problem #1	Problem #4
S	S
O	O
A	A
P	P

2) "Hybrid" POMR notes list SOAP one time and identify the applicable numbered problems under each note.

S
- Problem #1
- Problem # 4

O
- Problem # 1
- Problem #4

A
- Problem #1
- Problem # 4

P
- Problem #1 & 4

3) Untitled SOAP notes do not use a numbered problem list but document the current pertinent symptoms and diagnoses in the SOAP format.

Date of visit: 1/7/03

S - Patient tripped at home and has pain and swelling of left great toe.
O - X-ray - Fractured left toe, COPD and asthma- stable with home oxygen as needed.
A - Fractured toe, COPD
P - Splint toe, instructions to elevate foot, OTC pain reliever per label instructions. Phone numbers given for meals on wheels, follow up in office in 2 weeks. Call office if pain or swelling increases or 911 if experiencing trouble breathing.

QUICK FACTS

ICD-9-CM

(International Classification of Diseases 9th Revision-Clinical Modification)

OVERVIEW

This ICD-9-CM (International Classification of Diseases-9th Revision-Clinical Modification) QUICK FACTS serves as an easy reference to explain ICD-9-CM coding guidelines. Since diagnostic information is critical for risk adjusted payment, ICD-9-CM codes must be reported accurately.

USE CURRENT VERSION OF ICD-9-CM

- All hospitals/physicians must use current valid International Classification of Disease- 9th Edition-Clinical Modification (ICD-9-CM) codes.
- ICD-9-CM codes are updated annually on October 1.
- If hospitals/physicians use the Diagnostic Statistical Manual of Mental disorders, 4th edition (DSM IV) for coding, they will need to convert the information to the official ICD-9-CM codes.

RELATE DIAGNOSIS TO SERVICE PERFORMED & DOCUMENT

- The medical record must justify the diagnosis.
- The diagnosis reported must match the coding submitted by the hospital/physician as documented in the medical record.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided.
- The medical record must be retrievable to validate the diagnosis reported.

CODE TO THE HIGHEST LEVEL OF SPECIFICITY

Basic Coding guidelines prescribe the use of the most specific code (the highest level of specificity). ICD-9-CM is composed of codes with either 3,4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of 4th and/or 5th digits which provides greater specificity.

- Assign three-digit codes only if there are no four-digit codes within that code category.
- Assign four-digit codes only if there is no fifth-digit subclassification for that subcategory.
- Assign the fifth-digit subclassification code for those subcategories where it exists.

Coding guidelines recommend that an *unspecified code* should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Resources

Go to www.hcfa.gov/medlearn/cbt_icd9.htm for a computer-based training course on the ICD-9-CM. Additional resources for ICD-9-CM coding are located on the CMS web site at www.cms.hhs.gov (do a site search for ICD-9-CM) and the CSSC web site at www.mcoservice.com.

QUICK FACTS

ICD-9-CM Coding Process-Physician and Hospital Outpatient (International Classification of Diseases 9th Revision-Clinical Modification)

- ☐ Review the medical record to identify the reason for the visit.
- ☐ Review the medical record for other conditions and confirmed diagnoses that are related to the reason for the visit. Do not code conditions described as "rule out," "possible," or "suspected."
- ☐ Look up the main terms of these conditions in the ICD-9-CM index.

  Main terms may be followed by other descriptors in parentheses. These terms are called "non-essential modifiers". The presence or absence of these terms does not affect the coding of the main terms.

  Search the indented terms under each main term to find the closest description of the condition documented.

  The index may refer you to another main term.

  More than one main term may be required to fully describe the condition.
- ☐ Look up the codes selected in the Tabular Index.
- ☐ Read all definitions and follow all cross reference notes, inclusion notes and exclusion notes found at the beginning of each code category in the Tabular Index.
- ☐ Code to the highest specificity possible. If there is a fourth and fifth digit to select, use the most appropriate one.

  If the index has referred you to a code with the fourth digit of .8 (NEC-not elsewhere classified) or .9 (NOS-not otherwise specified) refer back to the medical record to see if other more specific listings in the code category may apply.
- ☐ Determine if any of the conditions can be combined or are symptoms of another condition and therefore not to be coded.
- ☐ First, list the diagnosis code chiefly responsible for the service(s) provided. Then, list codes for all other conditions documented.
- ☐ Code only those conditions that are supported by ***clinical*** medical record documentation on the corresponding date(s) of service.

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QUICK FACTS
Medical Record Documentation Tips

- ☐ Medical records should be organized in a systematic format for communication and retrievability.
- ☐ Notes on scrapes of paper, "sticky" notes, index cards, etc. are not acceptable.
- ☐ Only persons authorized to do so may document the medical record, and each person must be identified.
- ☐ Entries must be made at the time of treatment and dated.
- ☐ Avoid non-clinical remarks within the body of the record that mention any financial issues or unprofessional remarks about patients or other healthcare team members.
- ☐ Use only standard abbreviations and keep them to a minimum.
- ☐ Each page of the medical record should identify the patient.
- ☐ The medical record must contain sufficient information to identify the patient, justify the treatment (and level of care), support the diagnosis, document the patient's progress and the results of treatment, and promote continuity of care among healthcare providers.

Medical Records Must Include Documentation of:

- ☐ Admission diagnosis/initial impression.
- ☐ Reason for admission, visit, treatment, and/or consultation requests. Many of these reasons will be part of a list of final diagnoses.
- ☐ All operative and non-operative procedures, test results and consultations including the rationale for the procedure/treatment/test and evidence that the results or consultation were noted by the physician.
- ☐ Patient's response to care including any complications or conditions (diagnoses) that impact or extend the inpatient length of stay.
- ☐ Medications ordered, dispensed and any adverse reactions.
- ☐ Conclusions, instructions for follow-up and a summary of care including outcome, disposition, and final diagnoses.

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