2004 RISK ADJUSTMENT TRAINING
FOR MEDICARE ADVANTAGE ORGANIZATIONS
SPECIAL SESSIONS QUESTIONS & ANSWERS

Risk Adjustment Methodology Session I 08/10/04

Q: Some MA organizations found multiple challenges in working with aged calculations. Will there be similar challenges for MA organizations to capture the level of data required for frailty adjuster?
A: The functional impairment data for the frailty adjuster will be collected via the Health Outcomes Survey (HOS). Organizations that follow the standard HOS protocol should not experience an additional burden.

Q: Is CMS surveying for frailty by plan or organization?
A: Currently, the HOS requires a baseline group of 1,000 members per organization per year. CMS will assess the feasibility of administering the HOS at the plan level in the future.

Q: For MA organizations participating in a CMS disease management demonstration project, such as diabetes and congestive heart failure in the elderly, how are the frailty adjusters applied to those populations?
A: The frailty adjuster is not currently being applied to the disease management demonstration.

Q: Does implementation of the drug benefit apply to Program of All-Inclusive Care for the Elderly (PACE) organizations?
A: Yes, implementation of the Medicare Modernization Act (MMA) drug benefit does apply to PACE organizations.

Data Validation Special Session I 08/10/04

Q: What are the criteria used to determine the number of medical records that will be selected for validation?
A: CMS uses several sampling approaches. Some MA organizations are selected for the national sample, and others are targeted based on performance (e.g., problematic data where certain areas may be suggestive of issues). Based on the CY 2004 validation sampling criteria, the number of records selected for a given plan ranges from a few to approximately 150.

Q: How are Initial Validation Contractors (IVC) selected?
A: The IVC selection process is based primarily on Quality Improvement Organization (QIO) equivalent experience.

Q: Who receives the medical record request?
A: The medical record request is sent to the plan's Medical Compliance Officer or the designated contact person.

Q: Is the medical record request listed in a flat file format?
A: The request is in an EXCEL format.

Q: Are the 1996 Evaluation and Management (E/M) Documentation Guidelines acceptable to CMS?

A: E/M Guidelines address CPT physician service codes, not diagnosis codes. The 1996 E/M Documentation Guidelines were included in the data validation presentation as an example of the type of documentation acceptable to CMS. This background information regarding documentation in general has not changed. If a physician is using CMS' current E/M instructions (i.e., for 1995 and 1997) as a guide for reporting the level of services provided in a different year, the diagnosis would be documented in any of the following E/M components: the nature of presenting problem/chief complaint, past history, history of present illness, and examination/system review.

Risk Adjustment Methodology Session II 08/19/04

Q: What is the purpose of the new pharmacy data that CMS is collecting?

A: The new diagnosis codes for dates of service 07/01/03 through 06/30/04 are being collected to provide plans with an estimate of risk adjustment factors for the expanded CMS-Hierarchical Condition Category (CMS-HCC) model and the new drug risk adjustment model.

Q: How can an MA organization be sure that network physicians used these new diagnosis codes associated with the drug risk adjustment model?

A: Including the approved draft drug related diagnosis in the physicians' training program is perhaps the best method to assure the MA organization that their network physicians will code correctly for the drug risk adjustment model.

Q: Is the list of drug and expanded CMS-HCC diagnosis codes listed on the website?

A: The list of diagnosis codes for the draft Enhanced CMS-HCC and Drug Risk Adjustment models were released on 05/17/04 and may be found on http://www.cms.hhs.gov/healthplans/riskadj/.

Q: Is there a report MA organizations can request that will indicate the submission of duplicate diagnoses?

A: MA organizations can contact Customer Service and Support Center (CSSC) Operations and request the Risk Adjustment Processing System (RAPS) Duplicate Diagnosis Cluster Report. This report identifies diagnosis clusters with the 502-error code (i.e., the diagnosis cluster was accepted but not stored because a diagnosis cluster with the same attributes was already stored in the RAPS database). CSSC can restore reports for an MA organization for up to 7 years after the report was initially generated.

Q: Are the new codes the final codes for the drug data?

A: Although the list of codes indicates that it is a draft, MA organizations should consider this the final list unless notified otherwise. There may be a modest reduction in the future, but this is the current list that plans should use to submit data with dates of service beginning 07/01/04.

Q: Are the coefficients assigned to those new codes?
A: CMS is working on the coefficients for the drugs and enhanced CMS-HCC diagnoses codes. These coefficients will be announced next year with the final payment notice.

Q: Are MA organizations able to submit risk adjustment data for calendar year 2003 up until May 2005?
A: Yes, MA organizations may submit data for dates of service 01/01/03 through 12/31/03 until 05/13/05.

Q: If an MA organization is receiving from RAPS a large number of invalid diagnosis code messages, is it important to rework those invalid codes if they are not relevant to the model?
A: It is important to clarify exactly what message the MA organization is receiving. If the message is something other than the 501-error code (i.e., valid diagnosis but not relevant diagnosis for risk adjustment during this service period), MA organizations need to research the related codes, ensure that the physician visit is documented correctly, and correct those submissions where appropriate. If the error codes are 501's, research will not be required, as these diagnoses are not in the model.

Q: Will an MA organization receive the 450-error code if the diagnosis is submitted with a decimal point?
A: Yes, a diagnosis code submitted with the decimal will cause the 450-error code message, "diagnosis does not exist for this service through date."

Q: How will CMS capture the frailty factor in the risk adjustment system?
A: Frailty scores are not captured in the risk adjustment system. The frailty score is calculated separately for each organization based on survey-reported information. The frailty score is then added to the risk score of all community enrollees age 55-and-over at the appropriate step in the payment calculation.

Q: How will the frailty factor apply to new Senior Care Options (SCO) organizations?
A: Since the SCO demonstration has just begun, CMS will apply a default frailty score for 2005. In the future, CMS will use the survey information collected on enrollees of each SCO organization to determine the frailty scores.

Q: What is the timing for payment for the frailty factor?
A: The frailty adjuster will not be applied to MA organization in 2005. CMS will announce payment changes for 2006 at the appropriate time.

Q: Does CMS envision significant changes in the Monthly Membership Report (MMR) to accommodate the new 2006 process?
A: CMS is still working on the development of the reports and how to include MA organization-specific information in the MMR. This will probably include a separate report for prescription drugs. CMS is looking at ways to provide a combined payment at the organizational level followed by reports at the plan level explaining the payment calculation.

Q: Is there more information available on the Title I regulations level waivers for PACE and specialty plans?
A: We have no further information at this time.

Q: Is there any additional information for MA organizations about the changes to the health outcomes survey for the frailty factor?
A: Not at this point. MA organizations will receive further information from CMS at a later date.

Data Validation Special Session II 08/19/04

Q: Will the payment adjustment go up or down in the situation where it is found that another HCC that was not selected for the audit and was not previously submitted for the collection period be identified and submitted?
A: Generally the adjustment does go up and down. During the audit process the coder must look for all HCCs that the MA organization indicated for a particular date of service. CMS is currently working on an internal process for addressing additional HCCs that are found on the date of service in question.

Q: Will payment adjustment be specific to the HCC that was not validated, and will there be any extrapolations to the entire MA organization's payment?
A: CMS has not finalized the process for conducting payment adjustments for calendar year 2004 going forth. The CMS Administrator will issue this decision. For previous validations under the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model, adjustments were based on incorrect PIP-DCGs, and were applied only to sampled beneficiaries. CMS has always and will continue to use a sampling approach that will allow calculating estimates at the plan level in order to identify outliers.

Q: When does the Administrator usually make the decision for payment adjustment? Would the decision be uniform or particular to a health plan?
A: After all risk adjustment discrepancies have been confirmed, via second level review, the Administrator determines whether a payment adjustment will be required. The Administrator's decision is particular to the health plan in question.

Q: What is the logic behind not allowing the physician attestation as supporting documentation?
A: The physician attestation was set up as a communication document between the coder and physician. The physician attestation will not stand alone as a part of the clinical medical record. MA organizations should submit medical record documentation to support the codes listed on the attestation document.

Q: Are MA organizations required to submit the entire medical record for review?
A: MA organizations have the option of submitting the entire medical record or a portion of the medical record. Please note that if MA organizations submit the entire medical record, the coder will not be required to review the entire medical record to validate the code. The cover sheet must identify the date of service in the medical record. The date of service is critical in abstracting the diagnoses code from the medical record.

Q: If an MA organization is selected for payment adjustment based on medical record review findings, will the adjustments be reflected in the Monthly Membership Report (MMR)? Is there a second notice?
A: Yes, the payment adjustment will be reflected on the MMR. CMS will inform the MA organization via teleconference and/or a notice indicating the scheduled date for the payment adjustment and the month that the adjustment will appear on the MMR.

Q: If a discrepancy is found during the medical record review, will MA organizations have an opportunity to address the discrepancy and stop the adjustment, or is the validation that opportunity?
A: If our IVC finds a problem with the medical record during the receipt and tracking phase and prior to the deadline for submitting records, the IVC will contact the plan to:

- Advise the plan of the problem.
- Explain how the plan may submit corrected information.

If the discrepancy is found during the actual review phase, the plan will not have an opportunity at that time to correct the information and avoid possible payment adjustment.

If the discrepancy is found after the deadline or during the review phase and the plan is selected for payment adjustment, then the plan may submit corrective information only during the appeals process.

Diagnosis Codes & Risk Adjustment Session I 08/12/04

Q: Are there any methods or training tools available to educate medical staff and physicians?
A: The Physician Compact Disk (CD), Getting Started video training program CD and VHS, face-to-face training, and provider newsletters are acceptable forms of provider communication and education.

Q: Is there additional CMS documentation other than what is listed in the training manual on the definition of a face-to-face encounter/visit?
A: Page 13 of The Resource Guide in the 2004 Training Manual provides the official instructions for risk adjustment implementation of face-to-face encounters. Pathology and radiology services represent the only allowable exceptions to the face-to-face visit requirement. Table 3H in Section 3.2.3 (Physician Data) of the Data Collection Module in the 2004 Training Manual provides a list of acceptable physician data sources.

Q: Should a claim be resubmitted if the physician documents a rule-out diagnosis for example "suspicious skin lesion" (709.9, not in model) and then later determines the condition was "melanoma?"

A: The entire claim does not need to be resubmitted by the physician/provider. If the code was submitted to CMS, a diagnostic cluster correction needs to be submitted to RAPS or the Direct Data Entry (DDE). The Data Submission module in the 2004 Training Manual describes how to correct or add a diagnosis cluster. Please note that physician rule-outs are unacceptable documentation for data validation purposes.

Q: How should an unconfirmed diagnosis by a hospital inpatient facility be reported if the claim has been submitted and later the test results indicate that the data must be changed, i.e., the patient does not have the cancer coded?

A: This is an inherent problem to this guideline and CMS is aware of the issue. For validation purposes MA organizations must make sure that they provide acceptable medical record documentation that supports the ruled-out diagnosis code. For internal clinical and statistical purposes, the MA organizations may need to make a correction in their internal database. If the code was submitted to CMS, a diagnostic cluster correction needs to be submitted to RAPS or DDE.

Q: Are the 2003 Physician CD and Getting Started Training Program the most current versions?

A: Yes, these are the current materials with respect to the fundamentals of risk adjustment. Plans to update the Getting Started Training Program are on hold until the entire impact of the MMA is determined. MA organizations can send an email to encounterdata@aspensys.com to inquire about the materials. MA organizations can reproduce and send the materials to physicians and providers.

Diagnosis Codes & Risk Adjustment Session II 08/17/04

Q: If the ICD-9-CM code description (e.g., insulin dependent diabetes mellitus) changes between the dates of service and data validation, will it be counted as a discrepancy if the new description is not documented in the record?

A: No, this would not be counted as a discrepancy, provided that the year of the coding description change was within the data submission period. If, for example, the coding change occurred in October 2002, the change would be covered for the 2003 data submission period (i.e., 07/01/02 through 06/30/03).

Q: When will the diagnosis list on the CMS website be updated to reflect the changes listed in the Participant Guide?

A: CMS posed the draft list of new diagnosis codes for the Drug Risk Adjustment model and additional codes on its website on 05/14/04. You may review these codes at www.cms.hhs.gov/healthplans/riskadj/.

Q: How do you handle documenting co-morbidity during a physician office visit since the HCFA 1500 only has 4 lines for ICD-9-CM diagnosis codes? Is there a way to submit additional codes?

A: Providers/physicians do not have to submit another claim to submit the additional codes. MA organizations can use their own established internal procedures; use the RAPS format, or DDE to submit the diagnosis codes. The provider/physician must report all diagnoses from the encounter and must list them in the medical record. A participant noted that the HCFA 1500 form includes a section for notations, which can be used to document additional codes. Those MA organizations that choose to accept another claim or HCFA 1500 for the same encounter should note that one of the claims may be rejected in their internal processing system, but the additional codes can still be submitted to CMS by RAPS or DDE.

Q: Where in the record must a confirmed diagnosis be documented, for example if the lab report states that a patient has neuropathy due to diabetes? If a patient is started on an ACE inhibitor, which is specific for neuropathy complications, but the physician did not write "diabetes with neuropathy" in his note; will the validation reviewer consider this a discrepancy?

A: CMS prefers physicians to comment on lab results in their notes, stating the full diagnosis, however, if MA organizations submit all the supporting documentation for the condition coded, it will be reviewed and a determination made.

Q: Does medical record documentation also apply to a specialist where the physician has referred the patient (e.g., a cardiologist)?

A: Yes, the physician should document in the medical record that he has received the cardiologist report and is following up on the findings. When the supporting medical record documentation, including the cardiologist report and the primary care physician treatment notes, are provided, it is likely that the resulting cardiac condition can be validated.

Q: What is the proper way to report the situation where a patient visits a primary care physician in 2004 for a sprained ankle and the patient also saw an endocrinologist?

A: Each condition reported must be on the basis of a face-to-face visit. The endocrinologist should report the diabetes code for that visit to the MA organizations so it can be submitted to CMS. If it was a referral from the primary physician, there should be documentation by the primary care physician in the medical record regarding the endocrinologist findings and treatment for diabetes.

Q: What is the appropriate code for a breast cancer patient who has had a mastectomy, and is having radiation and chemotherapy? Is the cancer considered a current condition?

A: When surgical removal of a cancer is followed by adjunct chemotherapy or radiotherapy, the malignancy code is assigned as long as the treatment is active. These guidelines can be found in Coding Clinic 4th quarter 2002 p. 136.

Q: Is a patient on Tamoxifen coded as a person with acute cancer?
A: There is currently no specific official guidance on long term use of this anti-neoplastic drug. Therefore, the guideline in the above question applies. If the Tamoxifen is being prescribed as an adjunct chemotherapy treatment, the cancer would be coded as current. If it is being prescribed as a preventative, then the code for personal history of cancer would be appropriate.

Q: What is the proper way to report, if a physician notes that a patient has hypertensive heart disease and cardiomyopathy?
A: Report both of these conditions separately using the code for hypertensive heart disease and the code for cardiomyopathy.

Q: Is it appropriate for a nurse practitioner to initial hospital, lab, and radiology reports?
A: A nurse practitioner is a valid provider type. However the person making the notation in the medical record should be someone who is treating the patient and part of the patient's care team.

Q: Are there specific codes for disabled people?
A: A patient's disabled status for risk adjustment calculations is not based on diagnosis codes submitted. However, MA organizations should report all conditions relating to the patient's face-to-face visit, including those that describe the patient's disabilities. Many of these are V-codes such as amputation status, and may or may not impact the HCC assignment.

Q: We are receiving the error code 501 (valid diagnosis but not a relevant diagnosis for risk adjustment during this service period) for diagnosis codes that appear to be relevant on some beneficiaries, but not receiving the 501-code for other beneficiaries with the same diagnosis code. How should we address this?
A: The 501-code is an information edit. Contact CSSC Operations to determine the nature of the problem and for technical assistance.

The 3 C's of Risk Adjustment Session I 09/14/04

Q: Is there any feedback on how MA organizations are using the Physician CD to educate their physicians and office staff about risk adjustment?
A: Successful training methods have included extracting key points from the CD and developing a customized PowerPoint presentation and creating a text version of highlighted points. MA organizations should note that the introductory comments on the CD by Dr. Barbara Paul are especially relevant for physicians and reiterate CMS' position on the importance of maintaining medical record documentation and submitting accurate diagnosis codes.

Q: Who can provide technical assistance when MA organizations duplicate the CD labels?
A: MA organizations can contact Kim Slaughter by email at kslaughter@aspensys.com or by telephone at 301-519-5388.

Q: Have any MA organizations developed an incentive program to entice physicians to review the CD?
A: At this time, CMS is unaware of any MA organizations that have developed an incentive program to entice physicians to review the Physician CD.

Q: Can physicians receive Continuing Medical Education (CME) credits for viewing the CD?
A: At this time, CMS has no plans to apply for CME credits for the Physician CD training program.

Q: Can MA organizations add their own logo to the Physician CD label?
A: While MA organizations are encouraged to use all or portions of the Physician CD in the provider education efforts, they should not change the content of the training program or add their own label to the materials and the CD's label (available at www.mcoservice.com). It is also important to keep the 2003 date on the label, as it designates the version of the information in the training program. CMS encourages MA organizations to send a cover letter on their company letterhead when distributing the CD.

Q: Have any MA organizations implemented a data validation process/system to assist/educate physicians and specialists with audit activities?
A: At this time, CMS is unaware of any MA organizations that have formal data validation training programs for providers.

General Session and 3 C's of Risk Adjustment Session II 09/23/04

General Session

Q: Will CMS notify the MA organization in advance if CMS determines that their submission must be suspended due to the number of duplicate diagnoses being submitted?
A: If a plan is submitting too many duplicates (clusters with a 502 informational message) at the initial or final submission deadlines, CMS will contact the organization by email before terminating their data processing privileges through the Front-End Risk Adjustment System (FERAS) to alert them of the termination due to excessive duplicates.

Q: When looking at the number of duplicates, is the system looking at diagnoses that have already been submitted or just those in the current submitted file?
A: FERAS checks for duplicate ***clusters*** being submitted that have already been stored in the Risk Adjustment System (RAS). A duplicate diagnosis cluster (i.e., the same provider type, from and through dates, and diagnosis code) is one that has the same elements as a diagnosis cluster previously stored in RAS.

3 C's

Q: Does CMS or someone at the MA organization do reconciliation?
A: CMS calculates risk factors using all available data in order to determine the plan's reimbursement. Sometime in April of each year, CMS calculates risk factors for individual beneficiaries (based on risk adjustment data the plans submitted by the initial submission deadline) and determines the plans reimbursement. Then CMS calculates factors after the final submission deadline (reflecting any additional data submitted for the data collection period). CMS also recalculates the plan's reimbursement and compares the new payment amount with the original payment and makes the appropriate adjustments. The MA organization should perform an internal reconciliation. Basically, the organization reconciles CMS' reimbursement with the plan's computed reimbursement amount. Internal reconciliation requires that the organization knows what data it submitted and has the ability to simulate running the risk adjustment model in order to determine its own factors. If the plan discovers a discrepancy, it may contact Jeff Grant (jgrant1@cms.hhs.gov) at CMS to discuss the discrepancy.

Q: For what data submission period is CMS currently reconciling?
A: CMS will begin reconciling for CY 2004 (i.e., dates of service 01/01/03 through 12/31/03) after 05/13/05, the final submission deadline for CY 2004 data.

Q: If an MA organization has not submitted any 2003 data, will it be paid on the same factors as what they started out with?
A: If a plan did not submit any data for the entire data submission period, the plan would be significantly underpaid. All the enrollees in the plan would be considered healthy.

Q: If an MA organization submits no risk adjustment data after March 2004, but beneficiaries that previously had high risk factors die or terminate enrollment, would the loss of those beneficiaries have an impact on the plan's reimbursement just due to the fact that the plan lost those beneficiaries with high risk factors?
A: Deaths and terminations may impact the plan-level risk factor. Individual risk adjustment data impacts the beneficiary-level risk.

Q: Will CMS calculate risk adjusted payments for MA organizations based on 2004 data in 2005?
A: Yes, organizations should already be submitting 2004 data. They will receive initial 2005 risk factors based on data with through dates of service July through December 2003 and January through June 2004. Then, midway through the year, after a full calendar year of 2004 data is received, CMS will recalculate the factors for the 2005 payments.