RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help Medicare+Choice organizations, providers, physicians, and third party submitters locate information specific to risk adjustment.

The purpose of this Resource Guide is to identify and supply resources that will simplify and clarify both the terminology and the processes employed in the submission of risk adjustment data. An emphasis is given to recent, policy-relevant material.

This Resource Guide is a helpful tool for those who need a quick reference for technical concepts, or for those who need to provide employees with an introductory presentation to the risk adjustment data process. Where possible and appropriate, "screen shots" of important resources on the Internet have been included. These pages may also be utilized as a suitable visual aid for risk adjustment data instructors to enhance their presentation.

The information listed in the Resource Guide is arranged in seven sections:

- RISK ADJUSTMENT ACRONYMS AND TERMS
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- CSSC WEB RESOURCES
- CSSC REFERENCE DOCUMENTS
- CODING RESOURCES
- RISK ADJUSTMENT PROCESSING SYSTEM CROSSWALKS

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Cynthia Tudor: ctudor@cms.hhs.gov
Jeff Grant: jgrant1@cms.hhs.gov
Henry Thomas: hthomas@cms.hhs.gov
Jan Keys: jkeys@cms.hhs.gov

CUSTOMER SERVICE AND SUPPORT CENTER (CSSC) – http://www.mcoservice.com
The CSSC website provides "one-stop shopping" for M+C organizations regarding risk adjustment data submission needs. Visit mcoservice.com to register for email updates from the CSSC. The updates will serve as notification that new or updated information has been added to the website.

CSSC Contact Information
877-534-2772 (toll-free)
mcoservice@palmettogba.com

ASPEN SYSTEMS CORPORATION
For general questions about training and Risk Adjustment User Groups, please email Aspen Systems Corporation at the encounterdata@aspensys.com.

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RISK ADJUSTMENT ACRONYMS AND TERMS

RISK ADJUSTMENT ACRONYMS AND TERMS

ACRONYM	TERM
ACR	Adjusted Community Rates
ACRP	Adjusted Community Rate Proposal
ADS	Alternative Data Sources
ADL	Activities of Daily Living
AGNS	AT&T Global Network Services
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI X12 837	Variable Length File Format for Electronic Submission of Encounter Data
ASC	Ambulatory Surgical Center
ASPEN	Aspen Systems Corporation
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act 1999
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement and Protection Act of 2000
CAD	Coronary Artery Disease
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Refined Hierarchical Condition Category Risk Adjustment Model
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSSC	Customer Service and Support Center
CVD	Cerebrovascular Disease
CWF	Common Working File
CY	Calendar Year
DCP	Data Collection Period
DDE	Direct Data Entry
DHHS	Department of Health & Human Services
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DOB	Date of Birth
DoD	Department of Defense
DOS	Dates of Service
DRG	Diagnosis Related Group
DX	Diagnosis
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
ET	Eastern Time
FERAS	Front-End Risk Adjustment System
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
GHP	Group Health Plan Payment System
GROUCH	GHP Group Output User Communication Help System
GUI	Graphical User Interface
H#	M+C Organization CMS Contract Number
HCC	Hierarchical Condition Category
HCFA 1500	Medicare Part B Claim Filing Form

ACRONYM	TERM
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set
HHS	Department of Health and Human Services
HIC#	Health Insurance Claim Number (Beneficiary Medicare ID#)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICN	Internal Claim Number
IP	Internet Protocol
IVC	Initial Validation Contractor
JCAHO	Joint Commission on Accreditation of Health Care Organizations
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MBD	Medicare Beneficiary Database
M+C Organization	Medicare+Choice Organization
MCCOY	Managed Care Option Information System
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug Modernization Act of 2003
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MnDHO	Minnesota Disability Health Options
MOR	Monthly Output Report
MSA	Medical Savings Account
MSG	Message
MSHO	Minnesota Senior Health Options
NCH	National Claims History
NCPDP	National Council on Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDM	Network Data Mover
NMUD	National Medicare Utilization Database
NSF	National Standard Format
OIG	Office of Inspector General
Palmetto GBA	Palmetto Government Benefits Administrators
PACE	Program of All-Inclusive Care for the Elderly
PCN	Patient Control Number
PHS	PACE Health Survey
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
RAPS	Risk Adjustment Processing System
RAPS Database	Risk Adjustment Processing System Database
RAS	Risk Adjustment System
RHC	Rural Health Clinic
RRB	Railroad Retirement Board
RPT	Report
RT	Record Type
SAS	Statistical Analysis Software
SH#	Submitter CMS Contract Number
S/HMO	Social Health Maintenance Organizations
SNF	Skilled Nursing Facility

ACRONYM	TERM
SSD	Selected Significant Disease Model
SSN	Social Security Number
SUB ID	Submitter ID
SVC	Second Validation Contractor
TOB	Type of Bill
UB-92	Uniform Billing Form 92
VA	Veterans Administration
WPP	Wisconsin Partnership Program

CMS WEB RESOURCES

CMS Main Page

http://www.cms.hhs.gov

Announcement Letter on Resumption of Data Collection (March 29, 2002)

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

Advance Notice of Methodological Changes for Calendar Year (CY) 2004 (45-Day Notice)

http://cms.hhs.gov/healthplans/rates/2004/45day.pdf

Announcement of Calendar Year (CY) 2004 Medicare+Choice Payment Rates (May 12, 2003)

http://cms.hhs.gov/healthplans/rates/

Cover Letter Regarding Revised Medicare Advantage Rates for Calendar Year (CY) 2004 (January 16, 2004)

http://cms.hhs.gov/healthplans/rates/2004ma/cover/pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates (45-Day Notice)

http://cms.hhs.gov/healthplans/rates/2005/45day.pdf

Medicare Managed Care Manual

http://cms.hhs.gov/manuals/116_mmc/mc86toc.asp

Rate Book Information

http://cms.hhs.gov/healthplans/rates/

Risk Adjustment Models

http://cms.hhs.gov/healthplans/rates/

Healthplans Page

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

Risk Adjustment Page

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

Health Insurance Portability and Accountability Act (HIPAA) Page

http://www.cms.hhs.gov/hipaa/

Quarterly Provider Updates

http://www.cms.hhs.gov/providerupdate/main.asp

Operational Policy Letters

http://cms.hhs.gov/healthplans/opl/

Official Meeting Notices

http://cms.hhs.gov/providerupdate/notices.asp

Medicare Beneficiary Database User's Manual

http://cms.hhs.gov/healthplans/systems/mcouserguide.pdf

Official Coding Guidelines on Centers for Disease Control & Prevention Website

http://www.cdc.gov/nchs/data/icd9/icdguide.pdf

Risk Adjustment Model Output Report Letter

http://mcoservice.com/new/references/cmsinstructions.html

CMS REFERENCE DOCUMENTS

Health Plan Management System (HPMS)

HPMS is a CMS information system created specifically for the Medicare+Choice program that provides M+C organization level information.

Accessing HPMS

- Access to HPMS is accomplished via the Medicare Data Communications Network (MDCN).
- A User ID is required for HPMS access. If you do not currently have access, complete the "Access to CMS Computer Systems" form available at http://cms.hhs.gov/mdcn/hdcidform.asp or at the end of this Resource Guide.
- If M+C organizations experience difficulty logging into HPMS, please contact Don Freeburger (dfreeburger@cms.hhs.gov) 410-786-4586 or Neetu Balani (nbalani@cms.hhs.gov) 410-786-2548.

FINAL INSTRUCTIONS AS THEY APPEAR IN THE RENEWAL AND NONRENEWAL INSTRUCTIONS FOR THE 2003 CONTRACT YEAR FOR MEDICARE+CHOICE ORGANIZATIONS (dated 05/03/02) (http://www.cms.hhs.gov/healthplans/letters/default.asp)

Instructions for Risk Adjustment Implementation

Background
The Balanced Budget Act of 1997 gave the Secretary of Health and Human Services the authority to collect inpatient hospital data for discharges on or after July 1, 1997. CMS implemented the Principal Inpatient - Diagnostic Cost Group (PIP-DCG) risk adjustment method based on the principal inpatient hospital discharge diagnosis. The encounter data collection was expanded in 2000-2001 to include physician and hospital outpatient data. In May 2001, the Secretary announced a suspension of the requirements for filing physician and hospital outpatient encounter data collection pending a review of the administrative burden that was associated with that effort. As a direct result of that review, including consultation with M+C organizations, these instructions implement a streamlined process for M+C organizations to collect and submit data for risk adjustment, balancing burden reduction with improved payment accuracy.

Effective Dates
These instructions are effective for all risk adjustment data submitted for dates of service on or after July 1, 2002. Data from that date forward must be submitted for relevant diagnoses noted during hospital inpatient stays and hospital outpatient and physician visits. M+C organizations may begin submitting data on October 1, 2002 and must meet their first quarterly submission requirement by December 31, 2002. In addition, these instructions provide the guidelines for submitting 2003 reconciliation data for the PIP-DCG model after October 1, 2002.

Reporting
The requirements as described herein shall apply to all M+C organizations, the Program of All-Inclusive Care for the Elderly (PACE) and all active capitated demonstrations except United Mine Workers Association (UMWA) and the Department of Defense (DOD) Tricare. Additional data requirements may be required for demonstrations at the time of their renewal, typically under the "Special Terms and Conditions" section of their waiver.

Provider Type Definitions
The following sections define the provider types from which M+C organizations may submit diagnoses. Any diagnoses received from the provider types as defined may be submitted. For information on the minimum requirements for diagnosis submission, see the data submission instructions below. The provider types and their respective codes are hospital inpatient, which is further subdivided into principal hospital inpatient (01) and other hospital inpatient (02); hospital outpatient (10); and physician (20).

Hospital Inpatient Data
Inpatient hospital data should be differentiated based on whether it is received from within or outside of the M+C organization's provider network. Because the Code of Federal Regulations (CFR) requires that all M+C organization network hospitals have a Medicare provider agreement (see 42CFR422.204(a)3(i)), by extension, a network provider should have a Medicare provider billing number for a hospital inpatient facility. If a facility does not have a hospital inpatient Medicare provider number, the M+C organization

shall not submit diagnoses from that facility as hospital inpatient data. Table 1, at the end of these instructions, gives the list of valid provider number ranges for hospital inpatient facilities. Please note that it is not necessary for M+C organizations to receive the Medicare provider number from the hospital on incoming transactions, i.e., the M+C organization may utilize its own provider identifications system. Regardless of how M+C organizations identify their facilities, M+C organizations must be able to distinguish diagnoses submitted by facilities that qualify as Medicare hospital inpatient facilities from diagnoses submitted by non-qualifying facilities.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital inpatient facility. If the provider is a Medicare-certified hospital inpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare certified but is a Department of Veterans Affairs (VA) or DOD facility, the M+C organization must verify that it is a legitimate inpatient facility by contacting the Customer Service and Support Center (CSSC) prior to submitting data from that facility. If the hospital is not Medicare certified or VA/DOD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital inpatient facility prior to submitting any diagnoses from that facility.

To aid in determining whether or not a provider is a Medicare-certified hospital inpatient facility, the M+C organization may refer to the Medicare provider number. The Medicare provider number has a two-digit state code followed by four digits that identify the type of provider and the specific provider number. Table 1 outlines the number ranges for all facility types that CMS considers to be Medicare hospital inpatient facilities. The XX in the first two positions of every number represents the state code. If the facility's Medicare provider number is unknown, the M+C organization may verify the provider number with the facility's billing department.

Some hospitals also operate Skilled Nursing Facilities (SNFs) as separate components within the hospital or have components with "swing beds" that can be used for either hospital inpatient or SNF stays. M+C organizations shall not submit any diagnoses for stays in the SNF component of a hospital or from swing bed stays when the swing beds were utilized as SNF beds. Stays in both of these circumstances qualify as SNF stays and do not qualify as hospital inpatient stays. If the Medicare provider number is on the incoming transaction from the facility, the M+C organization may distinguish the SNF or SNF swing-bed stays by the presence of a U, W, Y or Z in the third position of the Medicare provider number (e.g., 11U001).

Principal Hospital Inpatient and Other Hospital Inpatient Diagnoses

M+C organizations must differentiate between the principal hospital inpatient diagnosis and all other hospital inpatient diagnoses when coding the provider type on the new risk adjustment transaction. According to the Official ICD-9 CM Guidelines for Coding and Reporting, the principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". The principal diagnosis as reported by the hospital shall be coded as Provider Type 01, Principal Hospital Inpatient. CMS strongly recommends that M+C organizations continue to collect electronic encounter data or claims from hospital inpatient stays to ensure the proper identification of the principal diagnosis.

The remaining diagnoses from a hospital inpatient stay shall be coded as Provider Type 02, Other Hospital Inpatient. The guidance for coding other conditions appears in Official ICD-9 CM Guidelines for Coding and Reporting, as well as in the section of these instructions titled Coexisting Conditions.

Outpatient Hospital Data

Hospital outpatient data includes any diagnoses from a hospital outpatient department, excluding diagnoses that are derived only from claims or encounters for laboratory services, ambulance, or durable medical equipment, prosthetics, orthotics, and supplies. Hospital outpatient departments include all provider types listed on Table 2 at the end of these instructions. Along with the provider types in the table, Table 2 also lists the valid Medicare provider number ranges for those provider types. The XX in the first two positions of every range represents the state code component of the Medicare provider number.

Because Medicare has multiple number ranges for many provider types, and continuous number ranges feature multiple provider types, a simplified list with the continuous valid Medicare provider number ranges for hospital outpatient facilities is provided in Table 3. CMS has included Federally Qualified Health Centers, Community Mental Health Centers, and Rural Health clinics in the list of outpatient facilities to ensure M+C organizations are allowed to submit complete physician data. These three facility

types utilize a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

M+C organizations should determine which providers qualify as hospital outpatient facilities in a similar manner as they determine which providers qualify as hospital inpatient facilities. As with hospital inpatient data, diagnoses collected from network providers are differentiated from diagnoses collected from non-network providers. Because all M+C organization network hospitals must have a provider agreement, all network hospital outpatient facilities must have a Medicare provider number within the range of valid hospital outpatient provider numbers (see Table 3 below). If a facility does not have a hospital outpatient Medicare provider number, the M+C organization shall not submit diagnoses from that facility as hospital outpatient data. It is not necessary that M+C organizations receive the Medicare provider number on incoming risk adjustment transactions, even if the transactions are electronic encounters or claims. However, M+C organizations must be able to distinguish diagnoses submitted by providers that qualify as hospital outpatient facilities from diagnoses submitted by non-qualifying providers.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital outpatient facility. If the provider is a Medicare-certified hospital outpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare certified but is a VA or DOD facility, the M+C organization must verify that it is a legitimate outpatient facility by contacting the CSSC prior to submitting data from that facility. If the hospital is not Medicare certified or VA/DOD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital outpatient facility prior to submitting any diagnoses from that facility.

As with hospital inpatient facilities, if the facility's Medicare provider number is unknown, the M+C organization may verify the provider number by contacting facility's billing department.

Physician Data

For purposes of risk adjustment data, physicians are defined by the specialty list in Table 4. This list includes certain non-physician practitioners, who for purposes of risk adjustment data will be covered under the broad definition of physicians. This list also includes multi-specialty groups and clinics. This inclusion is solely intended to allow M+C organizations to submit data based on claims received from groups and clinics that bill M+C organizations on behalf of individual practitioners covered on the specialty list.

Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as defined above) for medical services. Pathology and radiology services represent the only allowable exceptions to the face-to-face visit requirement, since pathologists do not routinely see patients and radiologists are not required to see patients to perform their services. Medicare fee-for-service coverage and payment rules do not apply to risk adjustment data; therefore, M+C organizations may submit diagnoses noted by a physician even when the services rendered on the visit are not Medicare-covered services. The diagnoses should be coded in accordance with the diagnosis coding guidelines in these instructions.

Data Collection

M+C organizations have several options for collecting data to support the risk adjustment submission. When M+C organizations collect data from providers, they may choose to utilize: 1) the standard claim or encounter formats, 2) a superbill, or 3) the minimum data set, i.e., the format used to report risk adjustment data to CMS.

Standard claim and encounter formats currently include the UB-92, the National Standard Format (NSF), and ANSI X12 837. All M+C organizations that collect electronic fee-for-service claim or no-pay encounters from their provider networks shall utilize the data from these transactions to prepare their risk adjustment data submissions. M+C organizations with capitated or mixed networks may also choose to use an electronic claim or encounter format to collect risk adjustment data from their capitated providers.

When Health Insurance Portability and Accountability Act (HIPAA) transaction standards become mandatory, all electronic claims or encounters sent from providers (physicians and hospitals) to health plans (M+C organizations) will constitute HIPAA-covered transactions. Any M+C organization that utilizes an electronic claim or encounter format for their risk adjustment data collection will need to convert to ANSI X12 837 version 40.10 when HIPAA standards become mandatory.

M+C organizations may elect to utilize a superbill or the minimum data set (HIC, diagnosis, “from date,” “through date,” and provider type) to collect risk adjustment data. Use of a superbill or the minimum data set to collect diagnoses does not violate HIPAA transaction standards, since neither of these data collection methods constitutes a covered transaction, i.e., these transactions are not claims or encounters. However, any M+C organization that utilizes an electronic claim or encounter to collect diagnoses from their providers shall submit the diagnoses collected on those claims and encounters. M+C organizations shall not utilize a superbill or the minimum risk adjustment data set to obtain diagnoses from providers who submit electronic claims or encounters, except when correcting erroneous diagnoses or supplementing incomplete diagnoses.

Regardless of the method(s) that the M+C organization utilizes to collect data from providers, any M+C organization may utilize any submission method accepted by CMS (UB-92, NSF, ANSI, risk adjustment data format, or direct data entry).

Diagnostic Coding

Medicare utilizes ICD-9-CM as the official diagnosis code set for all lines of business. In accordance with this policy, CMS will utilize ICD-9 diagnosis codes in the determination of risk adjustment factors. M+C organizations must submit for each beneficiary all relevant ICD-9 codes that are utilized in the risk adjustment model. M+C organizations must submit each relevant diagnosis at least once during a risk adjustment data reporting period, with the first period being July 1, 2002 – June 30, 2003. Future risk adjustment data reporting periods will be announced January 15, 2003.

At a minimum, the submitted ICD-9 codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. CMS has provided a list of the minimal ICD-9 codes required to group diagnoses for risk adjustment. In all cases, coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model. For the complete list of diagnoses used in the risk adjustment model, as well as the list of diagnoses with the minimum specificity required to group for the model, see web links at the end of these instructions.

M+C organizations must apply the following guidelines when collecting data from their provider networks. If the M+C organization utilizes an abbreviated method of collecting diagnoses, such as a superbill, the diagnoses may be coded to the highest level of specificity or to the level of specificity necessary to group the diagnosis appropriately for risk adjusted payments. If the M+C organization collects data using an encounter or claim format, the codes should already be at the highest level of specificity. CMS encourages M+C organizations to utilize the full level of specificity in submitting risk adjustment data. Regardless of the level of specificity of submitted diagnoses, a medical record must substantiate all diagnostic information provided to CMS.

The Official ICD-9 CM Guidelines for Coding and Reporting (see web links at end of instructions) provides guidance on diagnosis coding. This document provides guidelines for hospital inpatient, hospital outpatient and physician services.

ICD-9-CM codes are updated on an annual basis. Physicians and providers must begin using the ICD-9-CM codes as updated in October 2001 for risk adjustment data submitted on or after July 1, 2002. It is very important that physicians and providers use the most recent version of the ICD-9-CM coding book. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Information regarding ICD-9-CM codes is available on the Internet at http://cms.hhs.gov.

Coexisting Conditions

Physicians and providers should use the Official ICD –9-CM Guidelines for Coding and Reporting and Medicare fee-for-service rules when submitting risk adjustment data to M+C organizations. The official guidelines that govern those coexisting conditions that may be coded and reported by hospital inpatient, hospital outpatient and physician providers are summarized below. The guidelines for inpatient hospital stays are as follows:

"…all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."

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

"Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

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

Alternative Data Sources (ADS)
Alternative data sources include diagnostic data from sources other than inpatient hospital, outpatient hospital, and physician services. M+C organizations may use ADS as a check to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes. Two examples of ADS include pharmacy records and information provided to national or state cancer registries.

Note that M+C organizations may not utilize ADS as an alternative to diagnoses from a provider. If M+C organizations elect to utilize one or more ADS, they must ensure that the diagnosis reported to CMS is recorded in the beneficiary's medical record for the data collection period or that the medical record documents the clinical evidence of that specific diagnosis for the data collection period.

For example, prescription of an ACE inhibitor, alone, would not be considered as sufficient the sole data source of "clinical evidence" of CHF; instead the medical record would need to document an appropriate clinician's diagnosis of congestive heart failure during the data collection period (e.g., where an "appropriate clinician" is a physician/nurse practitioner/physician assistant). A laboratory test showing one reading of high blood sugar would also not be considered to be sufficient "clinical evidence" of diabetes--the medical record would need to document a clinician's diagnosis of diabetes during the data collection period.

Diagnosis Submission
For each enrolled beneficiary, M+C organizations shall submit each relevant diagnosis at least once during a data collection period. A relevant diagnosis is one that meets three criteria:

1) the diagnosis is utilized in the model;
2) the diagnosis was received from one of the three provider types covered by the risk adjustment requirements; and
3) the diagnosis was 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 visit to one of the three provider types covered by the risk adjustment data collection requirements. The first data collection period will cover all diagnoses submitted for dates of service from July 1, 2002 through June 30, 2003.

CMS will utilize the ""through date"" of a particular diagnosis when determining the "date of service" for purposes of risk adjustment; i.e., all diagnoses that have a "through date" that falls within the data collection year will be utilized in the risk adjustment model. For hospital inpatient diagnoses, the "through date" should be the date of discharge. All hospital inpatient diagnoses shall have a "through date". For physician and hospital outpatient diagnoses, the "through date" should represent either the

exact date of a patient visit or the last visit date for a series of services. For outpatient and physician diagnoses that correspond to a single date of service, M+C organizations have the option of submitting only the "from date", leaving the "through date" blank. When a M+C organization submits a "from date" and no "through date", the Risk Adjustment Processing System (RAPS) will automatically copy the "from date" into the "through date" field. The returned file, provided to the M+C organization, will contain both a "from date" and "through date" for every diagnosis.

Date Span

Date span is the number of days between the "from date" and "through date" on a diagnosis. For inpatient diagnoses, the "from date" and "through date" should always represent the admission and discharge dates respectively. Therefore, the date span should never be greater than the length of the inpatient stay. For physician and hospital outpatient data, the date span shall not exceed 30 days.

Submission Frequency

M+C organizations shall submit at least once per calendar quarter. Each quarter's submission should represent approximately one quarter of the data that the M+C organization will submit over the course of the year. The amount of records and diagnoses to which this corresponds depends upon the type of submission a M+C organization selects. If a M+C organization elects to use a claim or encounter submission, the ratio of records and diagnoses to enrollees will be much higher than if a M+C organization elects to use a quarterly summary transaction.

CMS will monitor submissions to ensure that all M+C organizations meet the quarterly submission requirements. For M+C organizations that do not receive a regular submission of superbills, claims, or encounter data from their providers, CMS strongly recommends that these organizations request new diagnoses from all network providers on a quarterly basis at a minimum to ensure accurate, complete and timely data submission.

Submission Methods

Data submission to CMS may be accomplished through any of the following methods:

1) full or abbreviated UB-92 Version 6.0;
2) full or abbreviated National Standard Format (NSF) Version 3.1;
3) ANSI X12 837 Version 30.51 (only for those submitters currently utilizing this version);
4) ANSI X12 837 Version 40.10;
5) the new RAPS format; and
6) on-line direct data entry (DDE) available through Palmetto Government Benefits Administrators.

Regardless of the method of submission that a M+C organization selects, all transactions will be subject to the same edits. The Front-End Risk Adjustment System (FERAS) will automatically format all DDE transactions in the RAPS format. Transactions that are submitted in claim or encounter formats will be converted to the RAPS format prior to going through any editing. The mapping from each claim or encounter transaction to the RAPS format is on the CSSC web site at www.mcoservice.com.

Each M+C organization should select the most efficient method for data submission, taking into account the unique nature of its data systems. M+C organizations may elect to utilize more than one submission method. All transactions will be submitted using the same network connectivity that M+C organizations currently utilize for encounter data submission. For assistance in utilizing any of the submission methods, please contact the Customer Service and Support Center (CSSC) at 1-877-534-2772.

Deleting Diagnoses

The RAPS will not perform adjustment processing. In place of the current adjustment process, there will be a diagnosis delete function available that will serve the same purpose. Each diagnosis cluster (diagnosis code, from and "through date"s, and provider type) will be stored separately as a unique cluster associated with a person'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. The correct diagnosis may be sent as a normal transaction. 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.

2003 Hospital Inpatient Data

M+C organizations should submit as much 2003 data as possible through the existing encounter data processing system. 2003 data is defined as hospital inpatient data for dates of discharge from July 1, 2001 though June 30, 2002. Any data submitted on or before September 27, 2002 will be processed through the existing systems and will be reported back to the M+C organizations in the existing report formats. This includes all data that is submitted in September 2002 and finalized in October 2002. Please note that the deadline for submitting data for 2003 risk adjustment is September 6, 2002, and the 2002 reconciliation data submission deadline will be September 27, 2002.

M+C organizations may submit reconciliation data for 2003 after the October 1, 2002 implementation of RAPS. Reconciliation data will be run through the PIP-DCG model. All reconciliation data must be submitted utilizing a full UB-92, the encounter version of the UB-92, or the ANSI X12 837 to ensure the accuracy of the PIP-DCG model. M+C organizations should submit only the 111 or 11Z bill types. The data will be converted at the FERAS into the RAPS format and sent through the normal RAPS processing. The returned report will be in the RAPS format, rather than the encounter data report formats. The transaction will be stored as one set of diagnosis clusters to maintain the integrity of the original transaction.

M+C organizations shall not submit adjustment transactions for 2003 reconciliation data after October 1, 2002. Any data submitted after that date should be submitted as a 111 or 11Z bill type. When M+C organizations need to correct a previously submitted transaction, M+C organizations shall send a new 111 or 11Z with the corrected information. In the same manner as CMS handled the original abbreviated hospital inpatient encounter data, CMS will check the from and "through dates" to identify duplicate inpatient transactions, determine which of the duplicate transactions was submitted most recently, and utilize the most recent transaction for calculating the risk adjustment factor.

Electronic Data Interchange (EDI) Agreements

All M+C organizations should have EDI agreements on file at Palmetto GBA, the front-end recipient of all encounter data. The language in encounter data EDI agreements has been updated to reflect the change from encounter data submission to risk adjustment data submission. All M+C organizations must complete a new EDI agreement prior to submitting to the new system. This change does not in any way change the network connectivity M+C organizations currently utilize, but merely aligns the language in the agreement with the new data rules.

Use of Third Party Submitters

M+C organizations may continue to utilize third-party vendors to submit risk adjustment data. Regardless who submits the data; CMS holds the M+C organization accountable for the content of the submission.

Data Validation
A sample of risk adjustment data used for making payments may be validated against hospital inpatient, hospital outpatient, and physician medical records to ensure the accuracy of medical information. Risk adjustment data will be validated to the extent that the diagnostic information justifies appropriate payment under the risk adjustment model. M+C organizations will be provided with additional information as the process for these reviews is developed.

M+C organizations must submit risk adjustment data that are substantiated by the physician or provider's full medical record. M+C organizations must maintain sufficient information to trace the submitted diagnosis back to the hospital or physician that originally reported the diagnosis. Since M+C organizations may submit summary level transactions without a link to a specific encounter or claim, establishing an appropriate audit trail to the original source of the data requires diligent information management on the part of the M+C organization.

Web Links
The following web links contain information cited within these instructions.

RAPS format, mapping, and edits
www.mcoservice.com

ICD-9-CM Public Use Files
http://cms.hhs.gov/paymentsystems/icd9/default.asp

ICD-9-CM Coding Guidelines
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm

Diagnosis Codes for Risk Adjustment
http://cms.hhs.gov/healthplans/riskadj/

Table 1: Hospital Inpatient Facility Types Acceptable for Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges

Type of Inpatient Hospital 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 2: Facility Types Acceptable for Hospital Outpatient Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges

Type of Outpatient Hospital 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 Clinic, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999
Psychiatric Hospitals	XX4000-XX4499

Table 3: Continuous Valid Medicare Provider Number Ranges For Hospital Outpatient Facilities

XX0001-XX0899 (also includes XXS001-XXS899 and XXT001-XXT899)
XX1225-XX1499
XX1800-XX2299
XX3025-XX3099
XX3300-XX3499
XX3800-XX3999
XX4000-XX4499
XX4600-XX4799
XX4900-XX4999
XX8500-XX8999

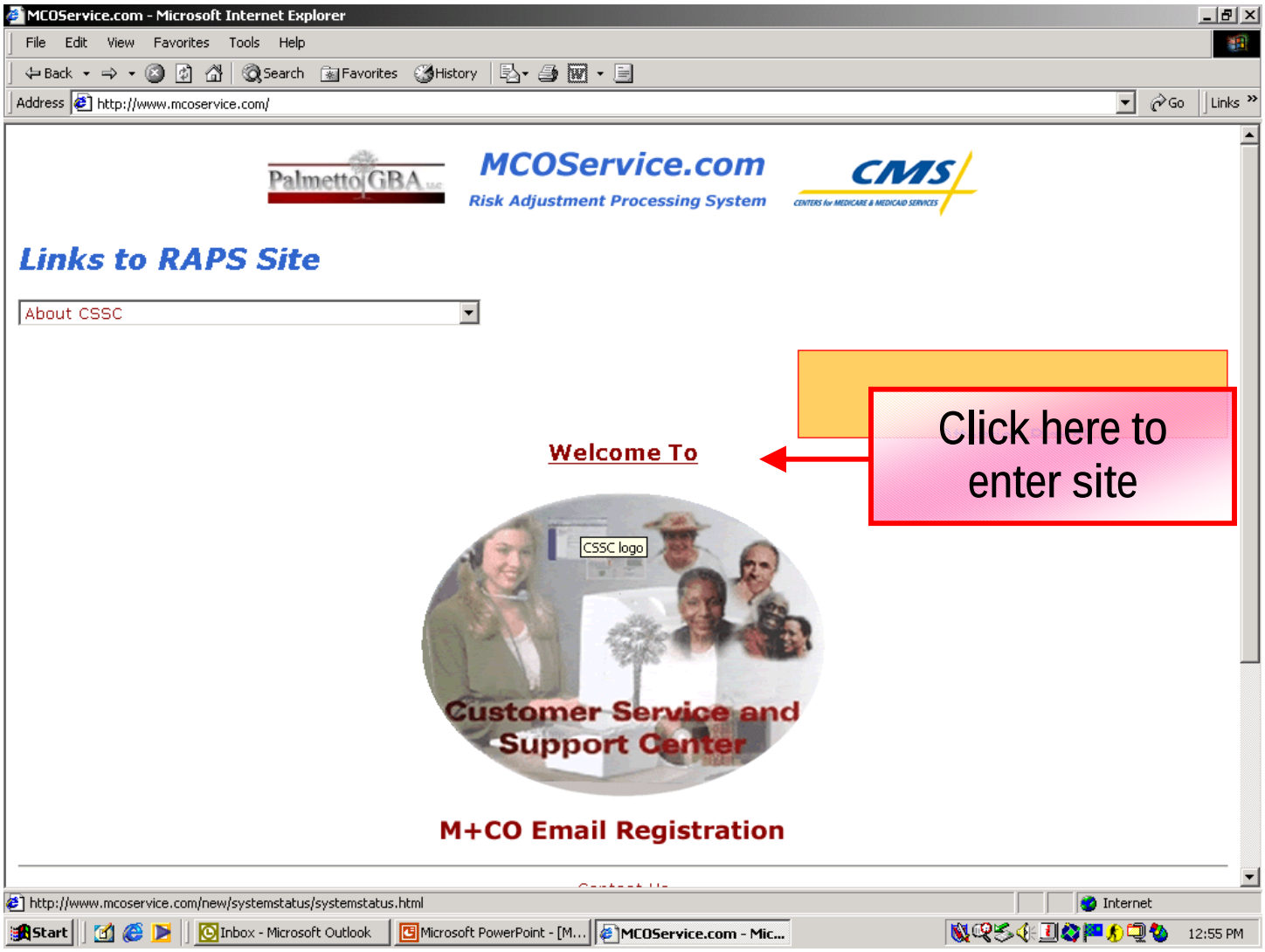
Table 4: Specialties Acceptable for Physician Risk Adjustment Data Submission and Associated Medicare Specialty Numbers

01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal medicine
12	Osteopathic manipulative therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/gynecology
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic surgery
22	Pathology
24	Plastic and reconstructive surgery
25	Physical medicine and rehabilitation
26	Psychiatry
28	Colorectal surgery
29	Pulmonary disease
30	Diagnostic radiology
33	Thoracic surgery
34	Urology
35	Chiropractic
36	Nuclear medicine
37	Pediatric medicine
38	Geriatric medicine
39	Nephrology
40	Hand surgery
41	Optometry (specifically means optometrist)
42	Certified Nurse Midwife
43	Certified Registered Nurse Anesthetist
44	Infectious disease
46	Endocrinology
48	Podiatry
50	Nurse practitioner
62	Psychologist
64	Audiologist
65	Physical therapist
66	Rheumatology
67	Occupational therapist
68	Clinical psychologist
70	Multispecialty clinic or group practice
76	Peripheral vascular disease
77	Vascular surgery
78	Cardiac surgery
79	Addiction medicine
80	Licensed clinical social worker
81	Critical care (intensivists)
82	Hematology
83	Hematology/oncology
84	Preventative medicine
85	Maxillofacial surgery
86	Neuropsychiatry
89	Certified clinical nurse specialist
90	Medical oncology
91	Surgical oncology
92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
97	Physician assistant
98	Gynecologist/oncologist
99	Unknown physician specialty

CSSC WEB RESOURCES

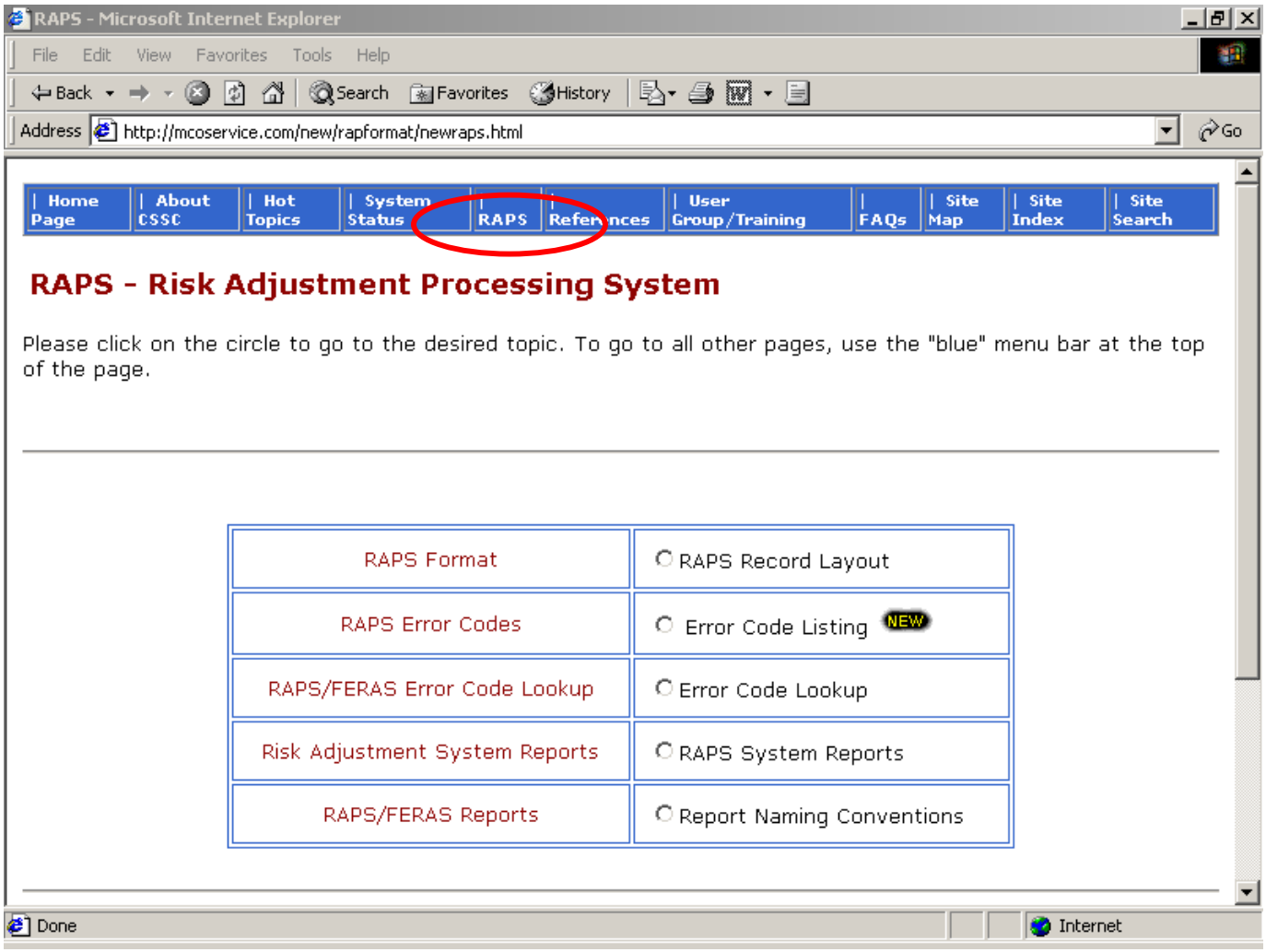
WWW.MCOSERVICE.COM

http://www.mcoservice.com



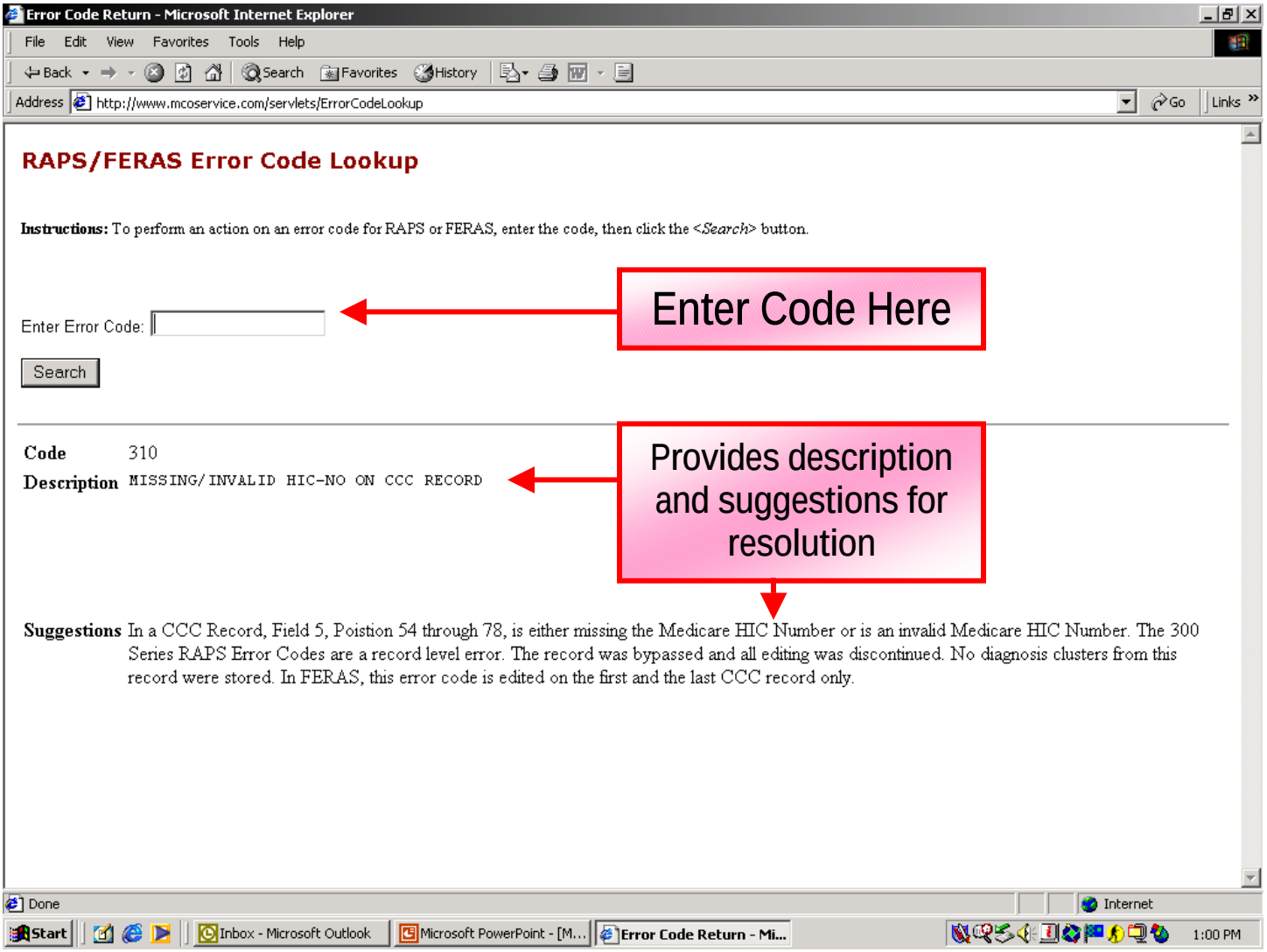
RAPS Resources

http://mcoservice.com/new/rapformat/newraps.html



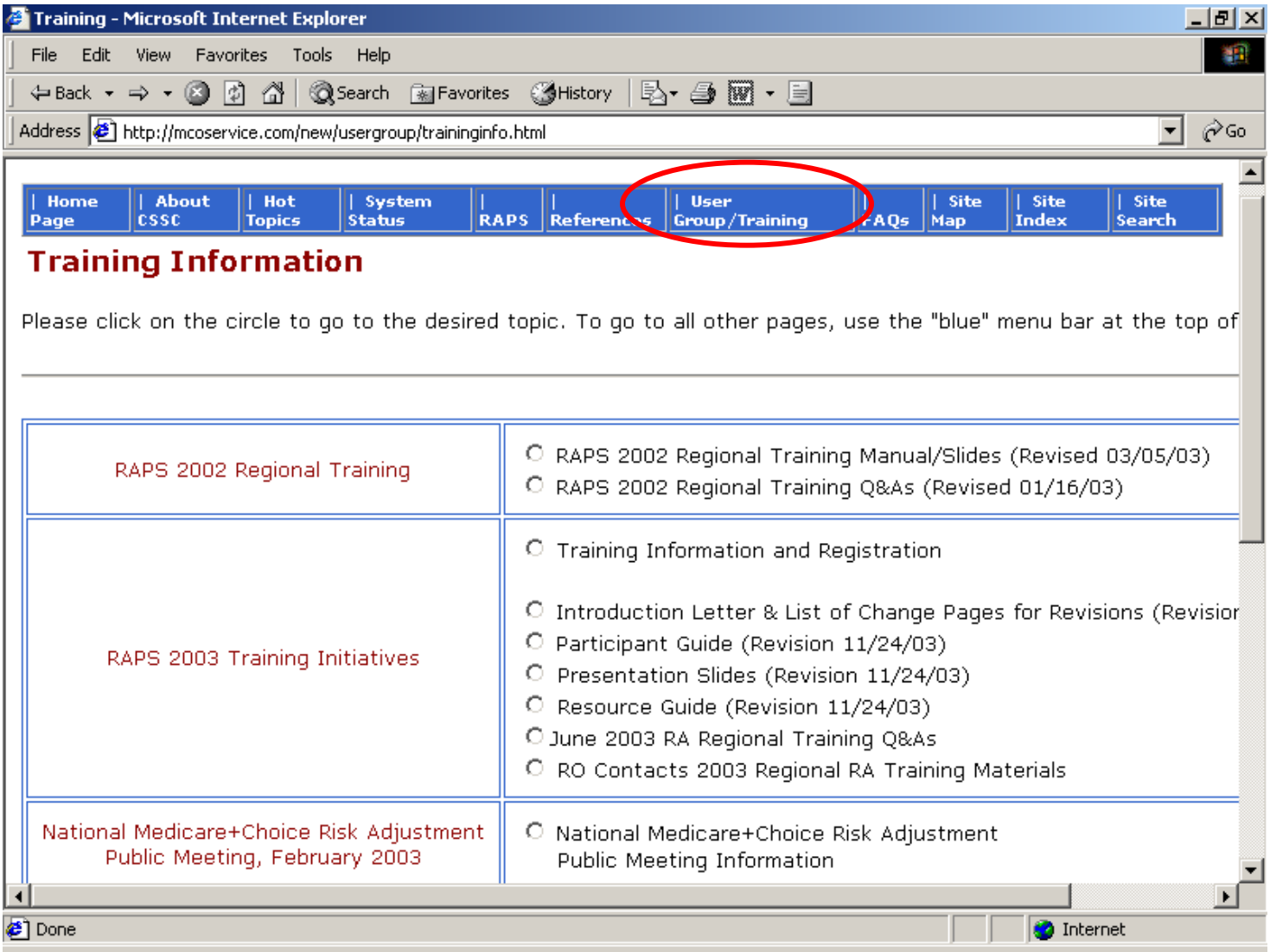
RAPS/FERAS Error Code Lookup

http://www.mcoservice.com/servlets/ErrorCodeLookup



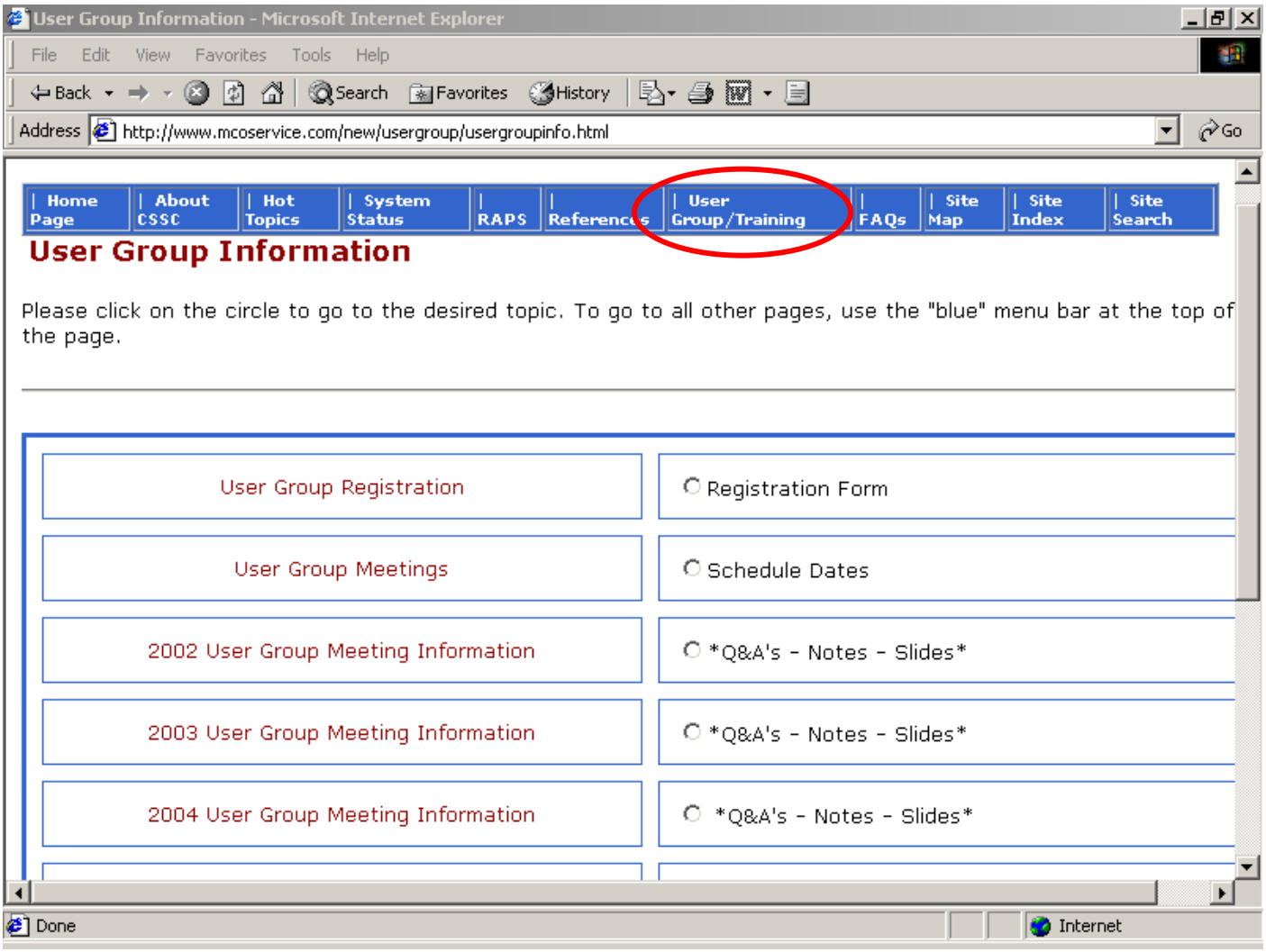
Training Guides and Updates

http://mcoservice.com/new/usergroup/traininginfo.html



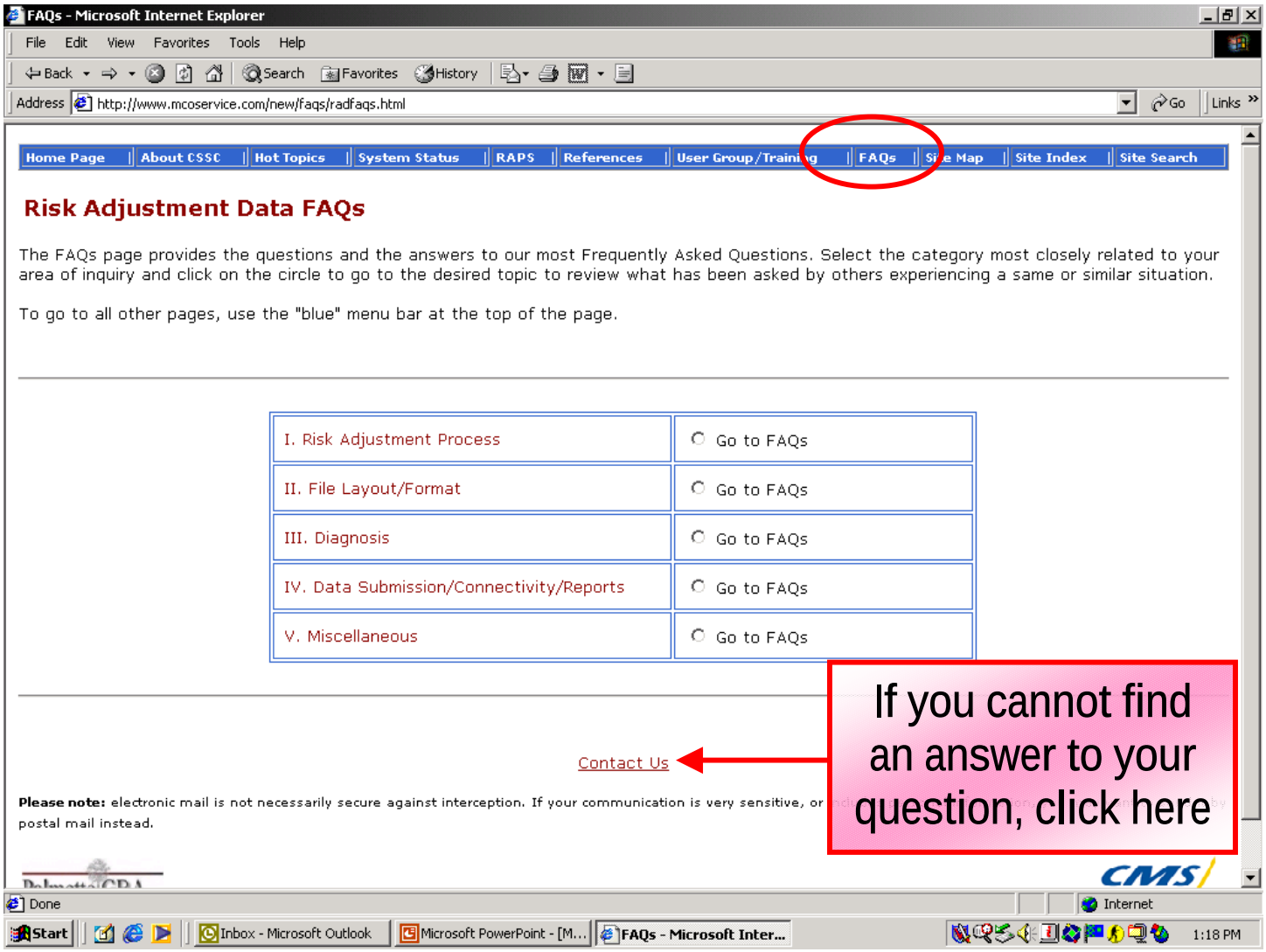
User Group Information

http://www.mcoservice.com/new/usergroup/usergroupinfo.html



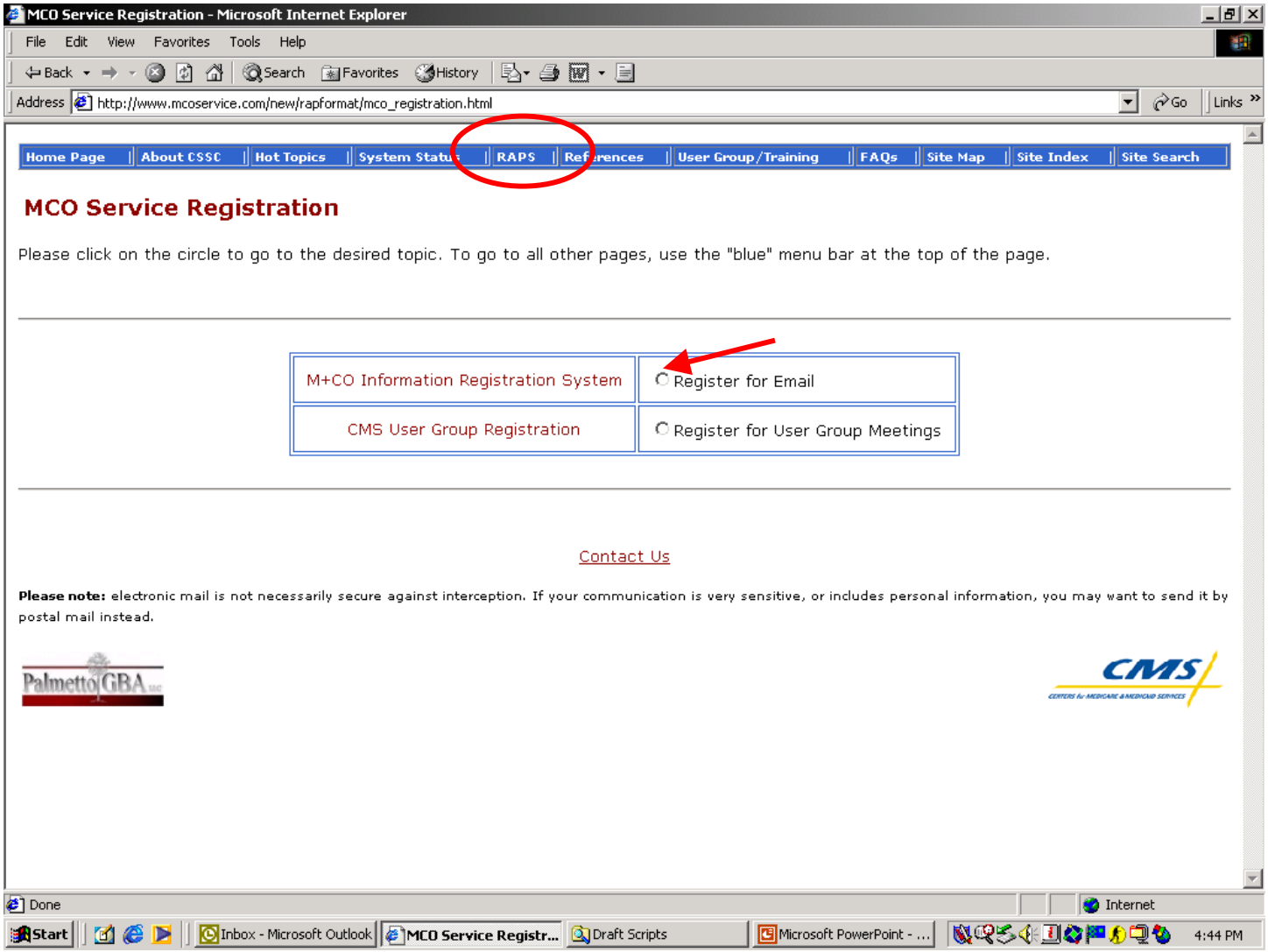
Frequently Asked Questions (FAQs)

http://www.mcoservice.com/new/faqs/radfaqs.html



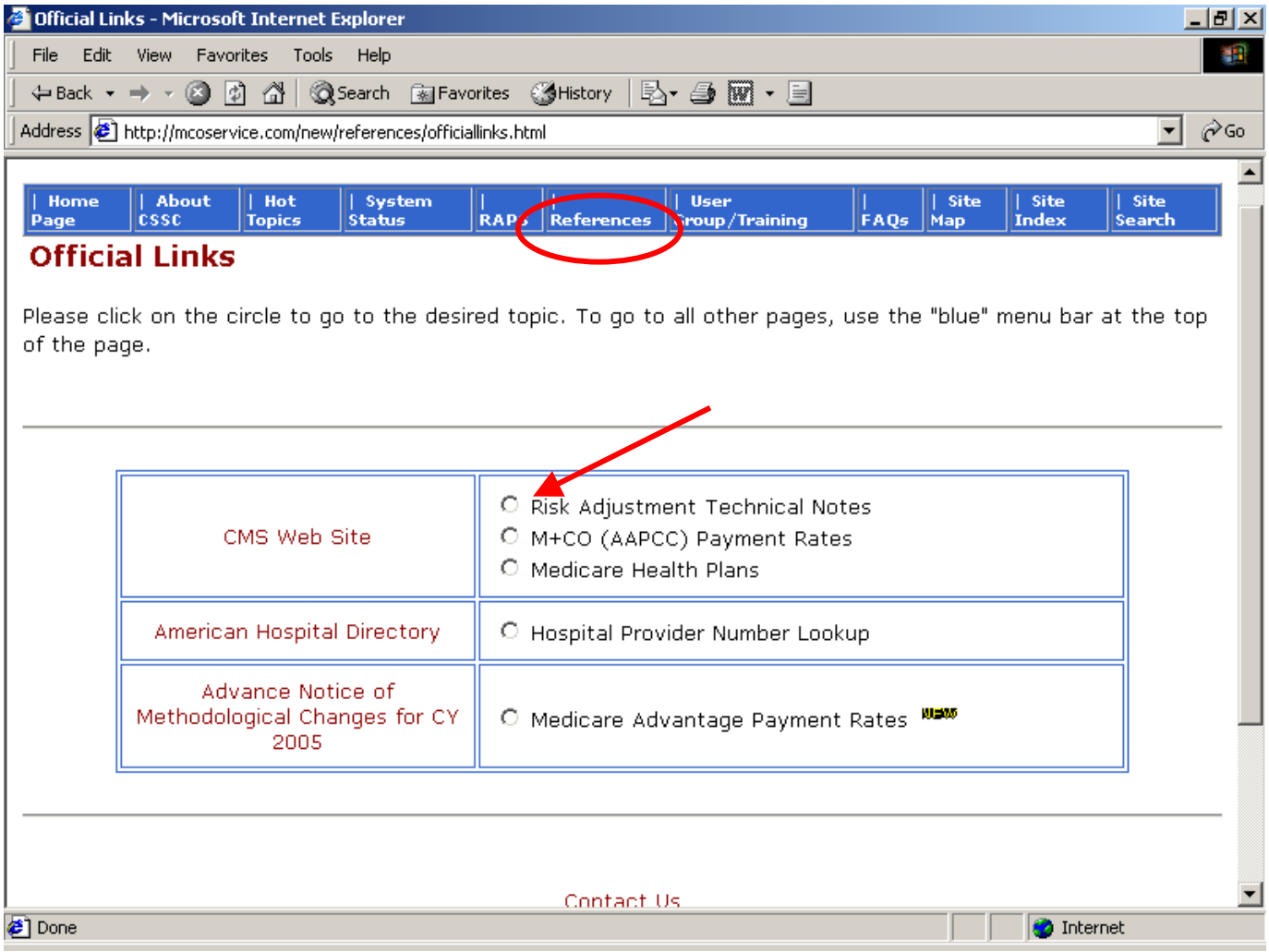
Register for Email Service

http://www.mcoservice.com/new/rapformat/mco_registration.html



Link to CMS Website

http://mcoservice.com/new/references/officiallinks.html



CSSC REFERENCE DOCUMENTS

TO: Managed Care Organizations Submitting Risk Adjustment Data

RE: EDI Enrollment and Submitter Application for Risk Adjustment Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Managed Care Organizations submitting Risk Adjustment Data. The CSSC and the Front-End Risk Adjustment System (FERAS) look forward to working with you in all aspects of the submission of risk adjustment data.

The following information must be completed and sent to the CSSC for enrollment for the submission of data for Risk Adjustment:

- EDI Agreement for Risk Adjustment Data collection
- Submitter Application
- Risk Adjustment NDM Specifications (For NDM users only)

Please note the following for submitting Risk Adjustment Data:

- A CMS Risk Adjustment Data EDI Agreement must be completed by each submitter and on file with CSSC, prior to submitting Risk Adjustment Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** 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.

- A Submitter ID (SHnnnn) will be assigned to you by the CSSC and will remain effective for ongoing submission of risk adjustment data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application return it to CSSC Operations with the completed EDI Agreement.

- You will be submitting all Risk Adjustment Data to the FERAS. Data may be submitted in one of the following formats, RAPS format, UB92, NSF and/or ANSI. All data submitted to the front-end will be sent to the Risk Adjustment Processing System (RAPS) in the risk adjustment data layout.

- If you are submitting the UB92, NSF or ANSI file format, it will be necessary to identify to the front-end the data is being submitted for translation to the RAPS format using the appropriate receiver ID as designated below:

    - UB 92 - Institutional Data - 80884 (RT01-6)
    - NSF - Professional Data - 80883 (AA0-17.0)
    - ANSI 4010 Institutional (80884) and Professional (80883) - ISA08, GS03, NM109 1000B

- Datasets are required to be set up for NDM users. The Risk Adjustment NDM Specifications should be completed and returned to the CSSC with the Submitter Application and the EDI Agreement.

- Technical Specifications are available based on the communication medium that is currently in use. NDM instructions and the FERAS User Guide are available on the mcoservice.com web site. Testing instructions for each medium are included within the document.

- On-Line transaction data entry is available through the secure MDCN FERAS web site. This option allows the user to key risk adjustment data directly into the front-end, creating the file for direct data submission.

- Reports are returned on all data submitted. The following report files are available for data submitted:

Response report generated by FERAS - per file submission
FERAS Response Report - RSP#####.RSP.FERAS_RESP
RSP#####.ZIP.FERAS_RESP (zip format)
RAPS – CMS generated reports per file submission
RAPS Return File RPT#####.RPT.RAPS_RETURN_FLAT
RPT#####.ZIP.RAPS_RETURN_FLAT (zip format)
RAPS Error Report RPT#####.RPT.RAPS_ERROR_RPT
RPT#####.ZIP.RAPS_ERROR_RPT (zip format)
RAPS Duplicate Diagnosis Cluster Report
RPT#####.RPT.RAPS_DUPDX_RPT
RPT#####.ZIP.RAPS_DUPDX_RPT (zip format)
RAPS Transaction Summary Report
RPT#####.RPT.RAPS_SUMMARY
RPT#####.ZIP.RAPS_SUMMARY_RPT (zip format)
RAPS - CMS generated reports monthly
RAPS Monthly Plan Activity Report
RPT#####.RPT.RAPS_MONTHLY
RPT#####.ZIP.RAPS_MONTHLY (zip format)
RAPS Cumulative Plan Activity Report
RPT#####.RPT.RAPS_CUMULATIVE
RPT#####.ZIP.RAPS_CUMULATIVE (zip format)

All reference material is available on the **www.mcoservice.com** web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the information provided.

CSSC Operations
PO Box 100275, AG 570
Columbia, SC 29202-3275
1-877-534-CSSC
www.mcoservice.com
FAX: 1-803-935-0171

Medicare+Choice Organization
Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or
With Medicare+Choice Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. The Eligible Organization Agrees:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization’s submissions, including the beneficiary's authorization and signature.

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct risk adjustment data discrepancies.

12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services Agrees To:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's

Name: _____

Title: _____

Address: _____

_____

City/State/ZIP: _____

By: _____

Title: _____ Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records.
Complete and mail this form with original signature to:

M+CO EDI Enrollment
P.O. Box 100275, AG-570
Columbia, SC 29202-3275

CSSC Risk Adjustment Data Submitter Application

Plan Number (Hnnnn):	
Plan Name:	
Address:	
Fax Number :	
Operations Contact Person:	
E-Mail address:	
Phone Number:	
Technical Contact Person:	
E-Mail address:	
Phone Number:	

What format do you plan to use to submit Risk Adjustment Data?

- o RAPS Format
- o M+CO NSF Format
- o UB 92 version 6.0
- o ANSI 837 4010

What Connection Type is established via the Medicare Data Communications Network (MDCN)?

Lease Line _____
IP _____
NDM _____
Dial up / Modem _____

Please list any additional Plan numbers your organization will submit data for:

Plan _____ Plan _____ Plan_____

Plan _____ Plan _____ Plan_____

Plan _____ Plan _____ Plan_____

Please return the completed submitter application, EDI Agreement and NDM specifications to CSSC Operations at the address below.

1-877-534-CSSC

www.mcoservice.com

FAX: 1-803-935-0171

Risk Adjustment NDM Specifications

The NDM Node connection is defined as follows:

NET ID: SCA
NODE ID: A70NDM.MC

APPLID: A70NDMMC

AGNS ID: PGBA

PLEASE ENTER YOUR NDM INFORMATION (Required):

NET ID: _____
NODE ID: _____

APPLID: _____

AGNS ID: _____

Your NDM User ID and password (if datasets are racf protected)

User ID: _____

Password: _____

RAPS Transaction Submission

DSN: **MAB.PROD.NDM.RAPS.PROD.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.RAPS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, AAA 6, must also indicate “TEST” or “PROD”, depending on the type of file being submitted.

Report Retrieval (enter names)

We will return reports to you in the following DSN’s. These datasets need to be GDGs to allow multiple files to be sent without manual intervention or overwriting of existing files.

Front End (FERAS) Response Report

Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=80,RECFM=FB,BLKSIZE=27920)

RAPS Return File
Frequency: Daily
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

RAPS Error Report
Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Summary Report
Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS DUPLICATE DIAGNOSIS CLUSTER REPORT (502 Error Report)
Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Summary Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Cumulative Report
Frequency: Monthly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

NOTE: If you submit the UB92, NSF or ANSI file format, you may submit to the DSNs below. However, with these file formats it is necessary to identify to the front-end the data is being submitted for translation to the RAPS format and data for risk adjustment processing by using the appropriate receiver ID as designated below:

Institutional Data, UB 92– 80884 (RT01-6)

Professional Data, NSF– 80883 (AA0-17.0)

Institutional (80884) and Professional (80883)ANSI 4010 –ISA08, GS03, NM109 1000B

NSF Format Submission
DSN: **MAB.PROD.NDM.EDS.CLM.NSF.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=320,BLKSIZE=27840)
Note: For testing, use **MAB.PROD.NDM.EDS.TCLM.NSF. submitter id(+1)**

UB92 Format Submission
DSN: **MAB.PROD.NDM.EDS.CLM.UBF.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=192,BLKSIZE=27840)
Note: For testing, use DSN= **MAB.PROD.NDM.EDS.TCLM.UBF. submitter id(+1)**

837 Format Submission
DSN: **MAB.PROD.NDM.EDS.CLMA.UBF.submitter (+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=80,BLKSIZE=27920)
Note: For testing, use **MAB.PROD.NDM.EDS.TCLMA.UBF.submitter (+1)**

DSN: **MAB.PROD.NDM.EDS.CLMA.NSF.submitter (+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=80,BLKSIZE=27920)

Note: For testing, use **MAB.PROD.NDM.EDS.TCLMA.NSF.submitter (+1)**

Please note that the test/prod indicator in the file must match the DSN.

CODING RESOURCES

E CODES

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
E95	POISON	55
E950	SUIC/SELF-POIS W SOL/LIQ	55
E9500	POISON-ANALGESICS	55
E9501	POISON-BARBITURATES	55
E9502	POISON-SEDAT/HYPNOTIC	55
E9503	POISON-PSYCHOTROPIC AGT	55
E9504	POISON-DRUG/MEDICIN NEC	55
E9505	POISON-DRUG/MEDICIN NOS	55
E9506	POISON-AGRICULT AGENT	55
E9507	POISON-CORROSIV/CAUSTIC	55
E9508	POISON-ARSENIC	55
E9509	POISON-SOLID/LIQUID NEC	55
E951	POISON-UTILITY GAS	55
E9510	POISON-PIPED GAS	55
E9511	POISON-GAS IN CONTAINER	55
E9518	POISON-UTILITY GAS NEC	55
E952	POISON-GAS/VAPOR NEC	55
E9520	POISON-EXHAUST GAS	55
E9521	POISON-CO NEC	55
E9528	POISON-GAS/VAPOR NEC	55
E9529	POISON-GAS/VAPOR NOS	55
E953	INJURY-STRANGUL/SUFFOC	55
E9530	INJURY-HANGING	55
E9531	INJURY-SUFF W PLAS BAG	55
E9538	INJURY-STRANG/SUFF NEC	55
E9539	INJURY-STRANG/SUFF NOS	55
E954	INJURY-SUBMERSION	55
E955	INJURY-FIREARM/EXPLOSIV	55
E9550	INJURY-HANDGUN	55
E9551	INJURY-SHOTGUN	55
E9552	INJURY-HUNTING RIFLE	55
E9553	INJURY-MILITARY FIREARM	55
E9554	INJURY-FIREARM NEC	55
E9555	INJURY-EXPLOSIVES	55
E9556	SELF INFLICT ACC-AIR GUN	55
E9557	SELF INJ-PAINTBALL GUN	55
E9559	INJURY-FIREARM/EXPL NOS	55
E956	INJURY-CUT INSTRUMENT	55

E CODES (CONTINUED)

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
E957	INJU-JUMP FROM HI PLACE	55
E9570	INJURY-JUMP FM RESIDENCE	55
E9571	INJURY-JUMP FM STRUC NEC	55
E9572	INJURY-JUMP FM NATUR SIT	55
E9579	INJURY-JUMP NEC	55
E958	INJURY/SELF-INJ NEC/NOS	55
E9580	INJURY-MOVING OBJECT	55
E9581	INJURY-BURN, FIRE	55
E9582	INJURY-SCALD	55
E9583	INJURY-EXTREME COLD	55
E9584	INJURY-ELECTROCUTION	55
E9585	INJURY-MOTOR VEH CRASH	55
E9586	INJURY-AIRCRAFT CRASH	55
E9587	INJURY-CAUSTIC SUBSTANCE	55
E9588	INJURY-NEC	55
E9589	INJURY-NOS	55
E959	LATE EFF OF SELF-INJURY	55

V CODES

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
V08	ASYMP HIV INFECTN STATUS	1
V421	HEART TRANSPLANT STATUS	174
V426	LUNG TRANSPLANT STATUS	174
V427	LIVER TRANSPLANT STATUS	174
V4281	TRNSPL STATUS-BNE MARROW	174
V4282	TRSPL STS-PERIP STM CELL	174
V4283	TRNSPL STATUS-PANCREAS	174
V4284	TRNSPL STATUS-INTESTINES	174
V432	HEART REPLACEMENT NEC	174
V4321	HEART ASSIST DEV REPLACE	174
V4322	ARTFICIAL HEART REPLACE	174
V44	ARTIFICIAL OPNING STATUS	176
V440	TRACHEOSTOMY STATUS	77
V441	GASTROSTOMY STATUS	176
V442	ILEOSTOMY STATUS	176
V443	COLOSTOMY STATUS	176
V444	ENTEROSTOMY STATUS NEC	176
V445	CYSTOSTOMY STATUS	176
V4450	CYSTOSTOMY STATUS NOS	176
V4451	CUTANEOUS-VESICOS STATUS	176
V4452	APPENDICO-VESICOS STATUS	176
V4459	CYSTOSTOMY STATUS NEC	176
V446	URINOSTOMY STATUS NEC	176
V448	ARTIF OPEN STATUS NEC	176
V449	ARTIF OPEN STATUS NOS	176
V451	RENAL DIALYSIS STATUS	130
V461	DEPENDENCE ON RESPIRATOR	77
V497	STATUS AMPUT	177
V4970	STATUS AMPUT LWR LMB NOS	177
V4971	STATUS AMPUT GREAT TOE	177
V4972	STATUS AMPUT OTHR TOE(S)	177
V4973	STATUS AMPUT FOOT	177
V4974	STATUS AMPUT ANKLE	177
V4975	STATUS AMPUT BELOW KNEE	177
V4976	STATUS AMPUT ABOVE KNEE	177
V4977	STATUS AMPUT HIP	177
V521	FITTING ARTIFICIAL LEG	177

V CODES (CONTINUED)

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
V55	ATTEN TO ARTIFICIAL OPEN	176
V550	ATTEN TO TRACHEOSTOMY	77
V551	ATTEN TO GASTROSTOMY	176
V552	ATTEN TO ILEOSTOMY	176
V553	ATTEN TO COLOSTOMY	176
V554	ATTEN TO ENTEROSTOMY NEC	176
V555	ATTEN TO CYSTOSTOMY	176
V556	ATTEN TO URINOSTOMY NEC	176
V558	ATTN TO ARTIF OPEN NEC	176
V559	ATTN TO ARTIF OPEN NOS	176
V56	DIALYSIS ENCOUNTER	130
V560	RENAL DIALYSIS ENCOUNTER	130
V561	FT/ADJ XTRCORP DIAL CATH	130
V562	FIT/ADJ PERIT DIAL CATH	130
V563	DIALYSIS	130
V5631	HEMODIALYSIS TESTING	130
V5632	PERITONEAL DIALYSIS TEST	130
V568	DIALYSIS ENCOUNTER, NEC	130

NEOPLASM GUIDELINES

A. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

B. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

C. Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:

1. When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.
2. When the admission/encounter is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia; the anemia is sequenced first followed by the appropriate code(s) for the malignancy.
3. When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
4. When the admission/encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

D. When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.

E. Admissions/Encounters involving chemotherapy and radiation therapy.

1. When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by chemotherapy or radiation treatment, the neoplasm code should be assigned as principal or first-listed diagnosis. When an episode of inpatient care involves surgical removal of a primary site or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.
2. If a patient admission/encounter is solely for the administration of chemotherapy or radiation therapy code V58.0, Encounter for radiation therapy, or V58.1, Encounter for chemotherapy, should be the first-listed or principal diagnosis. If a patient receives both chemotherapy and radiation therapy both codes should be listed, in either order of sequence.
3. When a patient is admitted for the purpose of radiotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.1, Encounter for chemotherapy.

F. When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

G. Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

RISK ADJUSTMENT
PROCESSING SYSTEM CROSSWALKS

ANSI-NSF 3051

RISK ADJUSTMENT PROCESSING SYSTEM						
ANSI X12 3051B CROSSWALK						
RECORD TYPE	**FIELD NO**	**FIELD NAME**	**FIELD LENGTH**	**POSITION**	**ANSI POSITION NUMBER**	**ANSI SEGMENT ID**
AAA	1.0	RECORD-ID	X(3)	1 - 3		
AAA	2.0	SUBMITTER-ID	X(6)	4 - 9	1-020	NM109
AAA	3.0	FILE-ID	X(10)	10 - 19	1 010	BGN02
AAA	4.0	TRANS-DATE	9(8)	20 - 27		**BGN03**
AAA	5.0	PROD-TEST-IND	X(4)	28 - 31	0 010	ISA15
BBB	1.0	RECORD-ID	X(3)	1 - 3		
BBB	2.0	SEQ-NO	9(7)	4 - 10		
BBB	3.0	PLAN-NO	X(5)	11 - 15	2 005	PRV03 (BI, 1C/ZZ)
CCC	1.0	RECORD-ID	X(3)	1 - 3		
CCC	2.0	SEQ-NO	9(7)	4 - 10		
CCC	3.0	SEQ-ERROR-CODE	X(3)	11 - 13		
CCC	4.0	PATIENT-CONTROL-NO	X(40)	14 - 53	2 130	CLM01
CCC	5.0	HIC-NO	X(25)	54 - 78	2 325.B 2 095	NM109 (C1) NM109 (HN)
CCC	6.0	HIC-ERROR-CODE	X(3)	79 - 81		
CCC	7.0	PATIENT-DOB	9(8)	82 - 89	2 115	DMG02 (D8)
CCC	8.0	DOB-ERROR-CODE	X(3)	90 - 92		
CCC	9.0	DIAGNOSIS-CLUSTER (occurs 10 times)		(93 - 412)		
CCC	9.1	PROVIDER-TYPE	X(2)	93 - 94		
CCC	9.2	FROM-DATE	9(8)	95 - 102	2 455.A	DTP03 (472)
CCC	9.3	THRU-DATE	9(8)	103 - 110	2 455.A	DTP03 (472)
CCC	9.4	DELETE-IND	X(1)	111		
CCC	9.5	DIAGNOSIS-CODE	X(5)	112 - 116	2 231	HI01.02(BR) HI02.02-HI04.02(BQ)
CCC	9.6	DC-FILLER	X(2)	117 - 118		
CCC	9.7	DIAG-CLUSTER-ERROR-1	X(3)	119 - 121		
CCC	9.8	DIAG-CLUSTER-ERROR-2	X(3)	122 - 124		
YYY	1.0	RECORD-ID	X(3)	1 - 3		
YYY	2.0	SEQ-NO	9(7)	4 - 10		
YYY	3.0	PLAN-NO	X(5)	11 - 15	2 005	PRV03 (BI, 1C/ZZ)
YYY	4.0	CCC-RECORD-TOTAL	9(7)	16 - 22		
ZZZ	1.0	RECORD-ID	X(3)	1 - 3		
ZZZ	2.0	SUBMITTER-ID	X(6)	11 - 16	1 020	NM109 (94)
ZZZ	3.0	FILE-ID	X(10)	10 - 19	1 010	BGN02
ZZZ	4.0	BBB-RECORD-TOTAL	9(7)	20 - 26		

ANSI-NSF 4010

RISK ADJUSTMENT PROCESSING SYSTEM						
ANSI X12 4010B CROSSWALK						
RECORD TYPE	**FIELD NO**	**FIELD NAME**	**FIELD LENGTH**	**POSITION**	**ANSI POSITION NUMBER**	**ANSI SEGMENT ID**
AAA	1.0	RECORD-ID	X(3)	1 - 3		
AAA	2.0	SUBMITTER-ID	X(6)	4 - 9	1 020	NM101 (41), NM109
AAA	3.0	FILE-ID	X(10)	10 - 19	1 010	BHT03
AAA	4.0	TRANS-DATE	9(8)	20 - 27		BHT04
AAA	5.0	PROD-TEST-IND	X(4)	28 - 31	0 010	ISA15
BBB	1.0	RECORD-ID	X(3)	1 - 3		
BBB	2.0	SEQ-NO	9(7)	4 - 10		
BBB	3.0	PLAN-NO	X(5)	11 - 15	2 035 2 015	REF02 NM109 (85,87)
CCC	1.0	RECORD-ID	X(3)	1 - 3		
CCC	2.0	SEQ-NO	9(7)	4 - 10		
CCC	3.0	SEQ-ERROR-CODE	X(3)	11 - 13		
CCC	4.0	PATIENT-CONTROL-NO	X(40)	14 - 53	2 130	CLM01
CCC	5.0	HIC-NO	X(25)	54 - 78	2 015 2 325	NM109 (C1) NM109 (C1)
CCC	6.0	HIC-ERROR-CODE	X(3)	79 - 81		
CCC	7.0	PATIENT-DOB	9(8)	82 - 89	2 032	DMG02
CCC	8.0	DOB-ERROR-CODE	X(3)	90 - 92		
CCC	9.0	DIAGNOSIS-CLUSTER (occurs 10 times)		(93 - 412)		
CCC	9.1	PROVIDER-TYPE	X(2)	93 - 94		
CCC	9.2	FROM-DATE	9(8)	95 - 102	2 455	DTP03 (472)
CCC	9.3	THRU-DATE	9(8)	103 - 110	2 455	DTP03 (472)
CCC	9.4	DELETE-IND	X(1)	111		
CCC	9.5	DIAGNOSIS-CODE	X(5)	112 - 116	2 231	HI01.02(BK) HI01.02(BF)
CCC	9.6	DC-FILLER	X(2)	117 - 118		
CCC	9.7	DIAG-CLUSTER-ERROR-1	X(3)	119 - 121		
CCC	9.8	DIAG-CLUSTER-ERROR-2	X(3)	122 - 124		
YYY	1.0	RECORD-ID	X(3)	1 - 3		
YYY	2.0	SEQ-NO	9(7)	4 - 10		
YYY	3.0	PLAN-NO	X(5)	11 - 15	2 035 2 015	REF02 NM109 (85,87)
YYY	4.0	CCC-RECORD-TOTAL	9(7)	16 - 22		
ZZZ	1.0	RECORD-ID	X(3)	1 - 3		
ZZZ	2.0	SUBMITTER-ID	X(6)	4 - 9	1 020	NM101 (41), NM109
ZZZ	3.0	FILE-ID	X(10)	10 - 19	1 010	BHT03
ZZZ	4.0	BBB-RECORD-TOTAL	9(7)	20 - 26		

ANSI UB92v3051

RISK ADJUSTMENT PROCESSING SYSTEM						
ANSI X12 3051A CROSSWALK						
RECORD TYPE	**FIELD NO**	**FIELD NAME**	**FIELD LENGTH**	**POSITION**	**ANSI POSITION NUMBER**	**ANSI SEGMENT ID**
AAA	1.0	RECORD-ID	X(3)	1 - 3		
AAA	2.0	SUBMITTER-ID	X(6)	4 - 9	1 020	NM101(41) NM109, ISA06, GS02
AAA	3.0	FILE-ID	X(10)	10 - 19	1 010	BGN02
AAA	4.0	TRANS-DATE	9(8)	20 - 27	1 010	BNG03, GS04
AAA	5.0	PROD-TEST-IND	X(4)	28 - 31		ISA15
BBB	1.0	RECORD-ID	X(3)	1 - 3		
BBB	2.0	SEQ-NO	9(7)	4 - 10		3.0
BBB	3.0	PLAN-NO	X(5)	11 - 15	2 235.E	NM101(PR) NM109
CCC	1.0	RECORD-ID	X(3)	1 - 3		
CCC	2.0	SEQ-NO	9(7)	4 - 10		
CCC	3.0	SEQ-ERROR-CODE	X(3)	11 - 13		
CCC	4.0	PATIENT-CONTROL-NO	X(40)	14 - 53	1 130	CLM01
CCC	5.0	HIC-NO	X(25)	54 - 78	2 095 2 325.B	NM101(QC) NM109
CCC	6.0	HIC-ERROR-CODE	X(3)	79 - 81		
CCC	7.0	PATIENT-DOB	9(8)	82 - 89	2 115	DMG02
CCC	8.0	DOB-ERROR-CODE	X(3)	90 - 92		
CCC	9.0	DIAGNOSIS-CLUSTER (occurs 10 times)		(93 - 412)		
CCC	9.1	PROVIDER-TYPE	X(2)	93 - 94		
CCC	9.2	FROM-DATE	9(8)	95 - 102	2 135.A	DTP01(232) DTP03
CCC	9.3	THRU-DATE	9(8)	103 - 110	2 135.A	DTP01(233) DTP03
CCC	9.4	DELETE-IND	X(1)	111		
CCC	9.5	DIAGNOSIS-CODE	X(5)	112 - 116	2 225.A	HI01(BJ) HI02(BK) HI03-HI10(BF)
CCC	9.6	DC-FILLER	X(2)	117 - 118		
CCC	9.7	DIAG-CLUSTER-ERROR-1	X(3)	119 - 121		
CCC	9.8	DIAG-CLUSTER-ERROR-2	X(3)	122 - 124		
YYY	1.0	RECORD-ID	X(3)	1 - 3		
YYY	2.0	SEQ-NO	9(7)	4 - 10		
YYY	3.0	PLAN-NO	X(5)	11 - 15	2 325.E	NM101(PR) NM109
YYY	4.0	CCC-RECORD-TOTAL	9(7)	16 - 22		
ZZZ	1.0	RECORD-ID	X(3)	1 - 3		
ZZZ	2.0	SUBMITTER-ID	X(6)	4 - 9	1 020	NM101(41) NM109, ISA06, GS02
ZZZ	3.0	FILE-ID	X(10)	10 - 19	1 010	BGN02
ZZZ	4.0	BBB-RECORD-TOTAL	9(7)	20 - 26		

RAPS-NSF-030402

FRONT END RISK ADJUSTMENT SYSTEM									
NSF FORMAT TO RISK ADJUSTMENT FILE FORMAT									
RECORD TYPE	FIELD NO	FIELD NAME	FIELD LENGTH	POSITION	RECORD TYPE	FIELD NO	FIELD NAME	FIELD LENGTH	POSITION
AAA	1.0	RECORD-ID	X(3)	1 - 3	AA0	1.0	RECORD-ID	X(3)	1 - 3
AAA	2.0	SUBMITTER-ID	X(6)	4 - 9	AA0	2.0	SUBMITTER-ID (SHnnnn)	X(16)	4 - 19
AAA	3.0	FILE-ID	X(10)	10 - 19	AA0	5.0	SUBMISSION-NUMBER	9(6)	35 - 40
AAA	4.0	TRANS-DATE	9(8)	20 - 27					
AAA	5.0	PROD-TEST-IND	X(4)	28 - 31	AA0	21.0	TEST/PRODUCTION INDICATOR	X(4)	254 - 257
BBB	1.0	RECORD-ID	X(3)	1 - 3	BA0	1.0	RECORD-ID	X(3)	1 - 3
BBB	2.0	SEQ-NO	9(7)	4 - 10					
BBB	3.0	PLAN-NO	X(5)	11 - 15	BA0	9.0	PLAN NUMBER	X(15)	48 - 62
CCC	1.0	RECORD-ID	X(3)	1 - 3	CA0	1.0	RECORD-ID	X(3)	1 - 3
CCC	2.0	SEQ-NO	9(7)	4 - 10					
CCC	3.0	SEQ-ERROR-CODE	X(3)	11 - 13					
CCC	4.0	PATIENT-CONTROL-NO	X(40)	14 - 53	CA0	3.0	PATIENT CONTROL NUMBER	X(17)	6 - 22
CCC	5.0	HIC-NO	X(25)	54 - 78	DA0	18.0	MEDICARE NUMBER (HICN)	X(25)	157 - 181
CCC	6.0	HIC-ERROR-CODE	X(3)	79 - 81					
CCC	7.0	PATIENT-DOB	9(8)	82 - 89	CA0	8.0	PATIENT DATE OF BIRTH	X(8)	59 - 66
CCC	8.0	DOB-ERROR-CODE	X(3)	90 - 92					
CCC	9.0	DIAGNOSIS-CLUSTER (occurs 10 times)		(93 - 412)					
CCC	9.1	PROVIDER-TYPE	X(2)	93 - 94					
CCC	9.2	FROM-DATE	9(8)	95 - 102	FA0	5.0	SERVICE FROM DATE	9(8)	40 - 47
CCC	9.3	THRU-DATE	9(8)	103 - 110	FA0	6.0	SERVICE TO DATE	9(8)	48 - 55
CCC	9.4	DELETE-IND	X(1)	111					
CCC	9.5	DIAGNOSIS-CODE	X(5)	112 - 116	EA0	32.0-35.0	DIAGNOSIS CODE 1 THRU 4	X(5)	179 - 198
CCC	9.6	DC-FILLER	X(2)	117 - 118					
CCC	9.7	DIAG-CLUSTER-ERROR-1	X(3)	119 - 121					
CCC	9.8	DIAG-CLUSTER-ERROR-2	X(3)	122 - 124					
YYY	1.0	RECORD-ID	X(3)	1 - 3	YA0	1.0	RECORD-ID	X(3)	1 - 3
YYY	2.0	SEQ-NO	9(7)	4 - 10					
YYY	3.0	PLAN-NO	X(5)	11 - 15	BA0	9.0	PLAN NUMBER (Hnnnn)	X(15)	48 - 62
YYY	4.0	CCC-RECORD-TOTAL	9(7)	16 - 22	YA0	10.0	BATCH CLAIM COUNT	9(7)	61 - 67
ZZZ	1.0	RECORD-ID	X(3)	1 - 3	ZA0	1.0	RECORD-ID	X(3)	1 - 3
ZZZ	2.0	SUBMITTER-ID	X(6)	4 - 9	ZA0	2.0	SUBMITTER ID (SHnnnn)	X(16)	4 - 19
ZZZ	3.0	FILE-ID	X(10)	10 - 19	AA0	5.0	SUBMISSION-NUMBER	9(6)	35 - 40
ZZZ	4.0	BBB-RECORD-TOTAL	9(7)	17 - 23	ZA0	8.0	BATCH COUNT	9(4)	66 - 69

RAPS-UBF-030402

FRONT END RISK ADJUSTMENT SYSTEM									
UB-92 FORMAT TO RISK ADJUSTMENT FILE FORMAT									
RECORD TYPE	FIELD NO	FIELD NAME	FIELD LENGTH	POSITION	RECORD TYPE	FIELD NO	FIELD NAME	FIELD LENGTH	POSITION
AAA	1.0	RECORD-ID	X(3)	1 - 3					
AAA	2.0	SUBMITTER-ID	X(6)	4 - 9	01	2.0	SUBMITTER ID (SHnnnn)	X(10)	3 - 10
AAA	3.0	FILE-ID	X(10)	10 - 19	01	17.2	FILE SEQUENCE NUMBER	X(6)	137 - 142
AAA	4.0	TRANS-DATE	9(8)	20 - 27	01	20.0	PROCESSING DATE	9(8)	155 - 162
AAA	5.0	PROD-TEST-IND	X(4)	28 - 31	01	18.0	TEST/PROD INDICATOR	X(4)	143 - 146
BBB	1.0	RECORD-ID	X(3)	1 - 3					
BBB	2.0	SEQ-NO	9(7)	4 - 10	10	3.0	BATCH NUMBER	X(2)	6 - 7
BBB	3.0	PLAN-NO	X(5)	11 - 15	31	15.0	CONTRACTOR NUMBER	X(5)	178 - 182
CCC	1.0	RECORD-ID	X(3)	1 - 3					
CCC	2.0	SEQ-NO	9(7)	4 - 10					
CCC	3.0	SEQ-ERROR-CODE	X(3)	11 - 13					
CCC	4.0	PATIENT-CONTROL-NO	X(40)	14 - 53	20	3.0	PATIENT CONTROL NUMBER	X(20)	5 - 25
CCC	5.0	HIC-NO	X(25)	54 - 78	30	7.0	HICN	X(19)	35 - 53
CCC	6.0	HIC-ERROR-CODE	X(3)	79 - 81					
CCC	7.0	PATIENT-DOB	9(8)	82 - 89	20	8.0	PATIENT DATE OF BIRTH	X(8)	56 - 63
CCC	8.0	DOB-ERROR-CODE	X(3)	90 - 92					
CCC	9.0	DIAGNOSIS-CLUSTER (occurs 10 times)		(93 - 412)					
CCC	9.1	PROVIDER-TYPE	X(2)	93 - 94	40	4	TYPE OF BILL		
CCC	9.2	FROM-DATE	9(8)	95 - 102	20	19.0	STATEMENT COVERS PERIOD FROM	9(8)	133 - 140
CCC	9.3	THRU-DATE	9(8)	103 - 110	20	20.0	STATEMENT COVERS PERIOD TO	9(8)	141 - 148
CCC	9.4	DELETE-IND	X(1)	111					
CCC	9.5	DIAGNOSIS-CODE	X(5)	112 - 116	70	4.0 - 12.0	PRINCIPLE/OTHER DIAGNOSIS CODES	X(6) EACH	25 - 78
CCC	9.6	DC-FILLER	X(2)	117 - 118					
CCC	9.7	DIAG-CLUSTER-ERROR-1	X(3)	119 - 121					
CCC	9.8	DIAG-CLUSTER-ERROR-2	X(3)	122 - 124					
YYY	1.0	RECORD-ID	X(3)	1 - 3					
YYY	2.0	SEQ-NO	9(7)	4 - 10					
YYY	3.0	PLAN-NO	X(5)	11 - 15	31	15.0	CONTRACTOR NUMBER	X(5)	178 - 182
YYY	4.0	CCC-RECORD-TOTAL	9(7)	16 - 22	95	6.0	NUMBER OF CLAIMS	9(6)	25 - 30
ZZZ	1.0	RECORD-ID	X(3)	1 - 3					
ZZZ	2.0	SUBMITTER-ID	X(6)	4 - 9	99	2.0	SUBMITTER ID (SHnnnn)	X(10)	3 - 12
ZZZ	3.0	FILE-ID	X(10)	10 - 19	01	17.2	BATCH #	X(6)	137 - 142
ZZZ	4.0	BBB-RECORD-TOTAL	9(7)	20 - 26	99	5.0	NUMBER OF BATCHES BILLED THIS FILE	9(4)	22 - 25

CMS OPERATIONS SPECIFICATIONS

Risk Adjustment 2004 Operations Specification

December 3, 2003

Change History

Date	Changed by	Description
17 Jun 2003	Wendy Couch	Initial Version
20 Aug 2003	Wendy Couch	Changes from 14 Jul 2003 meeting
28 Aug 2003	Wendy Couch	Revised process flow and impact to the text; enhanced front summary
29 Aug 2003	Wendy Couch	Minor changes suggested in RA Ops Spec Meeting
2 Sep 2003	Wendy Couch	Revised Process flow and reorganize paragraph 4
8 Se[2003	Wendy Couch	Incorporated C. Tudor's comments from previous meeting
12 Sep 2003	Wendy Couch	Incorporated J. Grant's comments
15 Sep 2003	Wendy Couch	Revised Process flow and reorganize paragraph 4
03 Oct 2003	Group	Incorporate answers to questions
31 Oct 2003	Jeff & Wendy	Incorporate Jeff's comments
14 Nov 2003	Jeff & Wendy	Incorporate Comments from various parties - mostly clarifications and removing duplicate information.
01 Dec 2003	Group	Baseline Document
03 Dec 2003	Jeff & Wendy	For transplant payments to beneficiaries changing to an ESRD Demonstration, change the percentage portion from ½ to 1/3.

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Risk Adjustment 2004 Operational Specification

1 Introduction

The purpose of this document is to coordinate the Risk Adjustment Factor (RAF) information between the following parties: CBC, DMCS- MMCS (and their contractor CSC), DMCS-RAS (and their contractor IBM), and GHP.

This document is in an interim state. The intent of the document is to capture information as it unfolds.

This document will be maintained by DMCS. Contact either Wendy Couch (410-786-6933) or Laquia Marks (410-786-312) to request changes. There is a log with a synopsis of the changes for each release on the second page of the document.

The distribution of this document is:

DMCS
Wendy Couch
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Sol Mussey, OACT

OTHER NON_CMS
Dave Freund, Fu
Terry Gallagher, IBM
Phyllis Kay, CSC

Please note that MMCS and GHP are used interchangeably in this document, unless stated otherwise.

This document is divided into 5 parts, as follows:

Paragraph 1, Introduction: This section introduces the purpose of the document, document maintenance, and the flow of the content within the document.

Paragraph 2, RA Payment Types: This section is a brief introduction to the different types of payments and RAFs.

Paragraph 3, RAFTiming: This section captures the timing issues associated with the creation of RAFs. It does not define when the RAF is used, that is defined in paragraph 4.

Paragraph 4, Payment Rules: This section captures both (1) the decisions on how to choose a RAF for payment and (2) the formula for calculating the Risk Adjusted Payment.

Paragraph 5, Sources: This section describes the sources for the data that GHP and MMCS will use to calculate the Risk Adjusted payment.

2 RA Payment Types

The GHP and MMCS payment systems will calculate the following types of payments:

- Hospice
- New Enrollee
- New Enrollee + Frailty
- Default for New Enrollee
- Default for New Enrollee+Frailty
- Community
- Community + Frailty
- Institutional
- Demographic ESRD
- PACE Demographic ESRD
- New Enrollee Dialysis
- Default for New Enrollee-Dialysis
- Dialysis
- Transplant
- Default for New Enrollee-Transplant
- New Enrollee Post-Transplant
- Default for New Enrollee-Post-Transplant
- Community Post-Transplant
- Institutional Post- Transplant

Please note that Working Aged (MSP and MSP for ESRD) will be implemented in 2004. However, they are not addressed in this document. These payments are based upon multipliers that will be applied at the Contract level. This will happen within APPS and not within either MMCS or GHP.

In general, in order to calculate the above payments, GHP and MMCS use corresponding Risk Adjustment Factors (RAF) as shown in Table 1 below:

Table 1. RA Payment RAFs and Sources

Payment Type	Corresponding RAF	Model/Tool	System Housing Model/Tool
Hospice	Non-Risk Adjusted Payment	Not applicable	Not applicable
New Enrollee	New Enrollee Factor	CMS-HCC	RAS
New Enrollee Plus Frailty	New Enrollee + Frailty Factor	CMS-HCC CBC Provided Table	RAS GHP/MMCS
Default for New Enrollee	Default for New Enrollee Factor	New Enrollee Base Default Table	GHP/MMCS
Default for New Enrollee Plus Frailty	Default for New Enrollee Factor + Frailty Factor	New Enrollee Base Default Table + 2004 Contract Level Payment File (Record Type F - Frailty Factor)	GHP/MMCS GHP/MMCS
Community	Community Factor	CMS-HCC	RAS
Community Plus Frailty	Community + Frailty Factor	CMS-HCC 2004 Contract Level Payment File (Record Type F - Frailty Factor)	RAS GHP/MMCS
Institutional	Institutional Factor	CMS-HCC	RAS
Demographic ESRD	Non-Risk Adjusted Payment	Not applicable	Not applicable
PACE/WPP Demographic ESRD	Non-Risk Adjusted Payment	Not applicable	Not applicable
New Enrollee Dialysis	New Enrollee Dialysis Factor	ESRD	RAS
Default for New Enrollee-Dialysis	Default for New Enrollee-Dialysis Factor	New Enrollee ESRD Default Table	GHP/MMCS
Dialysis	Dialysis Factor	ESRD	RAS

Payment Type	Corresponding RAF	Model/Tool	System Housing Model/Tool
Transplant	Transplant Factor	ESRD	RAS
Default for New Enrollee-Transplant	Default for New Enrollee-Transplant Factor	New Enrollee ESRD Default Table	GHP/MMCS
New Enrollee Post-Transplant	New Enrollee Post- Transplant Factor	ESRD	RAS
Default for New Enrollee-Post-Transplant	Default for New Enrollee-Post-Transplant Factor	New Enrollee Base Default Table	GHP/MMCS
Community Post-Transplant	Community Post-Transplant Factor	ESRD	RAS
Institutional Post-Transplant	Institutional Post-Transplant Factor	ESRD	RAS

3 RAF Timing

The detailed schedule for implementing the new systems and decommissioning the legacy systems will be addressed in a separate MSProject source.

The purpose of this section is to define a typical cyclical basis upon which RAS will run RAFs. The following two charts represent payment years 2004 and 2005:

CMS-HCC Model Runs, Regular Cycle, For Payment Year 2004

Name of Run	Data Collection Period	Data Submission Deadline	RAF Transmitted to MMCS	Payment Made from RAF
Initial RAF Calculation	07/01/02 - 06/30/03	09/30/03	11/15/03	2004 Payments made between: 1/1/04-6/30/04
2004 Mid-Year Calculation *	01/01/03 - 12/31/03	03/31/04	5/15/04	7/1/04-12/31/04
2004 Final Reconciliation	01/01/04 - 12/31/04	05/31/05	07/15/05	9/1/05

* In the Mid-year calculation, RAS will compute a non-lag RAF for all beneficiaries. However, those plans designated as Lag plans will not be paid using this recalculated beneficiary RAF, but, rather using the initial RAF calculation. This is only applicable to the Mid-Year calculation.

CMS-HCC Model Runs, Regular Cycle, For Payment Year 2005

Name of Run	Data Collection Period	Data Submission Deadline	RAF Transmitted to MMCS	Payment Made from RAF
Initial RAF Calculation	07/01/03 - 06/30/04	09/30/04	11/15/04	2005 Payments made between: 1/1/05-6/30/05
2005 Mid-Year Calculation	01/01/04 - 12/31/04	03/31/05	5//15/05	7/1/05-12/31/05
2005 Final Reconciliation	01/01/05 - 12/31/05	05/31/06	07/15/06	9/1/06

The Risk Adjustment System (RAS) will produce RAFs based on running a cohort of data (beneficiaries) through "models." For 2004 there will be 2 models: the CMS HCC model defined in this section of the document and the ESRD model defined in section 5.2.

RAS will process more than one run of the model(s) within a payment year, and it is anticipated that there will be different cohorts for each run within the 2004 payment year, as follows:

- For the initial run, Fu will process all 40M beneficiaries through the CMS HCC model. Fu will also process all ESRD beneficiaries through the ESRD model.

- For the mid-year calculation, RAS will run all beneficiaries that are enrolled in M+C on or after January 1, 2004, through the CMS HCC model. RAS will also run all ESRD beneficiaries through the ESRD model.

- For the 2004 final reconciliation, RAS will run all 40M beneficiaries through the CMS HCC model. RAS will also run every beneficiary that was ESRD between January 1 and December 31, 2004, through the ESRD model.

The Final Reconciliation RAF file will be received in July of the following year (July 2005 for 2004 payment year). The final set of RAFs causes recalculation of all beneficiary payments for the entire 2004 payment year. (January 2004 – December 2004). This final RAF is the basis for all adjustments for the 2004 payment year. The cohort for the 2004 Final Reconciliation (which is run in 2005) will include all beneficiaries who were alive on 1/1/04.

The ESRD Demonstrations are expected to go live in April 2004.

4 PAYMENT RULES

The purpose of this section is to define the following for each type of payment:

- The rules for determining which RAF to use for payment,

- The beneficiary level payment calculations, and

- Identify the source of the data/factors for GHP/MMCS. (NOTE: Section 5 will provide a more in-depth description of each source including who will provide them).

4.1 Payment Rules for All Payments

The following general rules apply to all beneficiary level payment calculations, regardless of RAF:

4.1.1 Lag/Non-Lag

Lag/Non-Lag: This rule only applies to selecting the factor created in the Mid-year RAF calculation. MMCS and GHP will know if all beneficiaries are lag or Non-lag based upon the MCO contract they are in, as defined in the 2004 Contract Level Payment File (see Section 5.9,). Record type I in the 2004 Contract Level Payment File will list MCOs that have opted to use the lag factor (versus the non-lag factor).

- All beneficiaries enrolled in MCOs listed in the 2004 Contract Level Payment File will have their payment based upon the lag factor through the payment year. In March of the following year, MMCS will adjust 2004 payments retroactively to reflect the difference between the lagged and non-lagged factor.

- All beneficiaries in MCOs which are not listed in the 2004 Contract Level Payment File (see Section 5.9.2) will have their payment based upon the non-lag factor. For the non-lagged contracts, an adjustment to the beneficiary payments for the year will be calculated from January to the current payment month in which the file is processed. This is not calculated for the lag contracts.

4.1.2 Changes in Plan Enrollment during the Payment Year

If a beneficiary changes in plan enrollment during a payment year, use the appropriate factor/payment methodology for the new plan effective the month of the enrollment change.

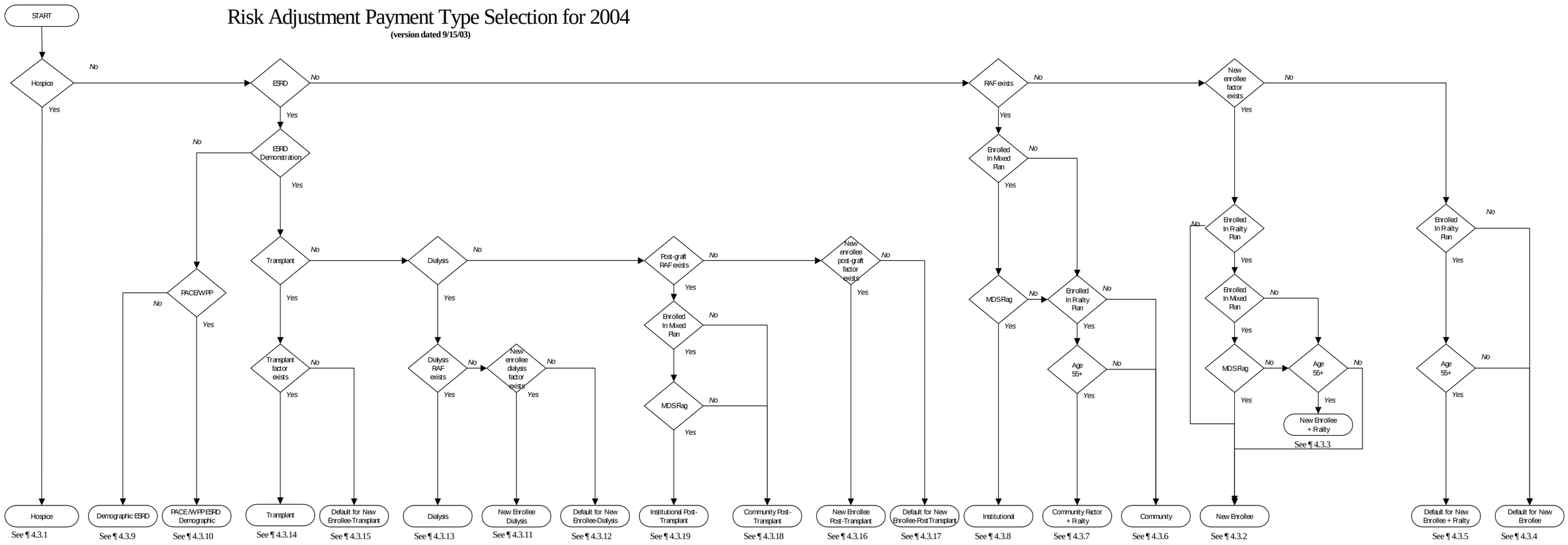
4.1.3 Changes in Contract during the Payment Year

For 2004, a contract should not change from a Community organization to an Institutional (Mixed) organization within the contract year or vice-versa. However, the system should be flexible enough to handle the "odd exception."

4.2 Overview of Choosing the RA Payment Type

The decision tree in Figure 1 is a graphical representation of the logic behind choosing the RA payment calculation to be applied to each beneficiary:

Figure 1. RA Decision Diagram



Use the logic in the chart in Figure 1 (above) to find the appropriate RAF driving the payment formula. These formulas, by RAF, are explained in paragraph 4.3.

GHP/MMCS will determine the appropriate RAFs for beneficiaries within a Demonstration by using the logic in the chart in Figure 1. At the time of discussion, this includes the following Demonstrations: PACE, WPP, Massachusetts Dual Eligible Demonstration, MnDHO and MnSHO.

The Risk Adjustment System (RAS) will produce RAFs based on running a cohort of beneficiaries through "models."

As shown in Table 2 (below), the RAS system will produce the following RAFs as a result of running a cohort of beneficiaries through either the CMS HCC Model or the ESRD model:

Table 2. RAFs Produced by HCC and ESRD Models

RAF	HCC Model	ESRD Model
New Enrollee Factor	X	
Community Factor	X	
Institutional Factor	X	
New Enrollee Dialysis Factor		X
Dialysis Factor		X
Transplant		X
New Enrollee Post-Transplant Factor		X
Community Post-Transplant Factor		X
Institutional Post-Transplant Factor		X

As a result of running beneficiaries through the CMS HCC model and the ESRD model, RAS will have the following types of RAFs for each beneficiary type:

Table 3. RAS RAFs for Each Beneficiary Type

	All Beneficiaries		ESRD Beneficiaries		
RAF	**Existing Beneficiary**	**New Enrollee**	**Existing Beneficiary**	**New Enrollee**	
New Enrollee Factor		X		X	Products of CMS HCC Model
Community Factor	X		X		
Institutional Factor	X		X		
New Enrollee Dialysis Factor				X	Products of ESRD Model
Dialysis Factor			X		
Transplant			X	X	
New Enrollee Post-Transplant Factor				X	
Community Post-Transplant Factor			X		
Institutional Post-Transplant Factor			X		

In general, the payment calculations described in paragraph 4.3 multiply the RAF by a Ratebook. Table 4 (below) provides a high level view of the ratebooks applied to each RAF in the payment calculation.

Table 4. Ratebooks and RAFs

RAF	Ratebook
Hospice	Not Applicable
New Enrollee Factor	Risk Adjustment Family of Ratebooks
New Enrollee + Frailty Factor	Risk Adjustment Ratebook
Default for New Enrollee	Risk Adjustment Family of Ratebooks
Default for New Enrollee + Frailty Factor	Risk Adjustment Ratebook
Community Factor	Risk Adjustment Family of Ratebooks
Community Factor + Frailty Factor	Risk Adjustment Ratebook
Institutional Factor	Risk Adjustment Family of Ratebooks
Demographic ESRD	State ESRD Demographic Ratebook
PACE/WPP ESRD*	State ESRD Demographic Ratebook
New Enrollee Dialysis Factor	ESRD Risk Ratebook
Default for New Enrollee-Dialysis	ESRD Risk Ratebook
Dialysis Factor	ESRD Risk Ratebook
Transplant Factor	ESRD Risk Ratebook
Default for New Enrollee-Transplant	ESRD Risk Ratebook
New Enrollee Post-Transplant Factor	Risk Adjustment Ratebook
Default for New Enrollee-Post-Transplant	Risk Adjustment Ratebook
Community Post-Transplant Factor	Risk Adjustment Ratebook
Institutional Post-Transplant Factor	Risk Adjustment Ratebook

NOTE: The Risk Adjustment Family of Ratebooks is defined in paragraph 5.3.

In general, the payment calculations to MCOs are blended using Demographic payments and Risk Adjusted payments. Table 5 (below) provides a high level summary of the types of Contracts and their blends for 2004.

Table 5. Anticipated Blends

Payment	Demographic %/Risk Adjusted Payment %
M+CO	70% /30%
PACE	90%/10%
EVERCARE	70%/30%
PHASE 1 DEMONSTRATIONS	70% /30%
PHASE II DEMONSTRATIONS	70% /30%
MASS DUAL ELIBIBLE DEMONSTRATION	90% /10%
CDM DEMONSTRATION	0%/100%
ESRD DEMONSTRATION (new)	0%/100%
ESRD DEMONSTRATION (old)	100%/0%
MNSHO	90%/10%
WPP	90%/10%
SHMO	90%/10%
MNDHO	90%/10%

If there is a conflict between Table 5 and the blend provided in the 2004 Contract Level Payment File (Section 5.9.3), the 2004 Contract Level Payment File will prevail.

The detailed views of the payment calculations by RAF are as follows:

4.3 Details for Each Payment Type

4.3.1 Hospice

A hospice payment is made for beneficiaries who have a current hospice election on file.The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for any of the scenarios are true, then the payment calculation should not be risk adjusted for the beneficiary.

This payment should be made when the following rule is met.
The beneficiary is in hospice.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will not apply any risk adjustment factor or blend to determine the beneficiary's payment.

4.3.2 New Enrollee Payment

A New Enrollee payment is made when a beneficiary has less than 12 months of Part B data and does not fall into a special category (e.g., ESRD or Institutional).

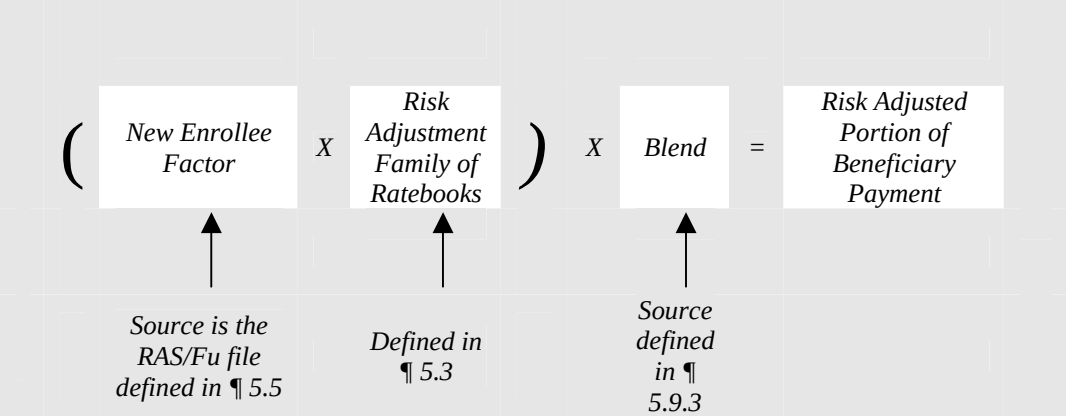
The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true for any one of the scenarios, then the payment calculation should be for a New Enrollee Factor payment.

For 2004, either ...

Scenario A ...	***Or***	***Scenario B ...***	***Or***	***Scenario C ...***
a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &
c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &		c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &		c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &
d) There is a New Enrollee Factor for the beneficiary on the Fu/RAS File, &		d) There is a New Enrollee Factor for the beneficiary on the Fu/RAS File, &		d) There is a New Enrollee Factor for the beneficiary on the Fu/RAS File, &
e) The beneficiary is not enrolled in a Frailty Plan.		e) The beneficiary is enrolled in a Frailty Plan, &		e) The beneficiary is enrolled in a Frailty Plan, &
		f) The beneficiary is enrolled in an Institutional (Mixed) Plan, &		f) The beneficiary is not enrolled in an Institutional (Mixed) Plan, &
		g) The beneficiary has an MDS flag.		g) The beneficiary is under age 55.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


(New Enrollee Factor X Risk Adjustment Family of Ratebooks) X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is the RAS/Fu file defined in ¶ 5.5
Defined in ¶ 5.3
Source defined in ¶ 5.9.3

4.3.3 New Enrollee Plus Frailty Payment

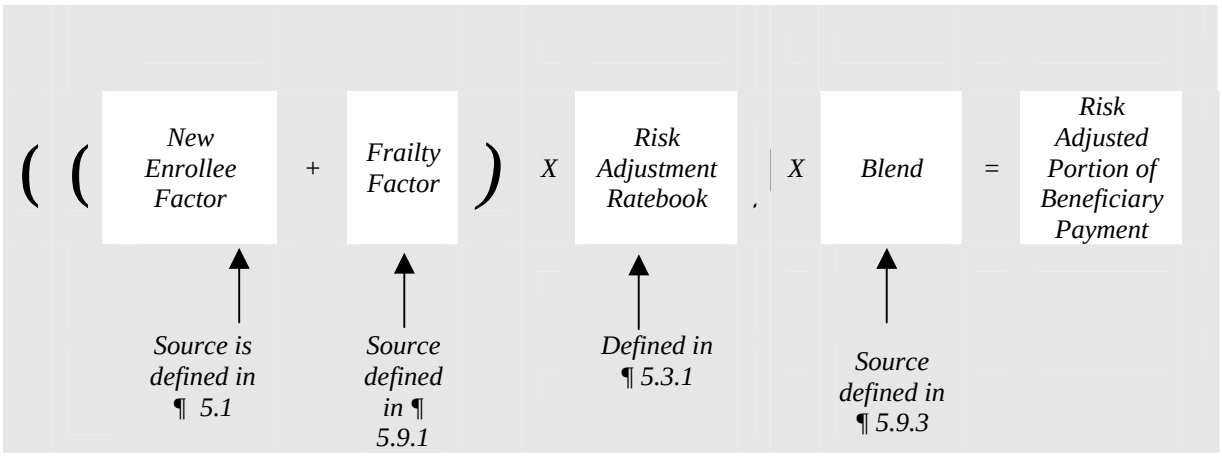
A New Enrollee Plus Frailty Factor payment is made when the beneficiary has less than one year of Part B data and they are enrolled in a Frailty Plan.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a New Enrollee Plus Frailty payment should be calculated for the beneficiary.

Scenario A ...	***Or***	***Scenario B ...***
a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &
c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &		c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &
d) There is a New Enrollee Factor for the beneficiary on the Fu/RAS File, &		d) There is a New Enrollee Factor for the beneficiary on the Fu/RAS File, &
e) The beneficiary is enrolled in a frailty plan, &		e) The beneficiary is enrolled in a frailty plan, &
f) The beneficiary is not enrolled in a Institutional (Mixed) Plan		f) The beneficiary is enrolled in a Institutional (Mixed) Plan
g) The beneficiary is age 55 or over		g) The beneficiary does not have an MDS flag
		h) The beneficiary is age 55 or over

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


((New Enrollee Factor + Frailty Factor) X Risk Adjustment Ratebook X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is defined in ¶ 5.1
Source defined in ¶ 5.9.1
Defined in ¶ 5.3.1
Source defined in ¶ 5.9.3

4.3.4 Default for New Enrollee Payment

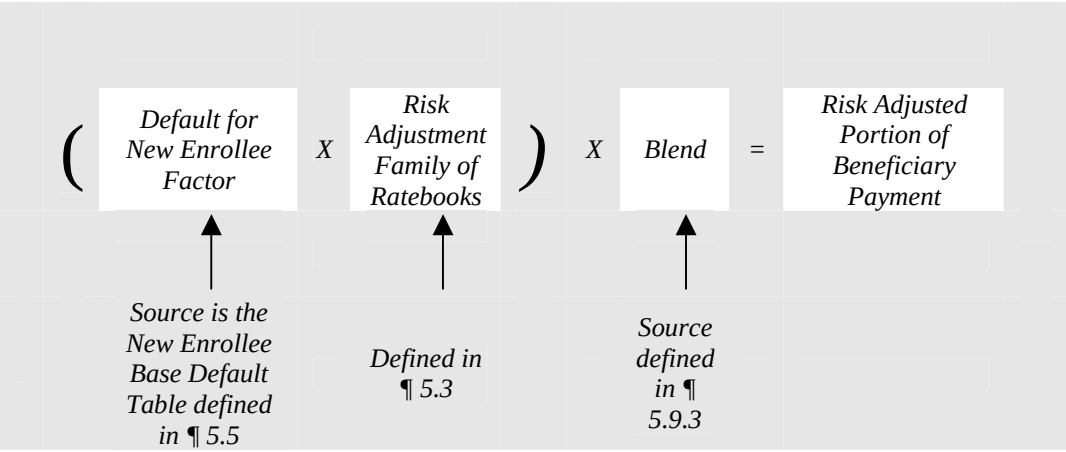
A Default for New Enrollee payment is made when no RAF is available for a beneficiary and the beneficiary does not fall into any other special category (e.g., Frailty or ESRD).

The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true for any one of the scenarios, then the payment calculation shoud be for a Default for New Enrollee.

For 2004, either …

Scenario A ...	***Or***	***Scenario B ...***
a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &
c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &		c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &
d) There is not a New Enrollee Factor for the beneficiary on the Fu/RAS File, &		d) There is not a New Enrollee Factor for the beneficiary on the Fu/RAS File, &
e) The beneficiary is not enrolled in a Frailty Plan.		e) The beneficiary is enrolled in a Frailty Plan, &
		f) The beneficiary is under age 55.
Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.		

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



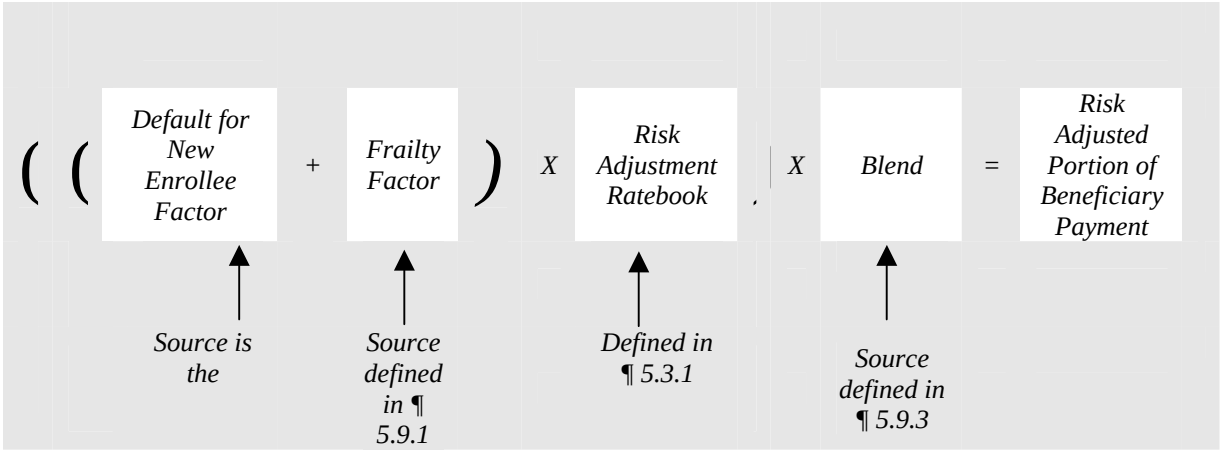
4.3.5 Default for New Enrollee Plus Frailty Payment

A Default for New Enrollee Plus Frailty Factor payment is made when no RAF is available for a beneficiary and the beneficiary is in a Frailty Plan.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a Default for New Enrollee Plus Frailty payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met …
a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &
c) There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &
d) There is not a New Enrollee Factor for the beneficiary on the Fu/RAS File, &
e) The beneficiary is enrolled in a Frailty Plan, &
f) The beneficiary is age 55 or over.
Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


((Default for New Enrollee Factor + Frailty Factor) X Risk Adjustment Ratebook X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is the
Source defined in ¶ 5.9.1
Defined in ¶ 5.3.1
Source defined in ¶ 5.9.3

4.3.6 Community Payment

A Community Factor payment is made when a beneficiary is not in an Institutional Plan, is not in a Frailty Plan, and is under age 55.

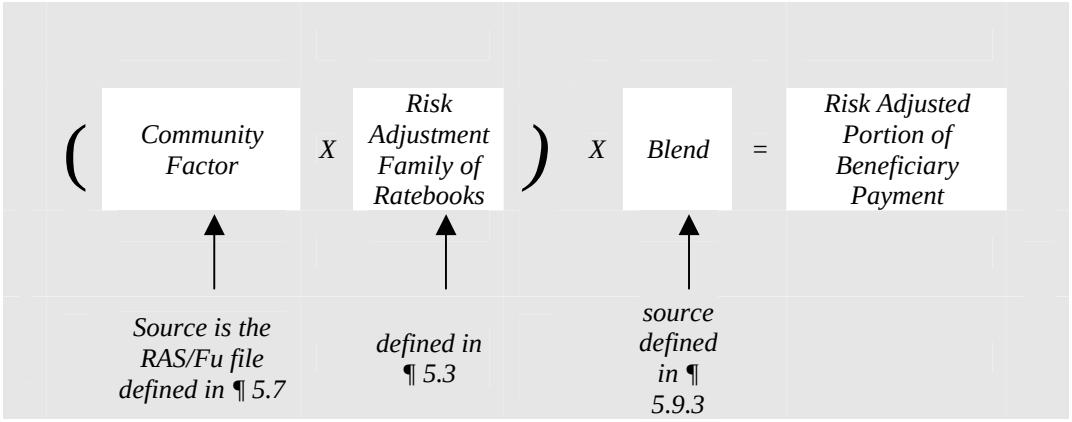
The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for any of the scenarios are true, then the payment calculation should be for a Community Factor payment.

For 2004, either...

Scenario A ...	***Or***	***Scenario B ...***	***Or***	***Scenario C ...***
a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &
c) There is a RAF for the beneficiary on the Fu/RAS File, &		c) There is a RAF for the beneficiary on the Fu/RAS File, &		c) There is a RAF for the beneficiary on the Fu/RAS File, &
d) The beneficiary is enrolled in an Institutional (Mixed) Plan,		d) The beneficiary is not enrolled in an Institutional (Mixed) Plan, &		d) The beneficiary is not enrolled in an Institutional (Mixed) Plan, &
e) The beneficiary does not have an MDS flag, &		e) The beneficiary is not enrolled in a Frailty Plan.		e) The beneficiary is enrolled in a Frailty Plan, &
f) The beneficiary is not enrolled in a Frailty Plan.				f) The beneficiary is under age 55.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


(Community Factor X Risk Adjustment Family of Ratebooks) X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is the RAS/Fu file defined in ¶ 5.7
defined in ¶ 5.3
source defined in ¶ 5.9.3

4.3.7 Community Plus Frailty Payment

A Community Plus Frailty payment is made when a beneficiary is in a Frailty Plan and follows the rules below.

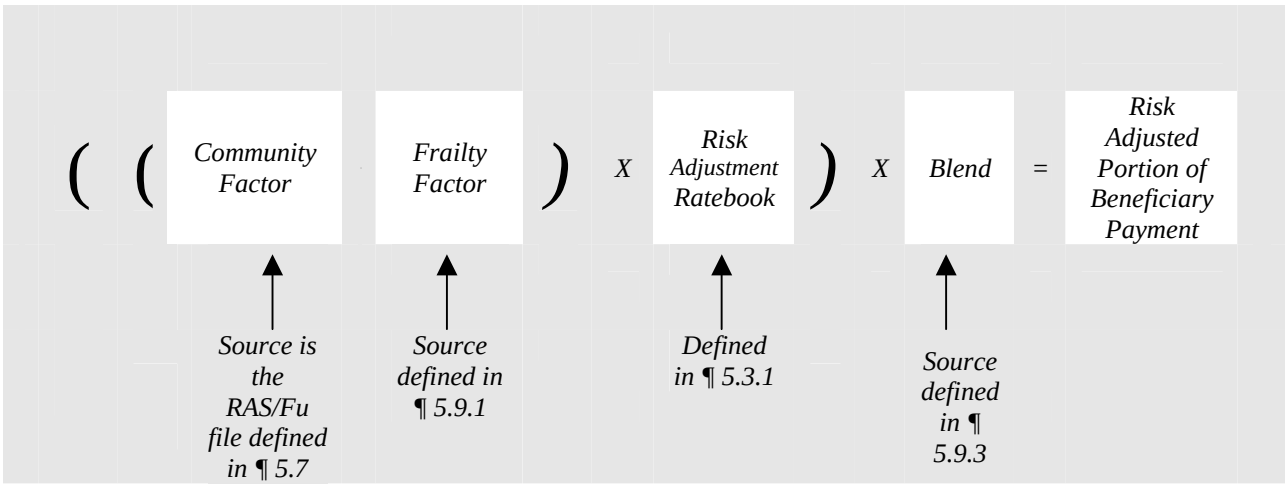
The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for either of the scenarios are true, then the payment calculation should be for a Community Plus Frailty Factor payment.

For 2004, either ...

Scenario A ...	***Or***	***Scenario B ...***
a) The beneficiary is not in hospice, &		a) The beneficiary is not in hospice, &
b) The beneficiary is not in ESRD, &		b) The beneficiary is not in ESRD, &
c) There is a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &		c) There is a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &
d) The beneficiary is enrolled in an Institutional (Mixed) Plan, &		d) The beneficiary is not enrolled in an Institutional (Mixed) Plan, &
e) The beneficiary does not have an MDS flag, &		e) The beneficiary is enrolled in a Frailty Plan, &
f) The beneficiary is enrolled in Frailty Plan; &		f) The beneficiary is age 55 or older.
g) The beneficiary is age 55 or older.		

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


((Community Factor) X Risk Adjustment Ratebook) X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is the RAS/Fu file defined in ¶ 5.7
Source defined in ¶ 5.9.1
Defined in ¶ 5.3.1
Source defined in ¶ 5.9.3

4.3.8 Institutional (Mixed) Payment

An Institutional Factor payment is made when a beneficiary is in an Institutional Plan, and has an MDS flag.

The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria below are true, then the payment calculation should be for a Institutional Factor payment.

This payment should be made when all of the following rules are met ...

a) The beneficiary is not in hospice, &

b) The beneficiary is not in ESRD, &

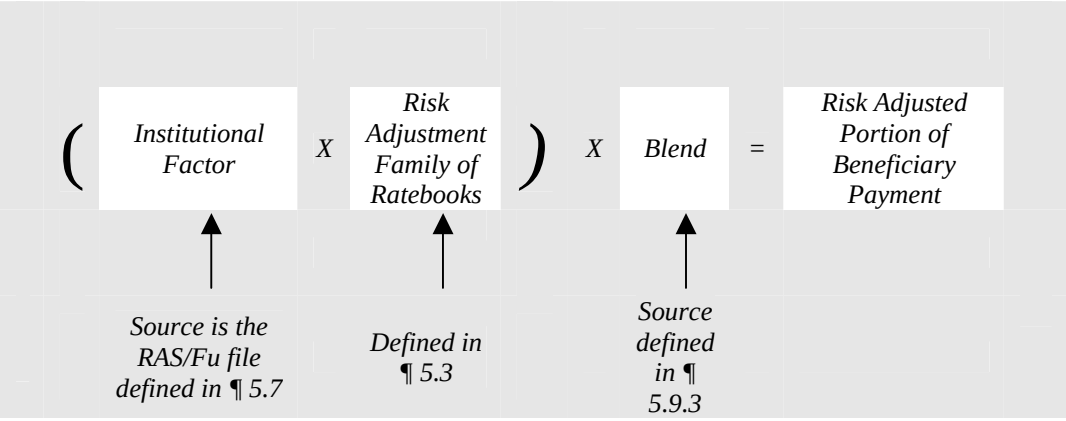
c) There is a Community or Institutional RAF for the beneficiary on the Fu/RAS File, &

d) The beneficiary is enrolled in an Institutional (Mixed) Plan, &

e) The beneficiary has an MDS flag.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.9 Demographic ESRD

A Demographic ESRD payment is made for non-Demonstration beneficiaries who have ESRD status.

The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for any of the scenarios are true, then the payment calculation should be for a Demographic ESRD Factor payment.

This payment should be made when all of the following rules are met ...
a) The beneficiary is not in hospice, &
b) The beneficiary is in ESRD status, &
c) The beneficiary is not in an ESRD Demonstration, &
d) The beneficiary is not in PACE/WPP
Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

Note: In 2005 and beyond all ESRD beneficiaries will be risk adjusted.

This is not a risk adjusted payment, therefore no formula is provided. This payment is made using the traditional ESRD payment methodology.

4.3.10 PACE/WPP ESRD Demographic

A PACE/WPP ESRD Demographic payment is made for PACE/WPP beneficiaries who have ESRD status.

The following chart follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for any of the scenarios are true, then the payment calculation should be for a PACE/WPP ESRD Demographic Factor payment.

This payment should be made when all of the following rules are met ...
a) The beneficiary is not in hospice, &
b) The beneficiary is in ESRD status, &
c) The beneficiary is not in an ESRD Demonstration, &
d) The beneficiary is in PACE/WPP
Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

Note: In 2005 and beyond all ESRD beneficiaries will be risk adjusted.

This is not a risk adjusted payment, therefore no formula is provided. This payment is made using the traditional PACE ESRD payment methodology.

4.3.11 New Enrollee Dialysis Payment

A New Enrollee Dialysis Factor payment is made when a beneficiary is on dialysis but has been in Medicare for less than one year, and therefore not enough data is available to determine a regular RAF.

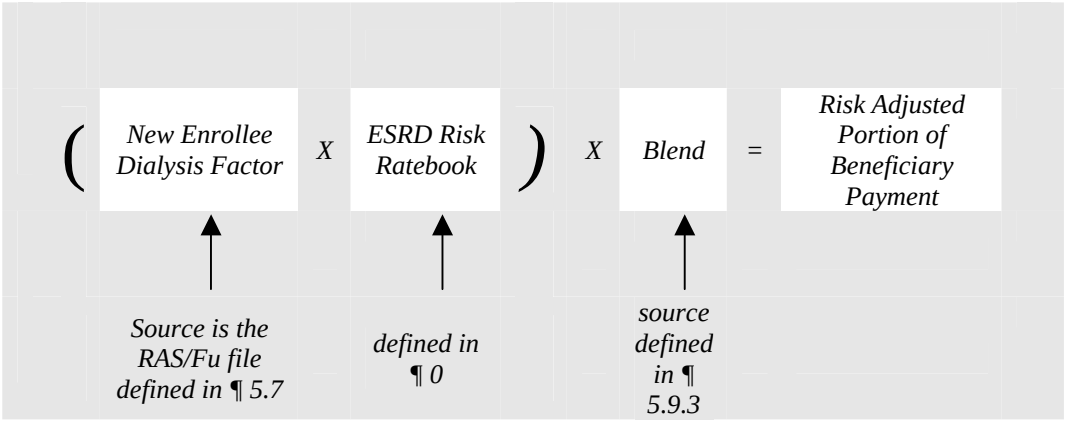
The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a New Enrollee Dialysis payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,
b) The beneficiary is in ESRD status,
c) The beneficiary is in an ESRD Demonstration,
d) The beneficiary is not in the transplant period, &
e) The beneficiary is on dialysis, &
f) The beneficiary does not have a dialysis RAF, &
g) There is a New Enrollee Dialysis Factor for the beneficiary on the RAS/Fu File

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.12 Default for New Enrollee- Dialysis Payment

A Default for New Enrollee Dialysis Factor payment is made when a beneficiary is on dialysis, and MMCS/GHP does not have a RAF.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a Default for New Enrollee Dialysis payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

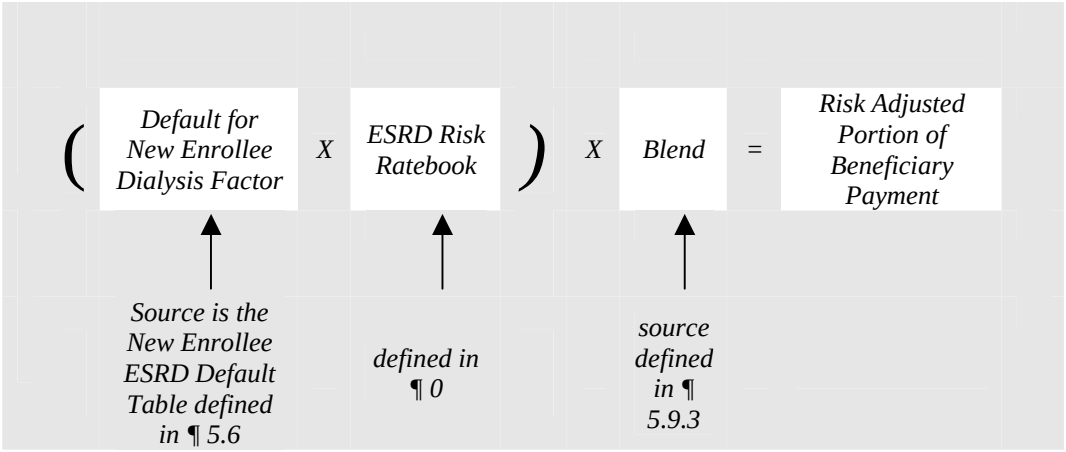
e) The beneficiary is on dialysis, &

f) The beneficiary does not have a dialysis RAF, &

g) There is not a New Enrollee Dialysis Factor for the beneficiary on the RAS/Fu File.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.13 Dialysis Payment

A Dialysis payment is made when the beneficiary is receiving dialysis. If the beneficiary is receiving dialysis at any time within the month, then the dialysis payment is made for the entire month.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

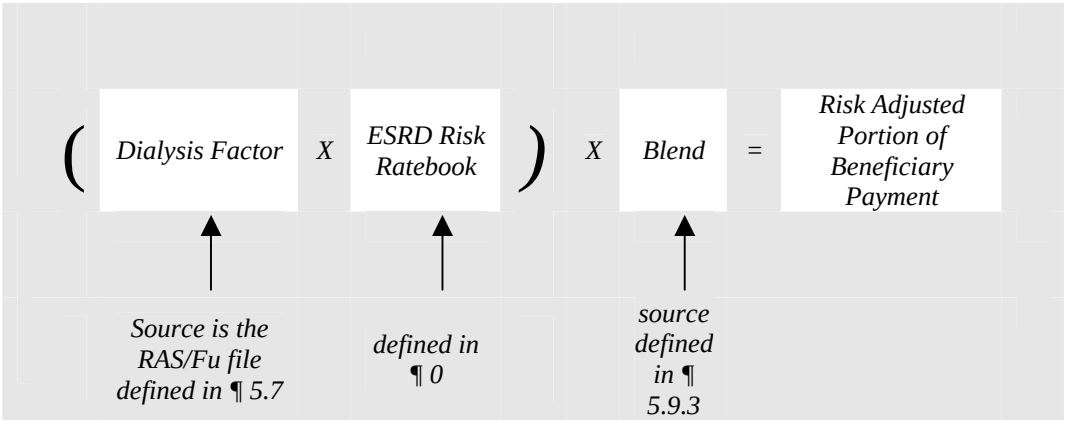
d) The beneficiary is not in the transplant period, &

e) The beneficiary is on dialysis, &

f) The beneficiary has a dialysis RAF.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.14 Transplant Payment

A Transplant Payment is made for a beneficiary during the first three months after having a graft. In 2004, MMCS and GHP will handle the timing of the transplant payments as follows:

- If the transplant takes place on the 1st, then the three month transplant period starts in that month and payment for that month will be based on the transplant factor, and

- If the transplant takes place on any date other than the 1st of the month, the three-month transplant payment period starts the month after the transplant takes place.

The Transplant Factor is a national factor that remains constant for each of the three months**.** A beneficiary is paid for all three months, regardless of whether or not the transplant was successful. A beneficiary is not paid for all three months if the beneficiary dies or dis-enrolls during the transplant period.

In 2004, GHP/MMCS will only pay for a transplant that occurs on or after the date of enrollment in the ESRD demonstration.

When a beneficiary receives a transplant prior to enrollment in an ESRD Demonstration, the beneficiary will be allowed to enroll during the three-month transplant period. Since the ESRD demonstration did not pay the initial cost of the transplant, MMCS/GHP will pay one third (1/3) the transplant rate during the transplant period for any beneficiaries who enroll in an ESRD demonstration after receiving a transplant.

For example, if a beneficiary receives a transplant on April 15, 2004 and enrolls in the ESRD demonstration effective May 1, 2004, the May, June and July payments for that beneficiary will be at one-third (1/3) the transplant rate. If that beneficiary enrolls effective June 1, 2004 the June and July payments will be at one-third (1/3) the transplant rate.

This rule will be handled as a post-implementation release to MMCS. The enrollments can be forced using the on-line. The payment for those beneficiaries will be calculated at the full transplant rate. The payments will be adjusted to the correct rate during the 2004 reconciliation.

If a beneficiary is in Dialysis status and converts to Transplant status, and MMCS/GHP are not aware of the change, and Dialysis payments are made, then MMCS/GHP will make the corrections to the payments retroactively back to the date of the change.

A beneficiary will be paid for multiple transplants as follows:

- If the additional transplant occurs after the three-month window for transplant payments ends, then a new three-month transplant period begins, or

- If the additional transplant occurs during the three-month window for transplant payments, then a new transplant period begins on the month of the most recent transplant. Therefore, it is possible for a beneficiary to be paid up to two months for the first transplant, receive an additional transplant, and start a new period of three months of transplant payments.

This payment should be made when all of the following rules are met ...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

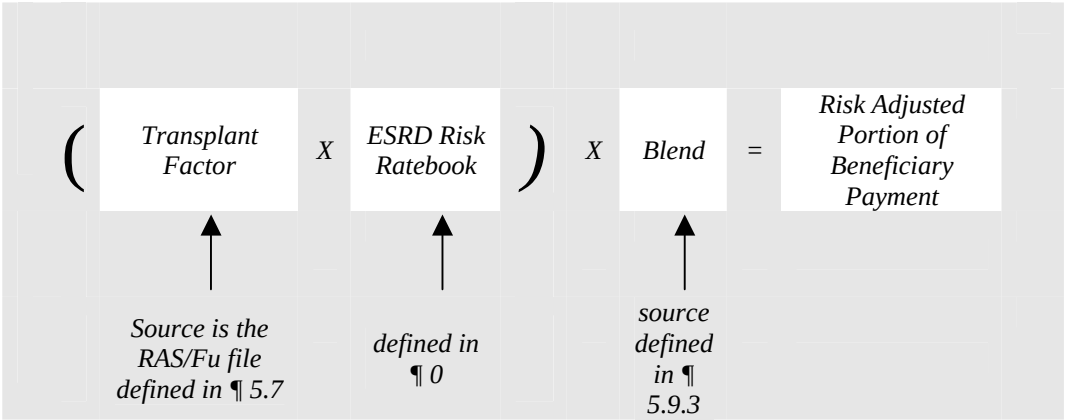
d) The beneficiary is in the transplant period, &

e) The beneficiary has a transplant factor.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

The chart to the right follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a Transplant payment should be calculated for the beneficiary.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.15 Default for New Enrollee - Transplant Payment

A Default for New Enrollee - Transplant payment is made when no RAF is available for a beneficiary and the beneficiary has had a transplant within the previous three months.

NOTE: Paragraph 4.3.14 lists several specific guidelines for transplant factor payments. All of these guidelines also apply to the Default for New Enrolleee-Transplant Payment.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a Default for New Enrollee - Transplant payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met ...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

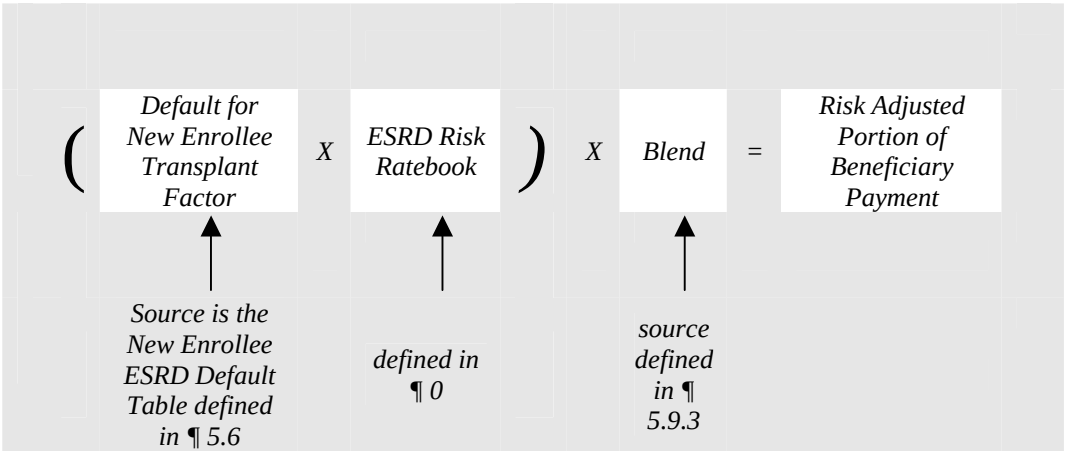
c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is in the transplant period, &

e) The beneficiary does not have a transplant factor.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.16 New Enrollee Post-Transplant Payment

A New Enrollee Post-Transplant Factor payment is made when a beneficiary has a functioning graft but has been in Medicare Part B for less than one year, and therefore not enough data is available to determine a regular RAF.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a New Enrollee Post-Transplant payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

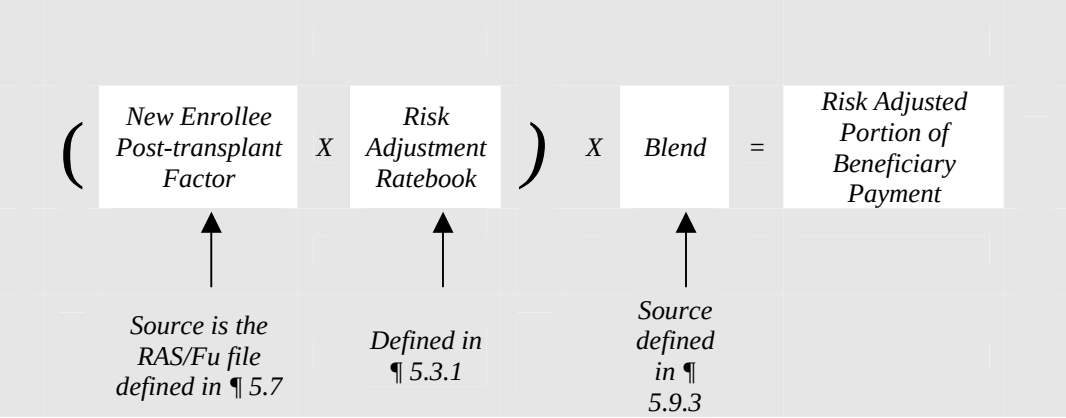
e) The beneficiary is not on dialysis, &

f) The beneficiary does not have a Community or Institutional Post-transplant RAF, &

g) The beneficiary has a New Enrollee Post-transplant RAF.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.17 Default for New Enrollee- Post-Transplant Payment

A Default for New Enrollee - Post-Transplant payment is made when the beneficiary has a functioning graft that is past the initial 3-month transplant period, however no RAF is available for a beneficiary.

The chart to the right follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then a Default for New Enrollee - Post-Transplant payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

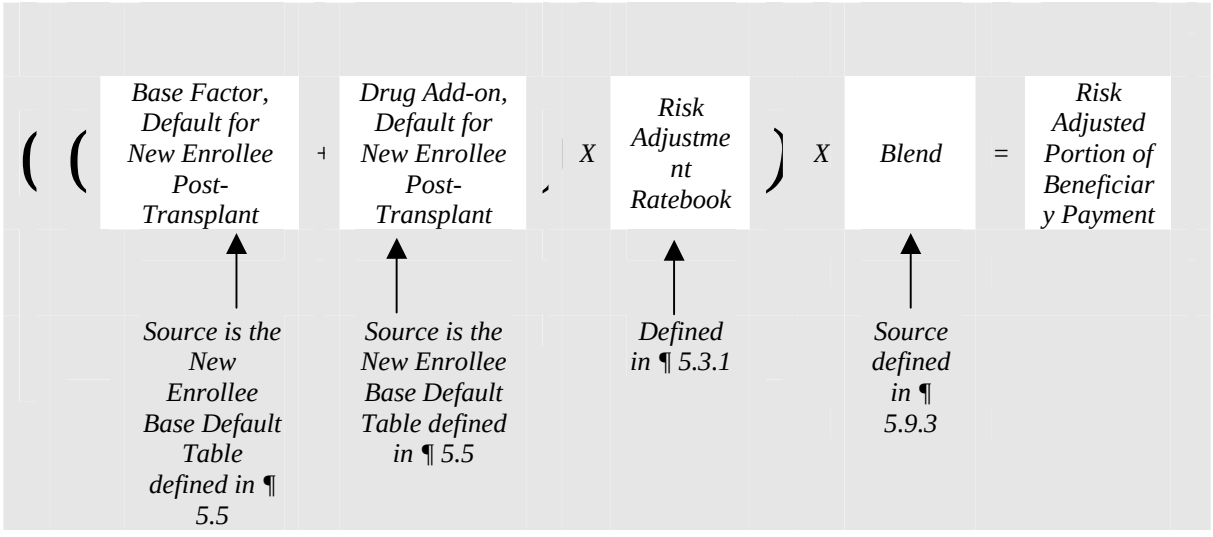
e) The beneficiary is not on dialysis, &

f) The beneficiary does not have a Community or Institutional Post-transplant RAF, &

g) The beneficiary does not have a New Enrollee Post-transplant RAF.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:



4.3.18 Community Post-Transplant Payment

A Community Post-Transplant Factor payment is made when a beneficiary has a functioning graft and they are not subject to a long term institutional RAF.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria for either of the scenarios are true, then a Community Post-Transplant payment should be calculated for the beneficiary.

For 2004, either…

Scenario A …

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

e) The beneficiary is not on dialysis, &

f) The beneficiary has Community and Institutional Post-transplant RAFs, &

g) The beneficiary is not enrolled in an Institutional (Mixed) Plan

Or

Scenario B …

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

e) The beneficiary is not on dialysis, &

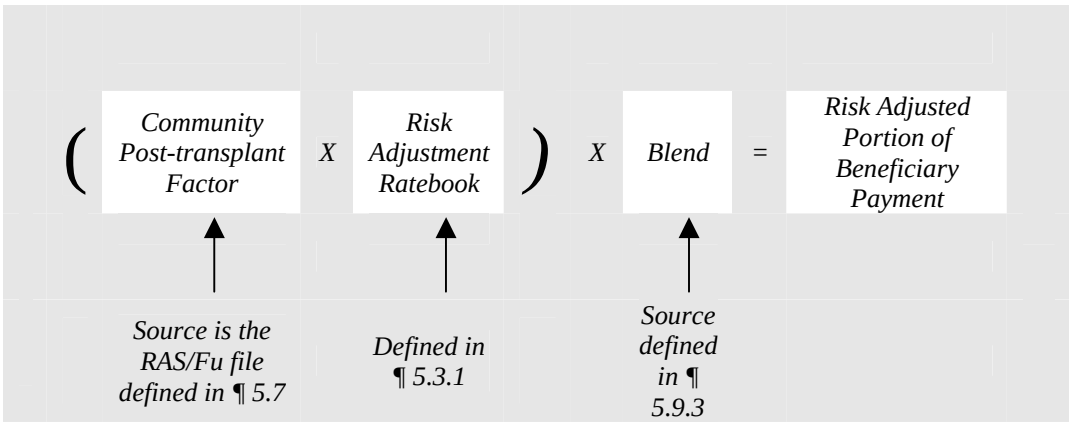
f) The beneficiary has Community and Institutional Post-transplant RAFs, &

g) The beneficiary is enrolled in an Institutional (Mixed) Plan, &

h) The beneficiary does not have an MDS flag.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers

If this payment type is chosen, then MMCS and GHP will calculate the risk-adjusted portion of the beneficiary's payment using the following formula:


(Community Post-transplant Factor X Risk Adjustment Ratebook) X Blend = Risk Adjusted Portion of Beneficiary Payment
Source is the RAS/Fu file defined in ¶ 5.7
Defined in ¶ 5.3.1
Source defined in ¶ 5.9.3

4.3.19 Institutional Post-Transplant

An Institutional Post-Transplant Factor payment is made when a beneficiary has a functioning graft and they are subject to a long term institutional RAF.

The chart below follows the decision diagram in Figure 1, and lays out the rules for choosing this payment type. If all the criteria are true, then an Institutional Post-Transplant payment should be calculated for the beneficiary.

This payment should be made when all of the following rules are met...

a) The beneficiary is not in hospice,

b) The beneficiary is in ESRD status,

c) The beneficiary is in an ESRD Demonstration,

d) The beneficiary is not in the transplant period, &

e) The beneficiary is not on dialysis, &

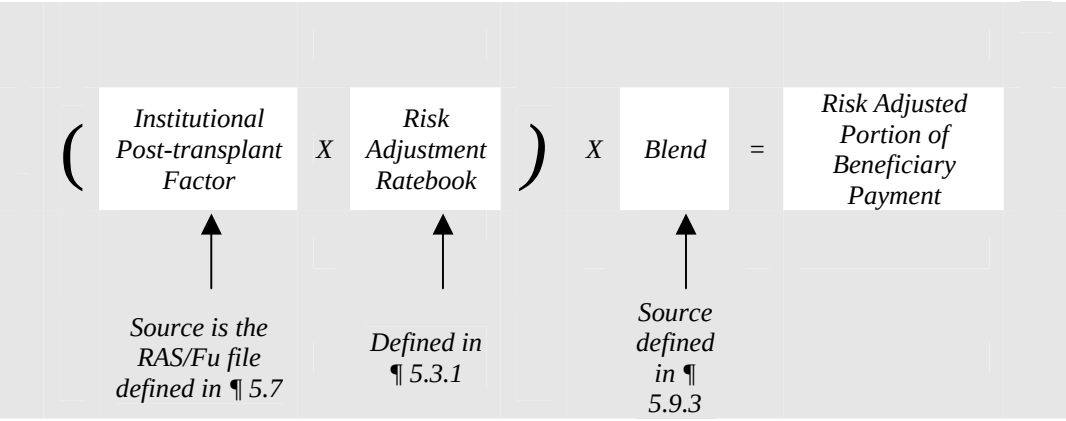
f) The beneficiary has Community and Institutional Post-transplant RAFs.

g) The beneficiary is enrolled in an Institutional (Mixed) Plan, &

h) The beneficiary has an MDS flag.

Appendix C provides a key between the rules above and the specific criteria to be applied by the system developers.

If this payment type is chosen, then MMCS and GHP will calculate the risk adjusted portion of the beneficiary's payment using the following formula:



5 Sources

The purpose of this section is to define the items to be provided to GHP and DMCS to support Risk Adjustment within the required schedule. Table 6 below provides a summary list. The table is followed by detailed explanations in the subsequent paragraphs.

Table 6. Schedule For Receipt of Software, Tables and Ratebooks

Item	Who	No Later than Date	Paragraph Described In Below
CMS HCC Model (Final version to be used in payment calculations)	From: ORDI (Mel Ingber) Through: Cynthia Tudor To: DMCS (George Manaras) and Fu	**June 2003**	5.1
ESRD Model	From: ORDI (Mel Ingber) Through: Cynthia Tudor To: DMCS (George Manaras) and Fu	**Draft** **Final:**	5.2
Risk Adjustment Ratebook	From: OACT (Mel Ingber) Through: Cynthia Tudor To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	**October 2003**	5.3
ESRD Risk Ratebook	From: ORDI (Mel Ingber) Through: Cynthia Tudor To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	**(?)**	0
New Enrollee Base Default Table	From: ORDI (Mel Ingber) Through: Cynthia Tudor To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	**May 2003**	
New Enrollee Dialysis Default Table	From: ORDI (Mel Ingber) Through: Cynthia Tudor To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	**(?)**	
Fu File / RAS File to GHP/MMCS	From: Fu and RAS (George Manaras) Through: Cynthia Tudor To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	Fu -Oct 03 RAS -	

Item	Who	No Later than Date	Paragraph Described In Below
Demonstration Ratebooks	From: **OACT** To: **GHP/MMCS**	**October**	5.8
2004 Contract Level Payment File	From: **Cynthia Tudor** To: MMCS (Mary Sincavage) and GHP (Kim Miegel)	**October**	5.9

5.1 CMS HCC Model

The CMS HCC Model is a SAS model developed by CMS/ORDI to calculate the non-ESRD RAFs.

The RAFs produced by the CMS HCC model are listed in Section 2. In Section 2, Table 2 lists the RAFs produced by CMS HCC model.

The model has two components, each of which uses unique and independent logic when calculating RAFs.

- The main component runs community and institutional risk adjustment factors for beneficiaries with 12 months of Part B Medicare eligibility during the data collection period. This component utilizes demographic and diagnosis information in calculating the factors.
- The new enrollee component calculates risk adjustment factors for beneficiaries with less than 12 months of Part B Medicare eligibility during the data collection period. This component uses only demographic data when calculating factors.
- Beneficiaries will receive only 1) the community and institutional RAF or 2) the new enrollee RAF.

5.2 ESRD Model

The ESRD Model is a SAS model developed by CMS/ORDI to calculate the ESRD RAFs.

The ESRD RAFs are listed in Section 2. In Section 2, Table 2 lists the RAFs produced by the ESRD model.

5.3 Risk Adjustment Family of Ratebooks

Risk Adjustment Family of Ratebooks refers to: the Risk Adjustment Ratebook, the Phase I Demonstration Risk Ratebook, or the Phase II Demonstration Risk Ratebook.

5.3.1 Risk Adjustment Ratebook

This is a county-level table of Risk Adjusted base rates. This ratebook should generally not change during the payment year; however, the system should be flexible enough to handle the "odd exception.

5.3.2 Phase I Demonstration Risk Ratebook

This is a county-level table of Risk Adjusted base rates. It is similar to the base risk adjustment rate book but is adjusted for each specific plan to a plan-negotiated rate. This ratebook should generally not change during the payment year; however, the system should be flexible enough to handle the "odd exception.

5.3.3 Phase II Demonstration Risk Ratebook

This is a county-level table of Risk Adjusted base rates. This ratebook has all the features of the risk adjustment ratebook, but the rates are the higher of the M+C risk adjustment ratebook and a 99% fee-for-service risk adjustment ratebook. This ratebook should generally not change during the payment year; however, the system should be flexible enough to handle the "odd exception.

5.4 ESRD Risk Ratebook

This is a State-level table of ESRD base rates. This ratebook should generally not change during the payment year; however, the system should be flexible enough to handle the "odd exception.

5.5 New Enrollee Base Default Table

This table is utilized by MMCS/GHP to calculate 1) new enrollee RAFs when none exists for a managed care enrollee and 2) post-transplant RAFs when none exists for an ESRD enrollee in post-transplant status. The format for 2004 is different from 2003. The detailed layout is **in May 12th notice**. In general, the format will include:

> *Two columns: Base Factor, and Drug Add-On (Post Graft). Four sets of columns:*
> *a. Base*
> *b. Medicaid*
> *c. Originally Disabled*
> *d. Medicaid and Originally Disabled*
>
> *Each set of rows is divided into Male and Female subsections, each of which is subdivided by age groups. The sex and age division is the same as in the current Default Risk Adjustment Base Factors Table for New Enrollees (See 12/13/02 RAS/MMCS ICD, Appendix D).*

5.6 New Enrollee ESRD Default Table

This table provides both the dialysis and the graft information.

For Graft status, the table provides a single factor; there are no bump-ups. This is one table that provides both dialysis and graft information, and not two separate tables.

For dialysis, the detailed layout is TBD. In general, the format will include:

> *Dialysis factors are divided into four sets of columns:*
> *a. Base*
> *b. Medicaid*
> *c. Previously Disabled*
> *d. Medicaid and Previously Disabled*
>
> *Each set of columns is divided into Male and Female subsections, each of which is subdivided by age groups.*

It is not certain whether the Medicaid and Previously Disabled Dialysis factors will be different from the Base Dialysis factors. Medicaid probably will be. The table design is intended to accommodate whatever decision is made.

5.7 Fu File / RAS File to GHP/MMCS

The RAS system will produce the RAFs identified in Section 2 Table 2, and hand them to MMCS via the Fu/RAS File. For the January 2004 payments, Fu will provide this file to GHP/MMCS.

On the Fu File, New Enrollee factors and RAFs will be mutually exclusive.

For the initial implementation, Fu and RAS will send RAFs to GHP/MMCS via a flat file.

The file layout coming from Fu and RAS will be generally the same, with some exceptions. The file layout coming from Fu is defined in Appendix B.

RAS will provide the data in the same format, with the exception of the following:
The RAS file will not contain the long-term institutional flag in field 10. In the RAS file, this field will be a filler of spaces.

The layout for this file appears in Appendix B - Fu File Format.

5.8 Section Reserved

5.9 2004 Contract Level Payment File

The source of this file is unknown as of 5/29/03.

It will contain the following four different record types:

Record Type F – contains Frailty Factors
Record Type G – contains the Non-Community MCO Indicator
Record Type H – contains the Non-70/30 blend MCOs
Record Type I – MCOs using the Lag Factor

5.9.1 Record Type F - Frailty Factor

The frailty factor will be calculated as an add-on to the beneficiaries payment. This will only apply to beneficiaries within Contracts that are designated as frailty Contracts. For each frailty Contract, the frailty factor will be based upon the information on beneficiaries within that Contract. The table will provide Frailty Factors by Contract (H#).

The file format for the records is as follows:

FIELD NAME	LENGTH	START POSITION	FORMAT/COMMENTS
Record Type	**1**	**1**	F = Frailty Factors
Contract Number	**5**	**2**	HXXXX
Effective Start Date	**8**	**7**	YYYYMMDD
Effective End Date	**8**	**15**	YYYYMMDD
Frailty Factor	**7**	**23**	NN.DDDD

5.9.2 Record Type G - Non-Community MCO Indicator

This file indicates what percentage of Institutional (Mixed) beneficiaries are enrolled in each Contract.

The file format for the records is as follows:

FIELD NAME	LENGTH	START POSITION	FORMAT/COMMENTS
Record Type	**1**	**1**	G = Non-Community MCOs[1]
Contract Number	**5**	**2**	HXXXX

[1] Assume that all contracts **not** on this file are Community MCOs.

Effective Start Date	**8**	**7**	YYYYMMDD
Effective End Date	**8**	**15**	YYYYMMDD

5.9.3 Record Type H - Non 70/30 Blend MCOs

The payments to MCOs are blended using Demographic payments and Risk Adjusted payments.

For determining payments, the system will refer to Record Type H of the 2004 Contract Level Payment File to determine the blend for the Contract.

The file format for the records is as follows:

FIELD NAME	LENGTH	START POSITION	FORMAT/COMMENTS
Record Type	1	1	H = Non 70/30 Blend MCO types[2]
Contract Number	**5**	**2**	HXXXX **<TBD>**
Blend	1	7	1 = 90DEMOG/10 RA 2 = 100 RA 3 = 100 DEMOG
Effective Start Date	8	8	YYYYMMDD
Effective End Date	8	16	YYYYMMDD

Generally, the Blend ratio for a contract should not change during a payment year. However, the system should be flexible enough to handle the "odd exception."

5.9.4 MCOs Using the Lag Factor

The file format for the records is as follows:

[2] Assume that all contract types **not** on this file are 70/30.

6 Rules for Storing RAFs

6.1 Initial Run

In November 2003, MMCS will receive a set of lag RAFS from RAS for January 2004 payments. MMCS will need to recreate payments, so MMCS must know what RAFS were used for calculating payments. The RAF used for calculating the beneficiary-level payment is stored on the beneficiary payment profile.

6.2 Mid-Year Run

The Mid-year run will result in additional RAFS that MMCS must store in the event a retroactive adjustment is required to be calculated based on a change to the beneficiary's status. The Mid-year run will result in both lag and non-lag RAFs.

Temporary storage is impacted in the mid-year run by the addition of the non-lag RAFs. The non-lag RAFs will be loaded into MMCS such that they will only replace the RAFs for beneficiaries in Contracts (H#) that are designated to receive the non-lag RAF. Therefore not all of the initial lag RAFS for January will be replaced.

6.3 Final Reconciliation Run

A history of all RAFs that are used for payments must be maintained on the beneficiary payment profile (archive).

7 Reports

TBD

Appendix A - Glossary

ESRD	End Stage Renal Disease
Lag RAF	RAF based on lag data. The timing of the lag data is defined in Section 3.
MSP	
Non-Lag RAF	RAF based on non-lag data. The timing of the non-lag data is defined in Section 3.
Working Aged	

Appendix B - Fu File Format

RISK ADJUSTMENT DOWNLOAD RECORD FOR CY2004 **("*" next to field number denotes change from previous version)**				
#	**FIELD NAME**	**LEN**	**START POSITION**	**FORMAT/COMMENTS**
1	Beneficiary Health Insurance Claim Number	11	1	• Internal CMS Format • 9 position CAN • 2 position unequated BIC (SSA) • Not missing • Unique within file • Variable by which file is sorted
2	Social Security Number	9	12	• Original SSN • All numeric • May be missing • Not unique within file
3	Surname	12	21	• Beneficiary's last name • First position alphabetic • Not missing
4	First Name	7	33	• First position alphabetic • Not missing
5	Middle Initial	1	40	• Alphabetic • May be missing
6	Date of Birth	8	41	• CCYYMMDD format • Not missing
*7	Previously Disabled Flag	1	49	• Y or missing • Y = previously entitled to Medicare due to disability
8	Medicaid Flag	1	50	• Y or missing • Y = Medicaid Status Applicable to Risk Adjustment Factors
*9	New Enrollee Flag	1	51	• Y or missing • Y = New Enrollee Factor used
*10	Long-Term Institutional Flag	1	52	• Y or missing • Y = on MDS as L/T Institutional
11	Sex	1	53	• Not missing • 0 = Unknown • 1 = Male • 2 = Female

RISK ADJUSTMENT DOWNLOAD RECORD FOR CY2004 **("*" next to field number denotes change from previous version)**				
#	**FIELD NAME**	**LEN**	**START POSITION**	**FORMAT/COMMENTS**
12	Start Date	8	54	• CCYYMMDD format • Not missing • All values are "20040101"
13	End Date	8	62	• CCYYMMDD format • Not missing • All values are "20041231"
*14	Community Factor	7	70	• NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*15	Institutional Factor	7	77	• NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*16	New Enrollee Factor	7	84	• Present only if new enrollee flag is set to Y • NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*17	New Enrollee Dialysis Factor	7	91	• Present only if new enrollee flag is set to Y • NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*18	New Enrollee Post-Transplant Factor	7	98	• Present only if new enrollee flag is set to Y • NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*19	Dialysis Factor	7	105	• NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero

RISK ADJUSTMENT DOWNLOAD RECORD FOR CY2004 **("*" next to field number denotes change from previous version)**				
#	**FIELD NAME**	**LEN**	**START POSITION**	**FORMAT/COMMENTS**
				• Values between 00.0010 and 99.9990
*20	Transplant Factor	7	112	• Not missing • NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*21	Community Post-Transplant Factor	7	119	• NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990
*22	Institutional Post-Transplant Factor	7	126	• NN.DDDD format • Leading N may be left <blank> • Rounded to 3 decimal places with trailing zero • Values between 00.0010 and 99.9990

Appendix C - Translation Between Business Rules and System Developer Criteria

When the payment rule set in paragraph 4 says ...	*The programmers will know this because ...*
The beneficiary is in hospice	On MBD there is a Hospice Coverage Period for the given payment month.
The beneficiary is not in hospice	Absence of Hospice Coverage period for the given payment month on MBD.
The beneficiary is in ESRD	On MBD is there an ESRD Coverage Period for the given payment month.
The beneficiary is not in ESRD	Absence of ESRD coverage period for the given payment month.
There is a Community or Institutional RAF for the beneficiary on the Fu/RAS File	Community or Institutional RAF exists for the beneficiary on the Fu/RAS File.
There is not a Community or Institutional RAF for the beneficiary on the Fu/RAS File	Absence of the Community or Institutional RAF for the beneficiary on the Fu/RAS file.
The beneficiary is enrolled in an Institutional (Mixed) Plan	The Institutional (Mixed) Plan is identified on the contract file, record type = "G", which indicates a non-community M+C.
The beneficiary is not enrolled in an Institutional (Mixed) Plan	The contract number is not on the contract file, record type = "G", therefore assume the contract is not an Institutional (Mixed) Plan.
The beneficiary is enrolled in a Frailty Plan	The Frailty Plan is identified on the contract file, record type = "F".
The beneficiary is not enrolled in a Frailty Plan	The contract number is not on the contract file, under record type = "F".
The beneficiary has an MDS flag	For 2004, the indication that the beneficiary is long-term institutional will be on the beneficiary-level risk adjuster record in the FU file. The field, long term institutional flag, will equal "Y" to indicate the beneficiary has long-term institutional.
The beneficiary does not have an MDS flag	For 2004, if the long-term institutional flag on the beneficiary-level risk adjuster record in the FU file is spaces, then the beneficiary does not have long-term

	institutional.
The beneficiary is under age 55*	On MBD, use the birth date to calculate the beneficiary's age.
The beneficiary is age 55 or over*	On MBD, use the birth date to calculate the beneficiary's age.
There is a New Enrollee Factor for the beneficiary on the Fu/RAS File,	The New Enrollee Factor for the beneficiary exists on the Fu/RAS File.
There is not a New Enrollee Factor for the beneficiary on the Fu/RAS File,	The New Enrollee Factor for the beneficiary does not exist on the Fu/RAS File.
The beneficiary is in an ESRD Demonstration	PICS will provide the Payment Bill Option (12), and Demo Type code (TBD) to determine if the beneficiary is in an ESRD Demonstration. For MMCS, this data will be stored in the MCO tables.
The beneficiary is not in an ESRD Demonstration	The contract number the beneficiary is enrolled in is not the corresponding Payment Bill Option and Demo Type Code for an ESRD Demonstration.
The beneficiary has a functioning graft	On the MBD, the beneficiary has had a transplant period, for which we have paid for 3 months. The transplant failure date does not exist. The beneficiary is not deceased. The beneficiary does not have a current dialysis period for the given payment month.
The beneficiary does not have a functioning graft	On the MBD, the beneficiary is currently on dialysis or deceased for the given payment period.
The beneficiary is on dialysis	On the MBD, the beneficiary has a dialysis period during the given payment month.
The beneficiary is not on dialysis	On the MBD, the beneficiary does not have a dialysis period during the given payment month.
The beneficiary is not in the transplant period	
The beneficiary does not have a dialysis RAF	

* Age is calculated as of February 1, 2004.

APPLICATION FOR ACCESS

APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

(Read and complete both sides of this form in ink)

1. **Type of Request** (Check only one) ☐ NEW ☐ CHANGE ☐ RECERTIFY ☐ DELETE

Last Name | First Name | MI

Current UserID

CAPITAL LETTERS
(Ø 1 2 3 4 5 6 7 8 9)

2. **User Information**

☐ CMS Employee
☐ Social Security Admin.
☐ FMC
☐ Contractor (non-Medicare)
☐ State Agency
☐ Office of the Inspector General
☐ Fraud Investigation
☐ End-Stage Renal Disease Network
☐ Federal (other than CMS)
☐ Mgd Care Org/Group Health Plan
☐ Vendor
☐ Railroad Retirement Board
☐ Medicare Contr/Intermediary/Carrier
☐ Peer Review Organization
☐ Researcher
☐ Other *(specify):* _____

a. SSN (*see Privacy Act Advisory Statement on back*)

e. Email Address *(non-CMS only)*

b. Mailing Address/Mail Stop

f. CMS Organization or Company Name

c. Central Office Desk Location

g. Company Telephone Number
( )

d. Daytime Telephone Number
( )

h. Contract Number(s) (*non-CMS only)*

3. **Type of Access Required (P**= Production, **D**=Development, **V**=Validation, **R**=Remote/Dialup Access**)**

a. **Application(s):**

	P	D	V	R		P	D	V	R
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )

b. **Subsystems:**

	P	D	V	R		P	D	V	R
CICS	( )	( )	( )	( )	OMVS	( )	( )	( )	( )
DB2	( )	( )	( )	( )	TSO	( )	( )	( )	( )
IDMS	( )	( )	( )	( )	WYLBUR	( )	( )	( )	( )
M204	( )	( )	( )	( )	OTHER _____	( )	( )	( )	( )
NDM	( )	( )	( )	( )	_____	( )	( )	( )	( )

d. **CMS Standard Desktop Software/LAN:**

	Email	No Email	Remote
Central Office	☐	☐	☐
DC1	☐	☐	☐
FMC	☐	☐	☐
ATL1	☐	☐	☐
BOS1	☐	☐	☐
CHI1	☐	☐	☐
DAL1	☐	☐	☐
DEN1	☐	☐	☐
KCM1	☐	☐	☐
NYC1	☐	☐	☐
PHI1	☐	☐	☐
SEA1	☐	☐	☐
SF01	☐	☐	☐
Other _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

c. **Expected Frequency of Use:** (*non-CMS only)* ☐ Daily ☐ Monthly ☐ Quarterly ☐ Annually

4. **Reason for Request**

5. **Authorization:** We acknowledge that our Organization is responsible for all resources to be used by the person identified above and that requested accesses are required to perform their duties. We understand that any change in employment status or access needs are to be reported immediately via submittal of this form.

Requesting Official

Print Name

Signature Date

Telephone Number CMS Userid

Contract Number Contract Exp. Date or 'Not-to-Exceed' Date

Approving Official
(*for non-CMS user only*)

Print Name

Signature Date

Title Organization

Telephone Number CMS Userid

CMS RACF Group Administrator

Print Name

Signature Date

Telephone Number

Desk Location Organization or Region

(July 2001)

PRIVACY ACT ADVISORY STATEMENT
Privacy Act of 1974, P. L. 93-579

The information on side 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's (formerly HCFA's) computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on this form will be maintained in the Individuals Authorized Access to the Centers for Medicare & Medicaid (CMS) Data Center Systems of Records and may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED. REG. 41329 (08-11-94) and as CMS may establish in the future by publication in the *Federal Register*.

Collection of the Social Security Number (SSN) is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in delaying the processing of this request.

SECURITY REQUIREMENTS FOR USERS OF CMS's COMPUTER SYSTEMS

CMS (formerly HCFA) uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of Federal programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in Federal computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. CMS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. CMS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to CMS Computer Systems containing sensitive information must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the con sequences of unauthorized or illegal transactions.
- Do not browse or use CMS data files for unauthorized or illegal purposes.
- Do not use CMS data files for private gain or to misrepresent yourself or CMS.
- Do not make any disclosure of CMS data that is not specifically authorized.
- Do not duplicate CMS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter CMS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of CMS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from Federal Service, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

_____ _____

Signature of User Date

Instructions for Completing the Application for Access to CMS Computer Systems

This form is to be completed and submitted whenever the following situations occur:
– A user **requires access** to a CMS computer system to perform their job duties. (Submit NEW Request)
– A user **changes names**, has a **change in access needs, job duties,** or **moves to another component.** (Submit CHANGE Request)
– A user receives notice that they must **recertify** their access needs. (Submit RECERTIFY Request)
– A user **retires, resigns,** is **removed from a contract with CMS,** or for any reason **no longer requires access**. (Submit DELETE Request)

Section 1: Type of Request COMPLETE FOR ALL REQUESTS. Check one box indicating type of request, enter name and current CMS UserID in blocks indicated, if using one. A separate form must be submitted for each action desired.

Section 2: User Information COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS. Check employee type, and complete blocks a. through h.

CMS Employees – Blocks e., g. and h. may be left blank. If not stationed at CMS Central Office, provide a complete mailing address in block b. and leave block c. blank.

Non-CMS Employees – Block c. may be left blank if not stationed at CMS Central Office. For block h., if your contract number is unknown, obtain it from your Project Officer or your CMS contact person.

Section 3: Type of Access Required COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS.

For NEW Requests – Check each type of access required. List the names of all CMS applications you require access to (i.e., OSCAR, CROWD, CAFM, CLIA) in block a., Application(s). For each application, check the appropriate columns to indicate the environment(s) access is needed in, and if remote access is required. DO NOT USE THIS BLOCK TO ENTER SOFTWARE THAT IS PART OF THE STANDARD CMS WORKSTATION CONFIGURATION; SEE BLOCK D. Use block b., Subsystems, to request access not specific to particular applications. This block is used to note accesses such as native TSO commands, usually required by system developers. If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. Non-CMS employees should complete block c., Expected Frequency of Use. If access to a CMS desktop or LAN is required, check your location in block d., CMS Standard Desktop Software/LAN. Checking this box will ensure you have access to all software available on the standard CMS workstation (i.e., Word, Excel, GroupWise, etc.).

For CHANGE Requests – If access needs have changed, enter an 'A' to add, or a 'D' to delete, for each type of access requiring a change. (Most changes in job duties or organizational placement require a change in access needs.) If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. For name changes only, leave this block blank and go to Section 4.

For RECERTIFY Requests – Check each type of access required to perform your job duties. If additional accesses are required, submit a separate change request. **(Those accesses currently held but not checked will be lost.)** If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, be sure to specify here and in Section 4, Reason for Request.

Section 4: Reason for Request COMPLETE AS REQUIRED.

For NEW Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For CHANGE Requests – Note the nature of the action requiring a change. For name changes, include previous and new names. For organizational changes, include old and new organization names. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For RECERTIFY Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For DELETE Requests – Note the nature of the action requiring the removal of accesses.

Read, sign and date the back of the form. Then obtain signatures for Section 5.

Section 5: Authorization COMPLETE FOR ALL REQUESTS. All requested information must be supplied or noted 'N/A'.

CMS Employees – **Requesting Official:** The immediate supervisor must sign and complete the Requesting Official block. The **RACF Group Administrator** must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Non-CMS Employees – **Requesting Official:** The Project Officer, if designated, must sign and complete the Requesting Official block. For Medicare Contractors/Intermediaries/Carriers, a designated company contact must sign and complete the Requesting Official block. For others, the CMS Liaison/Contact or ADP Coordinator must sign and complete the Requesting Official block. (IT IS IMPORTANT THAT CONTRACT NUMBER AND EXPIRATION DATE ARE INCLUDED WHERE APPLICABLE. IF ACCESS IS REQUIRED FOR MULTIPLE CONTRACTS, THE NUMBER AND EXPIRATION DATE FOR THE CONTRACT WITH THE LONGEST PERIOD OF PERFORMANCE SHOULD BE USED. IF NO CONTRACTS APPLY, AN APPROPRIATE 'NOT-TO-EXCEED' DATE SHOULD BE NOTED, OR 'N/A' IF INDEFINITE ACCESS IS REQUIRED.) **Approving Official:** The immediate supervisor of the Requesting Official must sign and complete the Approving Official block. For Medicare Contractors/Intermediaries/Carriers, the Consortium Contractor Management Staff member assigned as Contractor Manager for the company must sign and complete the Approving Official block. The **RACF Group Administrator** should note the preferred group for UserID assignment in Section 1. They must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Required Signatures for Applications for Access to CMS Computer Systems

Type of CMS User	Requesting Official	Approving Official	RACF Administrator
CMS Employee	Immediate Supervisor	N/A	HQ or Regional GA
State User	RO Coordinator (OSCAR, MDS, OASIS or ASPEN Coordinator) or Project Officer	Division Director*	Regional GA
Medicare Contractor/ Intermediary/Carrier	Company Contact	Consortium Contractor Management Staff Member	Regional GA
Managed Care Organization/ Group Health Plan	Project Officer	Division Director*	HQ GA
Researcher	Project Officer	Division Director*	HQ or Regional GA
Office of Inspector General	OIG Supervisor	OIG Regional GA	HQ GA
Other Federal Agency (Inter/Intra Agency)	System of Records Owner or CMS Liaison or Project Officer or Contact Person	Division Director*	HQ or Regional GA
Contractor (non-Medicare)	Project Officer	Division Director*	HQ or Regional GA
Vendor	Project Officer	Division Director*	HQ or Regional GA
Peer Review Organization Member	Project Officer	Division Director*	HQ or Regional GA
ESRD Network Member	Project Officer	Division Director*	HQ GA

*When Division Director signature would be redundant or not applicable, first-line supervisor of Requesting Official may sign as Approving Official.

(July 2001)