

Presentation Objectives

- Define
 - Purpose and objectives of risk adjustment data validation (RADV)
 - New RADV policies and parameters
 - RADV stages and requirements
 - Documentation dispute
 - Payment adjustment implementation approach
 - Appeals



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Risk Adjustment Data Validation

- Purpose: to ensure risk adjusted payment integrity and accuracy
- Method: Review of hospital (inpatient & outpatient) and physician medical records
- Objectives:
 - Verify enrollee CMS-HCCs
 - Identify risk adjustment discrepancies
 - Calculate enrollee-level payment error
 - Estimate national and contract-level payment errors
 - Implement contract-level payment adjustments



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Risk Adjustment Data Validation: New Approaches

- CMS will make contract-level payment adjustments based on findings from enrollee samples
- Documentation dispute process available for organizations to dispute enrollee-level HCC findings
- New documentation for missing medical records will not be allowed during dispute process – organizations should make “best effort” to submit medical records during initial request
- Appeals process will follow documentation dispute process

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2007 RADV Project Parameters

- January 2007 contract and enrollee cohort
- Eligible contracts: January 2007 active MA contracts, PACE, and dual demonstration organizations (all receive risk adjusted payments)
- Eligible January 2007 enrollees
 - Continuously enrolled with at least one HCC - enrollees in the same contract from January 2006 through January 2007 (national and contract samples)
 - Non-continuously enrolled with at least one HCC - enrollees who switch between contracts and/or MA and FFS from January 2006 through January 2007 (national sample only)
- Data collection period: January 2006 through December 2006 dates of service

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Risk Adjustment Data Validation

- Submitted risk adjustment diagnoses map to HCCs and result in payment increases
- All HCCs that contributed to payment for the sampled enrollees will be reviewed
- Medical record documentation must provide diagnosis evidence to substantiate the enrollee HCC(s) being validated

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Risk Adjustment Data Validation Guiding Principle

- Risk adjustment diagnoses submitted for payment must be:
 - Documented in a medical record from a face-to-face encounter (between a patient and provider)
 - Coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting
 - Assigned based on dates of service within the data collection period AND
 - From an appropriate RA provider type and RA physician specialty

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Risk Adjustment Discrepancy

- Definition: HCC assigned based on submitted risk adjustment diagnoses differs from the HCC assigned after medical record review
- Impacts enrollee risk score
- Changes payment for enrollee



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Medical Record Review Overview

- Core Project Contractors
 - Lead Analytic Contractor (LAC)
 - Facilitates management and tracking of all project data, analysis, and policy decisions
 - Medical Record Review Contractors (MRRCs)
 - Serve as initial and second independent medical record reviewers to confirm risk adjustment discrepancies
 - Use inter-rater reliability (IRR) process to ensure coding consistency and accuracy
 - Conduct documentation dispute process
 - Employs experienced ICD-9-CM coders to
 - Abstract diagnosis codes; and
 - Validate provider type, physician specialty, and date(s) of service



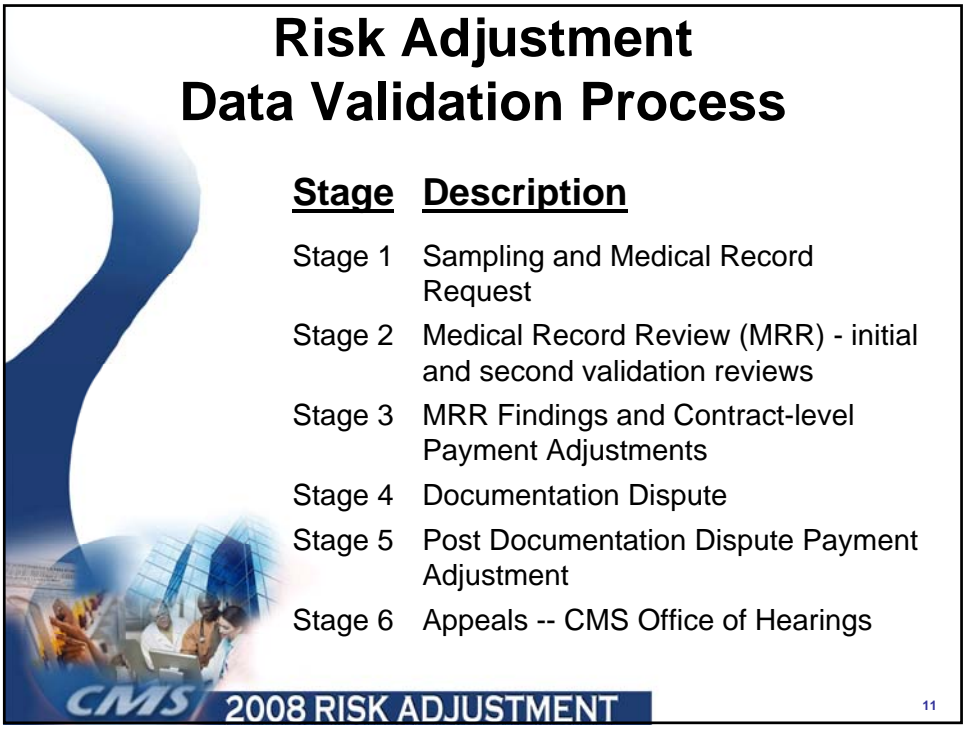
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Risk Adjustment Data Validation Process

Stage Description

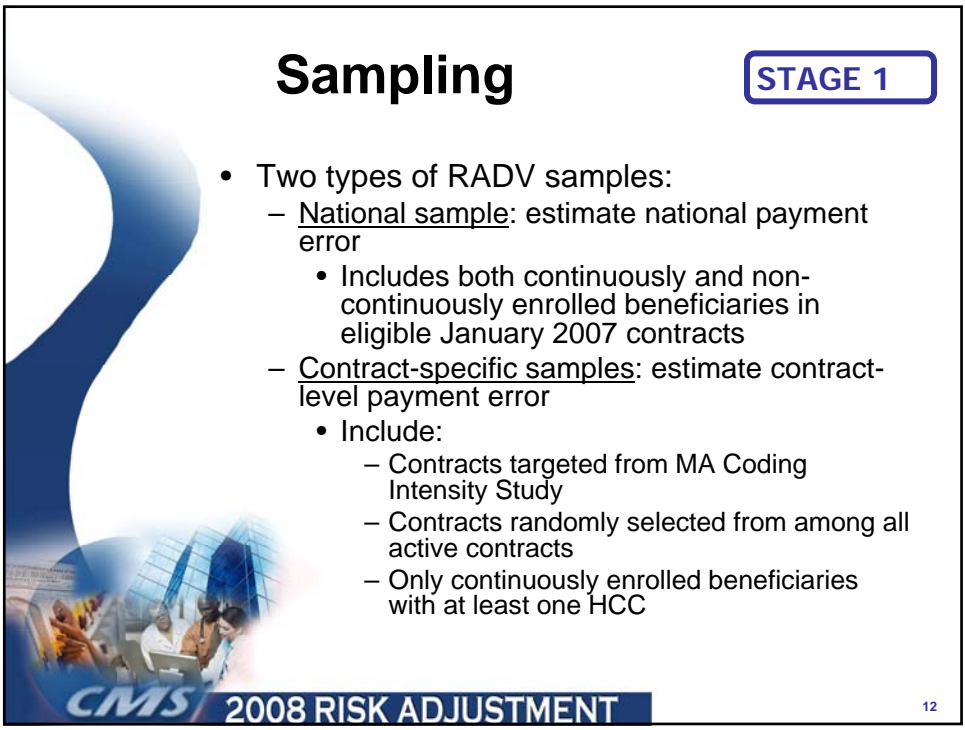
- Stage 1 Sampling and Medical Record Request
- Stage 2 Medical Record Review (MRR) - initial and second validation reviews
- Stage 3 MRR Findings and Contract-level Payment Adjustments
- Stage 4 Documentation Dispute
- Stage 5 Post Documentation Dispute Payment Adjustment
- Stage 6 Appeals -- CMS Office of Hearings



Sampling

STAGE 1

- Two types of RADV samples:
 - National sample: estimate national payment error
 - Includes both continuously and non-continuously enrolled beneficiaries in eligible January 2007 contracts
 - Contract-specific samples: estimate contract-level payment error
 - Include:
 - Contracts targeted from MA Coding Intensity Study
 - Contracts randomly selected from among all active contracts
 - Only continuously enrolled beneficiaries with at least one HCC



Medical Record Request

STAGE 1

Three segments

- Request
- Submission (MAO Response)
- Receipt



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Request Process (continued)

STAGE 1

Request

- CMS & MRRCs notify MA Compliance Officer of contract selection and request point of contact information
- Selected contracts receive
 - Enrollee list containing diagnoses and HCCs to be validated
 - Instructions for submitting medical records
 - Coversheets for each unique enrollee HCC being validated containing
 - Enrollee demographic information
 - Risk adjustment data (HCCs and ICD-9-CM codes)



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Request Process (continued)

STAGE 1

Submission (MAO Response)

- Verify sampled enrollee demographic data on the coversheet
- Use Enrollee List to help identify submitted diagnoses, providers, and service dates
- Establish contact and ongoing communication with providers
- Request and obtain medical records from providers – recommend using CMS provided:
 - Model provider letters
 - CMS-signed explanatory cover letters
 - HIPAA Fact Sheet



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Request Process (continued)

STAGE 1

Submission (MAO Response)

- Select the “one best medical record” for each enrollee HCC
 - Where the enrollee may have medical records from multiple providers and/or dates of service, select and submit only the “one best medical record” to support the HCC
- Provide medical records for HCCs where the MAO submitted risk adjustment diagnoses for enrollees
 - Where an enrollee is “non-continuously” enrolled, identify only the HCC(s) for which the MAO submitted RA diagnoses and provide medical record documentation for that HCC
- Complete a medical record coversheet for each enrollee HCC (see sample coversheet)



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Request Process (continued)

STAGE 1

Submission (MAO Response)

- Ensure that the medical record
 - Is dated for the date of service (must be within the data collection period)
 - Contains signature and credentials of the provider of service
 - Is sufficient for the coder to determine that a patient evaluation was performed by a physician (or acceptable physician extender)
- Attach coversheet to relevant clinical documentation
 - Each medical record must have at least one coversheet attached
 - Where a medical record supports more than one HCC, attach all relevant HCC coversheets to that medical record



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Request Process (continued)

STAGE 1

Submission (MAO Response)

- Package medical records and submit by the deadline
 - Follow all security requirements for medical record packaging, data, and submission
 - Submit medical records via hardcopy, electronic media, or confidential faxed copy
- Medical records will not be accepted after CMS' official deadline



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Request Process (continued)

STAGE 1

Receipt

– The MRRC will

- Receive and log medical records and coversheets
- Conduct administrative and clinical checks
- Provide technical assistance where possible



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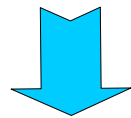
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Medical Record Review

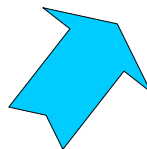
STAGE 2

GOOD DOCUMENTATION = ACCURATE PAYMENTS

Visit



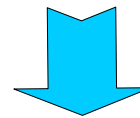
Document Visit



Assign Diagnosis Code



ICD-9 Code



Submit and Obtain Risk Adjusted Payment



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Medical Record Review (continued)

STAGE 2

Requirements for Documentation Submitted for Medical Record Review

- Concise → Reason for the face-to-face visit
- Consistent → Services rendered
- Complete → Conclusions, diagnoses, and follow-up
- Logical → Assignment of ICD-9-CM codes based on clear and legible clinical documentation
- Authenticated → By the provider of service (signature and credentials)
- Dated → Date of service noted

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Medical Record Review (continued)

STAGE 2

- Unacceptable Sources of Risk Adjustment Data
 - Follow *Data Collection* module for information on
 - Covered facilities
 - Non-covered facilities
 - Acceptable physician specialties



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Medical Record Review (continued)

STAGE 2

- Unacceptable Types of Risk Adjustment Data Validation Documentation
 - Superbill
 - Physician-signed attestation
 - List of patient conditions (hospital outpatient and physician settings - see problem list guidance)
 - Date(s) of service outside the data collection period



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Medical Record Review (continued)

STAGE 2

- Unacceptable Types of Diagnoses (outpatient hospital and physician settings)
 - Probable
 - Suspected
 - Questionable
 - Rule out
 - Working



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Medical Record Review (continued)

STAGE 2

Types of Acceptable Physician Signatures and Credentials	
Hand-written signature or initials, including credentials	<ul style="list-style-type: none"> • <i>Mary C. Smith, MD; or M.C.S., MD</i>
Signature stamp, including credentials	<ul style="list-style-type: none"> • Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	<ul style="list-style-type: none"> • Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by") • Must be password protected and used exclusively by the individual physician



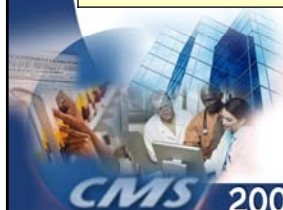
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Medical Record Review (continued)

STAGE 2

Types of Unacceptable Physician Signatures and Credentials	
TYPE	UNACCEPTABLE unless...
Typed name	<ul style="list-style-type: none"> • Authenticated by the provider
Non-physician or non-physician extender (e.g., medical student)	<ul style="list-style-type: none"> • Co-signed by acceptable physician
Provider of services' signature without credentials	<ul style="list-style-type: none"> • Name is linked to provider credentials or name on physician stationery



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Medical Record Review (continued)

STAGE 2

- Risk Adjustment Discrepancy Types
 - Invalid Medical Records
 - Unacceptable provider type or physician specialty
 - Date(s) of service outside of data collection period
 - Missing provider signature or credentials
 - Missing Medical Records
 - Cannot assign ICD-9-CM code due to insufficient or incomplete documentation
 - No medical record documentation submitted for the enrollee could support the HCC
 - Coding Discrepancies that change HCC assignment
 - ICD-9-CM code assigned after validation changes an original enrollee HCC



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MRR Findings and Contract-Level Payment Adjustments

STAGE 3

- MA organizations will receive
 - Enrollee-level HCC findings
 - Contract-level annual payment error estimate
 - Instructions for submitting enrollee HCC-level documentation disputes
 - Contract-level payment adjustments



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Documentation Disputes

STAGE 4

- MA organizations may dispute enrollee-level HCC findings based on the application of the ICD-9-CM guidelines by the MRRCs
- The dispute process cannot be used to address:
 - Missing medical records of any kind
 - Additional medical record documentation of any kind



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Post Documentation Dispute- Payment Adjustment

STAGE 5

- CMS will
 - Use dispute findings to re-estimate payment error
 - Make additional contract-level payment adjustments based on revised error estimates



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Appeals

STAGE 6

Process for filing requests for appeal to CMS Office of Hearings will soon be announced



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Recommendations & Lessons Learned

- Independent (non-CMS) Validation Activities
 - Conduct ongoing internal process to confirm accuracy of risk adjustment diagnoses from providers
 - Organize an internal validation team (e.g., MCO, IT, quality, compliance, coding)
 - Use newsletters and CMS training tools to inform internal staff and physicians about risk adjustment



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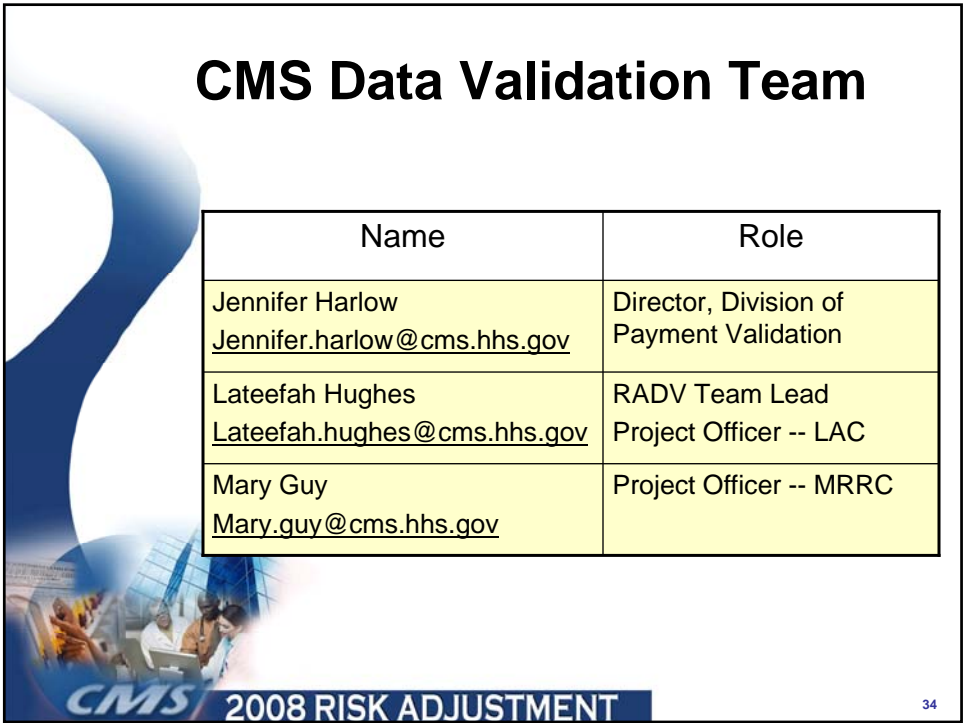
Recommendations & Lessons Learned to Date (continued)

- CMS-related Validation Activities
 - Query your provider data
 - Establish and maintain communication with providers
 - Organize an internal validation team
 - Plan accordingly—may require more effort to obtain medical records from
 - Specialists
 - Non-contracted providers
 - Hospital outpatient or PCP settings
 - Use data validation technical assistance tools
 - Ensure medical record documentation is complete
 - Submit medical records as you receive them from providers
 - Adhere to the submission deadline



CMS Data Validation Team

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Mary Guy Mary.guy@cms.hhs.gov	Project Officer -- MRRC



EVALUATION



Please take a moment to complete the evaluation form for the Data Validation (Medical Record Review) Module.

THANK YOU!

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