




MODULE 7 – RISK ADJUSTMENT DATA VALIDATION

Purpose (Slide 2)

To provide participants with an understanding of the risk adjustment data validation process.

Objectives (Slide 3)

- Identify
 - The purpose and goals of risk adjustment data validation
 - The stages of risk adjustment data validation
 - Risk adjustment data discrepancies
- Understand
 - The components of a medical record request
 - Requirements for acceptable medical record documentation
 - Payment adjustments and appeals
- Provide
 - Recommendations and lessons learned.

ICON KEY	
Example	
Reminder	
Resource	

7.1 Risk Adjustment Data Validation

7.1.1 Purpose of Risk Adjustment Data Validation (Slide 4)

Data validation occurs after risk adjustment data are collected and submitted, and payments are made to the Medicare Advantage (MA) organizations. CMS uses medical record review to validate the accuracy of risk adjustment diagnoses submitted by MA organizations for payment. Future data validation activities may include other data monitoring activities.

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

Purpose: To ensure risk adjusted payment integrity and accuracy



7.1.2 Objectives of Risk Adjustment Data Validation (Slide 5)

The primary objectives of risk adjustment data validation are to:

- Identify:
 - Confirmed risk adjustment discrepancies
 - Contracts in need of technical assistance to improve the quality of risk adjustment data
- Measure:
 - Accuracy of risk adjustment data
 - Impact of discrepancies on payment
- Improve/Inform:
 - Quality of risk adjustment data
 - The CMS-Hierarchical Condition Category (HCC) model.

7.1.3 Good Documentation = Accurate Payment (Slide 6)

Good documentation begins at the time of the patient's face-to-face encounter with the physician. The physician documents the clinical findings in the medical record. The medical record is used to determine ICD-9-CM codes. The pertinent information from the patient encounter is submitted to the MA organization for payment.

7.1.4 Guidelines for Risk Adjustment Data Validation (Slide 7)

The guidelines for risk adjustment data validation reflect the purpose and goals described above. Beginning with the CY2004 payments, validation activities incorporated the review of hospital inpatient, hospital outpatient, and physician medical records. This process reflects the implementation of the CMS-HCC model that began with CY2004 payment. Beginning with CY2006 payments, validation activities incorporated RxHCC data. This process reflects the implementation of the CMS RxHCC model that began with CY2006 payment.

Guiding Principle: The risk adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter, coded according to the *ICD-9-CM Guidelines for Coding and Reporting*; assigned based on dates of service within the data collection period, and submitted to the MA organization from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source.

In addition to the Guiding Principle, risk adjustment data validation guidelines include the following:

- The medical record documentation must support an assigned HCC.
- Beneficiary HCCs and risk adjustment records are selected based on risk adjustment diagnoses (ICD-9 codes), provider type, and the Health Insurance Claim (HIC) number that are submitted to the Risk Adjustment Processing System (RAPS).



- Given the flexibility of the Guiding Principle, contracts must select **“one best medical record”** to support each beneficiary HCC identified for validation. This means the contract decides whether to submit a hospital inpatient, hospital outpatient, or physician medical record when more than one option is available.
- Since CMS does not collect provider identifiers for risk adjustment, MA organizations must be able to track and locate supporting medical record documentation.
- Once a MA organization selects the “one best medical record,” the organization must identify the date of service to be reviewed to facilitate the medical record review process. The coders that are hired to review the medical records on behalf of CMS will not search beyond the date of service identified by the MA organization for the review.
- Payment adjustments are based on confirmed risk adjustment discrepancies.
- An appeals process is in place to address disagreement with a confirmed risk adjustment discrepancy.

7.1.5 Medical Record Documentation (Slide 8)

As stated in the *1997 Documentation Guidelines for Evaluation and Management Services*, “Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes.”

7.1.6 Overview of Risk Adjustment Data Validation (Slides 9-10)

Risk adjustment data validation is the process of verifying that diagnosis codes submitted by the MA organization for payment are supported by medical record documentation for an enrollee. It involves the review of hospital inpatient, hospital outpatient, and physician medical records. Since contracts must select the “one best medical record” to validate the HCC from hospital inpatient, hospital outpatient, and physician medical records, the approach is flexible. Additionally, the data validation approach is based on the CMS risk adjustment models:

- CMS-HCC—CY 2004 and beyond for Part C
- CMS RxHCC—CY 2006 and beyond for Part D.

Hereafter for purposes of this module only, the term “HCC” refers to both CMS-HCCs and RxHCCs.

CMS contracts with two independent review contractors to conduct medical record reviews. The initial validation contractor (IVC) conducts facilitates the process and conducts the initial review of medical records. The second validation contractor (SVC) receives the discrepant medical records from the IVC, confirms risk adjustment discrepancies that are identified by the IVC, and implements the appeals process. Both IVC and SVC use certified coders to abstract diagnosis codes and validation provider type, physician data source, and date(s) of service.

7.1.7 Risk Adjustment Discrepancies (Slide 11)

Risk adjustment discrepancies are identified when the HCC assigned based on risk adjustment data submitted by the MA organization differs from the HCC assigned after validation. Risk adjustment discrepancies affect the beneficiary risk score because of the change in HCC.

7.1.8 Data Validation Activities (Current and Future) (Slide 12)

CMS has several data validation activities on which it is or will be working. They are as follows:

- CY 2004
 - July 12, 2007: Disseminated plan-specific findings to MA organizations in the targeted sample.
 - August 29, 2007: Conducted teleconference to communicate the CY 2004 pre-reconciled medical record review national results.
 - Mid-October 2007: Anticipate mailing pre-reconciled findings to MA organizations with enrollees selected for the national sample.
- CY 2005
 - Quality checking the IVC and SVC results.
 - Anticipate releasing findings in the late fall.
- CY 2006
 - Selected contracts notified in May 2007.
- CY 2007
 - CMS to sample after final data submission deadline (January 31, 2008).

7.1.9 Risk Adjustment Data Validation Process (Slide 13)

Risk adjustment data validation occurs every year. Figure 7A illustrates the overall data validation process. This process involves the coordination of multiple entities such as CMS, MA organizations, and CMS contractors. The data validation process begins with selecting MA organizations, then beneficiaries and their respective HCCs. This occurs after the risk adjustment data submission deadline for calendar year payment. The stages of the risk adjustment data validation process are briefly described below:

- ➔ **STAGE 1** **Contract Selection:** CMS designs a sampling plan to select MA organizations for risk adjustment data validation. Once the MA organizations are selected, individual beneficiaries and their HCCs are selected on the basis of the sample framework. The sample is based on payment year risk adjustment data. Every MA organization has a chance of being selected for validation.
- ➔ **STAGE 2** **Medical Record Request Process:** Stage 2 is defined by three distinct segments: 1) medical record request; 2) medical record submission (contract response); and 3) medical record receipt. After the sample has been drawn, medical records are requested from the selected MA organizations. All correspondence with MA organizations related to Stage 1 is facilitated by the IVC.
- ➔ **STAGE 3** **Medical Record Review:** After medical records are received by the IVC, certified ICD-9 coders review the medical records to validate the selected beneficiary HCC(s). During this stage, data discrepancies are identified. Data discrepancies occur when beneficiary medical record documentation does not match the risk adjustment data submitted for payment. A data discrepancy that results in an HCC assignment change is known as a risk adjustment

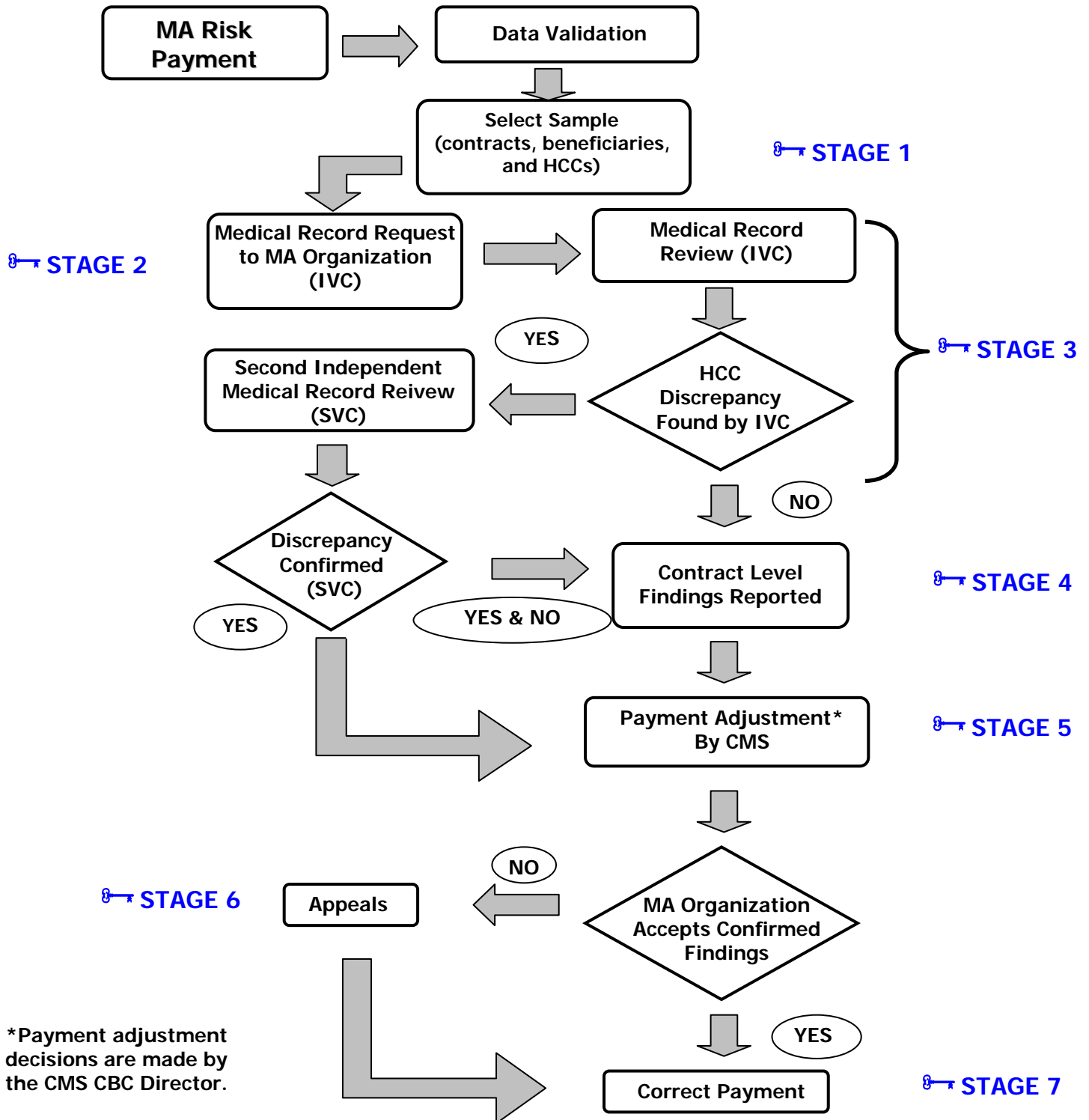


discrepancy. All identified risk adjustment discrepancies undergo a second, independent medical record review to confirm the discrepancy. The second medical record review is conducted by the SVC. This activity is transparent to MA organizations. There is no correspondence between the SVC and contracts during this stage.

- 8→ **STAGE 4** **Contract-Level Findings:** At this point in the data validation process, CMS communicates contract-level findings from Stage 3 to the selected MA organizations. Data discrepancies determined by medical record review are described. Additional feedback such as national and contract-level response rates and discrepancy rates are provided. Contract patterns, systemic problems, and contracts in need of additional technical assistance may also be identified during this stage.
- 8→ **STAGE 5** **Payment Adjustment:** The CMS CBC Director makes all decisions with regard to payment adjustment based on validation findings. A payment adjustment is based on a confirmed risk adjustment discrepancy. If the CMS CBC Director decides to make the adjustment, then the change in the risk adjustment payment is applied. Payment adjustments are typically reflected in the Monthly Membership Report (MMR).
- 8→ **STAGE 6** **Appeals:** After payment adjustments are made, MA organizations have the option of appealing the change. In the event that a contract chooses to appeal, then the organization has 60 days from the date of the payment adjustment to respond. This process is fully described in the *Appeals* section of this module.
- 8→ **STAGE 7** **Correct Payment:** The conclusion of the appeals process determines the correct risk adjusted payment for an MA organization. The original payment adjustment decision may stand (unchanged) or be reversed. All appeal decisions are final.

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Figure 7A – Data Validation Process



7.2 Components of the Risk Adjustment Data Validation Process

The key components of the data validation process include: 1) sampling; 2) the medical record request process and the receipt of medical record documentation by the IVC; and 3) the medical record review.

7.2.1 Contract Selection STAGE 1 (Slide 14)

Sampling

Sampling for data validation is conducted on an annual basis. Sampling involves the selection of contracts, beneficiaries, and the beneficiary HCC(s). The sample is drawn from risk adjustment data submitted for the payment year (data collection period, January 1 through December 31). The sampling approach includes both random and targeted components. Some contracts may be selected randomly, while others may be targeted.

Under the CMS-HCC model, CMS expects to select a national sample for each payment year. The purpose of the national sample is to derive national net payment error and risk adjustment discrepancy estimates for the payment year. In addition to the national random sample, some targeted sampling will be employed. The targeting criteria may include:

- Patterns in the risk adjustment data that are suggestive of potential problems.
 - A contract may be targeted for data validation because the risk adjustment data for that contract showed a disproportionately high number of HCCs.
- Past performance from previous data validation years.
 - A contract may be selected for medical record review as a result of a high error rates from prior validation activities.

In addition, CMS may sample based on random selection of specific contract types(s). The medical records reviewed for a beneficiary could reflect either the entire HCC profile (all HCCs) or a subset of one or more HCCs. Every MA organization has equal opportunity of being selected.

7.2.2 Medical Record Request Process STAGE 2 (Slides 15)

During Stage 2 CMS works with the IVC to implement the process for requesting and receiving medical records from MA organizations. Stage 2 is defined by three distinct segments: 1) medical record request; 2) medical record submission (contract response); and 3) medical record receipt.



7.2.2.1 Medical Record Request - Initial Contact Letter (Slide 16)

On behalf of CMS, the IVC sends an initial contact letter to the Medicare compliance officer for each MA organization selected for validation. The purpose of the initial contact letter is to: 1) inform the compliance officer that the organization was selected for data validation; and 2) request a primary point of contact (either the compliance officer or a designee) to be responsible for facilitating the medical record request process for the organization.

7.2.2.2 Medical Record Request - Beneficiary List (Slide 16)

A list of contract-specific selected beneficiaries for each selected MA organization is sent to the confirmed primary contact person for the MA organization. The beneficiary list is generated based on risk adjustment data submitted for the enrollee sample. The list may be provided to MA organizations either in advance of or in conjunction with the medical record request instructions package. The purpose of the list is to provide MA organizations with ample opportunity to easily identify the selected enrollees in their systems, and establish contact with the specific provider(s) of services for those enrollees. As previously mentioned, CMS does not require or store provider identification numbers as part of risk adjustment data. Therefore, the MA organization must use data systems that can:

- Track and locate the requested medical records.
- Link a specific diagnosis to a specific provider.

The beneficiary list is provided in an electronic spreadsheet format, which displays:

- MA organization's name,
- Current Contract ID (H-number), and
- Previous Contract ID (H-number)—this information is furnished if the contract ID used during the data collection period differs from the current contract ID.

For each selected enrollee the following information is included in the beneficiary list:

- Coversheet ID number (A masked ID tracking number that can be found on the bottom left of each HCC coversheet)
- Enrollee Last Name
- Enrollee First Name
- Enrollee Date of Birth
- Enrollee HIC Number
- Validation HCC
- ICD-9-CM code(s) related to the validation HCC—you must submit a medical record to support the enrollee HCC.

Note that the beneficiary list will contain a line for each enrollee's unique HCC. This means that if an enrollee has multiple different HCCs, each line for the enrollee will comprise a unique HCC and all associated risk adjustment diagnoses that were submitted by your organization for that HCC. Therefore, a complete enrollee HCC profile could comprise multiple lines on the beneficiary list. Table 7A displays a sample beneficiary list. The information shown on the line with each beneficiary HCC reflects all ICD-9 codes submitted by the MA organizations for that HCC.

 **Example 1**

For beneficiary Joe K. Smith - HCCs 38, 80 and 16 will be validated. For HCC 38, the MA organization may rely on one of the five ICD-9 codes associated with that HCC to identify the date of service and provider, and **“one best medical record”** for review. The organization could also opt to identify a provider that rendered a diagnosis that is not on the list, but will map to HCC 38. Contracts should take advantage of whichever approach yields the most efficient results.

TABLE 7A – BENEFICIARY LIST

MA Organization Name – Health Plan for People with Medicare											
Current Contract ID: H1111											
Previous Contract ID: H0000											
Coversheet ID #	LAST NAME	FIRST NAME	MI	DOB	HIC	HCC	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE
H1111-10005-HCC38	Smith	Joe	K	09/02/1925	183838279A	HCC 38	7101	446	4460	4465	71430
H1111-10005-HCC80						HCC 80	40201	40491	416		
H1111-10005-HCC16						HCC 16	2506	25062	2508	25080	
H1111-10006-HCC16	Johnson	James		8/16/1937	987699890A	HCC 16	2506	2508			
H1111-10007-HCC2	Mumford	Anne	A	03/15/1933	986023456A	HCC 2	0382	0389			
H1111-10007-HCC79						HCC 79	42741	51883			

7.2.2.3 Medical Record Request - Comprehensive Instructions and Coversheets (Slide 16)

A comprehensive instructions package is sent to MA organizations to facilitate the request for submitting medical records. This package will at a minimum include the following:

- Detailed instructions for requesting records from providers and submitting to the IVC;
- Guidance and best practices to further assist organizations with the request process;
- A list of the beneficiaries (as previously described) and their HCCs;
- CMS letters addressed to providers describing the overall risk adjustment data validation approach;
- HIPAA fact sheet to discuss HIPAA privacy;
- CMS sample request letters to providers; and
- Coversheets for each enrollee HCC.

The organizations must request records from hospital inpatient, hospital outpatient, or physician providers. When requesting medical records from your providers, be sure to attach the HIPAA fact sheet and include your MA organization contact information. This will facilitate the provider’s contacting you in the event the provider has questions with regard to the medical record request.

When requesting medical records from providers, the organization must make every effort to limit disclosure of beneficiary health information to the minimum necessary as it pertains to the specific diagnosis (es) as rendered by the provider. This means that if the organization finds a date of service for which one provider rendered a diagnosis then the organization should only request from that provider medical record documentation for the respective diagnosis.

7.2.3 Medical Record Submission (Slide 17)

MA organizations must submit medical records and all corresponding coversheets for each enrollee HCC to the IVC. In responding to the medical record request, MA organizations must select the “one best medical record” to support the enrollee HCC.

7.2.3.1 Medical Record Submission and Coversheets (Slide 17)

Under the CMS-HCC model, beneficiaries could have more than one HCC. Therefore, one coversheet will be generated and provided for every HCC being validated for each selected beneficiary. Each coversheet shows every risk adjustment diagnosis that was submitted to RAPS and generated the same HCC. Attachment A provides a sample beneficiary HCC coversheet with directions for completion.

Note that if one enrollee has two different HCCs, the contract will receive two separate HCC coversheets for that enrollee. In addition, one medical record could be used to support multiple HCCs. If you identify a medical record that supports more than one HCC selected for validation, then complete each HCC coversheet, and attach them to that the one medical record.

The coversheet is where the concept of the “one best medical record” is applied. The coversheet will at a minimum provide enrollee demographic information, stored risk adjustment data (HCC and ICD-9 codes). The MA organization must select and submit the best medical record and indicate on the coversheet the provider type and date(s) of service to be reviewed for the HCC. The date(s) of service could include a range of consecutive dates if the record is from a hospital inpatient provider or one date if the record is from a hospital outpatient or physician provider.



All coversheets must be returned regardless of whether a medical record is submitted to support the HCC. MA organizations must complete the coversheets to identify the information being submitted. Complete medical record coversheets are essential to timely medical record review.



If an MA organization is unable to submit the required medical record(s) to support the enrollee HCC(s), it must complete the coversheet as per the instructions package prior to submitting the coversheet to the IVC. This will inform the IVC that no medical record could be obtained to support the HCC.

CMS reimburses MA organizations for each medical record submitted per beneficiary HCC; however, only one medical record per beneficiary HCC will be accepted for reimbursement. If one record supports more than one beneficiary HCC, then the contract will receive reimbursement for one record. Reimbursement checks are sent by the IVC after completion of data validation activities.



Guidance for Submitting Medical Records to the IVC

1. Do not submit medical records for date(s) of service that occurred outside of the data collection period.
2. If you select an inpatient discharge to substantiate the HCC(s), submit the entire inpatient medical record. Do not just submit parts of the record that may state the diagnosis as inpatient coding guidelines may differ from those for outpatient settings depending on the diagnosis.
3. Several organizations choose to submit medical record documentation that reflects only the physician face-to-face portion of an inpatient record when the entire inpatient record is not available. When this is the case complete the coversheet to reflect a "physician" provider type and the date of service in the medical record for which the physician visit occurred during the inpatient stay. Only submit the medical record page(s) for the selected physician face-to-face.

If the entire inpatient medical record is available, the contract should opt to submit the entire record and complete the coversheet as appropriate to reflect the date range for the stay. It is likely that this approach would not limit the amount of diagnoses to be abstracted for the stay.

4. In order to prevent medical record information from inadvertently being attached to the wrong coversheet(s), be sure that all coversheets are stapled to the record whenever possible. We understand that this may be difficult to do with large inpatient medical records. If necessary, consider the use of rubber bands to attach coversheets with the records. Do not submit loose documentation or documentation with only paper clips.
5. If you are submitting for multiple organizations (i.e., those with different "H" numbers), separate the records for the different organizations.
6. Unless instructed by the IVC, submit only one coversheet per enrollee HCC. Only one coversheet—the first—will be accepted. If you are unsure whether a record substantiates an HCC, you must determine whether to submit it or wait for another record.
7. Do not clip together medical records for multiple different enrollees.
8. When in doubt about the clinical documentation in a medical record and you have no viable substitute, send the medical record even if you do not believe the record supports the HCC. We may find that the record does support the HCC and/or could contain clinical information that result in risk adjustment ICD-9 codes that were not previously submitted CMS.
9. **SUBMIT ALL MEDICAL RECORDS AND COVERSHEETS BY THE OFFICIAL DEADLINE.** In the event that you are unable to submit a medical record(s), you must complete as per the instructions package and return the coversheets to the IVC.

7.2.4 Medical Record Receipt by the IVC and Reimbursement (Slide 18)

Once medical records are selected by the MA organization, the organization must submit them to the IVC for data validation. Upon receipt, the IVC will log medical records into a chart-tracking database on the basis of the barcode on each medical record coversheet. This method identifies the date the medical record was received for a given HCC. To protect patient confidentiality, all records are stored in a secure, designated area accessible only to those having direct responsibility for risk adjustment data validation activities.

When the coversheet and medical record are received by the IVC, the following intake process is initiated:

- Administrative check—confirms beneficiary demographic information, including name, HIC number, and service date within or outside of the collection period.
- Clinical check—determines whether the:
 - Record is from an appropriate provider type.
 - Pertinent components needed for coding are included in the record.
 - Record is dated and signed.

Based on the administrative and clinical checks, the IVC may elect to contact (telephone call or email message) the MA organization to request clarification or additional information. This step is provided as a service to the organization and normally is performed only if the records are received in a timely manner.

After intake, the medical record (with coversheet) is assigned to a category. The possible categories include:

- Identified as “okay” for review;
- Problem; or
- Missing medical record.

Throughout the data validation process, CMS and its contractors will make a reasonable effort to alert MA organizations of medical record documentation issues and allow contracts the opportunity to correct problems.

7.2.4.1 Medical Record Documentation STAGE 3 (Slide 19)

Proper medical record documentation is the key to accurate payment and successful data validation. The accurate assignment of ICD-9-CM diagnosis codes is based on thorough medical record documentation. Therefore, risk adjusted payment accuracy also relies on medical record documentation. Remember, a beneficiary HCC is assigned based on a diagnosis cluster that has been submitted to RAPS.

Below are some general guidelines for medical record documentation, based on the sources of the documentation.

7.2.4.2 General Guidelines for Hospital Inpatient Medical Record Documentation (Slide 20)

Hospital inpatient medical records are generally considered to be the most reliable source of diagnostic coding because hospitals employ certified professional coders.

Coding

According to the *ICD-9-CM Official Guidelines for Coding and Reporting*, for hospital inpatient stays a medical record reviewer should code the principal diagnosis and:

...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 required medical record documentation should include, but is not limited to, the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic (radiology, cardiology, etc.) testing reports
- Discharge summary.

7.2.4.3 General Guidelines for Hospital Outpatient and Physician Medical Record Documentation (Slide 20)

Hospital outpatient and physician office medical records should include, but are not limited to, the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Diagnostic reports (to support documentation)
- Consultation reports



Submit all relevant medical record components needed to validate the date of service, beneficiary, the HCC, and ICD-9 code selected. When you submit medical record documentation to support only the physician face-to-face that occurred during an inpatient stay, the same medical components are needed; however, the medical record documentation will be reviewed in accordance with *Diagnostic Coding and Reporting Guidelines for Outpatient Services*.

Only services that occurred on the date of service are reviewed. The overall guidelines for medical record documentation from hospital outpatient sites and physician offices are:

- A coder can determine from the documentation that an evaluation of the patient was performed by a physician or an acceptable physician extender (e.g., physician assistant, nurse practitioner).
- An ICD-9-CM code can be assigned on the basis of the evaluation and clinical findings/treatment.
- Physician signature, physician credentials and date entries are present.

Coding

Per the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

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.

Per *Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services*, Part C of the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.



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

In some cases, additional guidance is needed when relying on certain types of hospital outpatient and physician office medical record documentation. (For additional information, see the *Guidance for Problem Lists*, *Guidance for Radiology Reports*, and *Guidance for Nursing Home Resident Medical Records* sections of this module.)

7.2.4.4 Unacceptable Medical Record Documentation (Slides 21-22)

Several sources of medical records and types of documentation are **not acceptable** for risk adjustment data validation.

Unacceptable Sources of Medical Records

- Skilled nursing facility (SNF) (See *Additional Guidance*)
- Freestanding ambulatory surgical center (ASC)
- Alternative data sources (e.g., pharmacy)
- Unacceptable physician extenders (e.g., nutritionist)
- Durable medical equipment (DME)



Unacceptable Types of Medical Record Documentation

- Superbill
- Physician-signed attestation
- A list of patient conditions
- A diagnostic report that has not been interpreted
- Any documentation for dates of service outside the data collection period

Unacceptable Types of Diagnoses (outpatient hospital and physician settings)

- Probable
- Suspected
- Questionable
- Rule out
- Working

For additional information about unacceptable types of risk adjustment diagnoses, see Module 5 of the Participant's Guide.

7.2.4.5 Physician Signatures, Physician Credentials, and Dates of Service (Slides 23-24)

As stated in CMS' 2008 Call Letter (available on the CMS web site at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>):

For purposes of risk adjustment data submission and validation, the MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. (Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.) This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. In these instances, the coders are able to determine that the beneficiary was evaluated by a physician or an acceptable physician data source. (For additional information on acceptable physician data sources, see the above section titled *Filtering for Acceptable Provider Types and Physician Data Sources*.)

We have identified medical records where it is unclear if the beneficiary is actually evaluated by a physician, physician extender, or other. In several cases, we have found encounters that are documented on physician's stationery but appear to be signed by a non-physician provider. For example, a medical record appears on group stationery for a given date of service. The medical record is signed but the provider's name and credentials are not furnished on the stationery. Thus, the coders are unable to determine whether the beneficiary was evaluated by a physician, medical student, nurse practitioner, registered nurse, or other provider. This type of medical record documentation is incomplete and unacceptable for risk adjustment and, therefore, will be counted as a risk adjustment discrepancy.

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Thus, all dates of service that are identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner). The physician must authenticate each note for which services were provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signature. Signature stamps must comply with state regulations for authentication. For example, some states may require provider initials in conjunction with the stamped signature.

If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. **Some examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," or "Validated by," and include the practitioner's name and credentials and the date signed.**



Medical records will be reviewed if there is dated medical record documentation (e.g., handwritten or transcribed consultation report, discharge summary) with a physician signature and credentials.



A medical record that lacks a date or physician signature and credentials is invalid and will not be reviewed.

TABLE 7B – TYPES OF ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

TYPE	ACCEPTABLE
<ul style="list-style-type: none"> Hand-written signature or initials, including credentials 	<ul style="list-style-type: none"> Mary C. Smith, MD; or MCS, MD
<ul style="list-style-type: none"> Signature stamp, including credentials 	<ul style="list-style-type: none"> Must comply with state regulations for signature stamp authorization
<ul style="list-style-type: none"> 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

TABLE 7C – TYPES OF UNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

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



7.2.4.6 Additional Guidance

To further assist MA organizations in determining the “one best medical record”, below is guidance on radiology reports, problem lists, nursing home resident medical records. Information about medical record documentation resources is also furnished.

Guidance for Radiology Reports

Medical record documentation from radiologists presents an interesting challenge for data validation. The radiologist generally provides two types of radiology services—diagnostic (e.g., chest x-ray) and therapeutic (e.g., radiation therapy). Based on experience with radiology documentation from an ambulatory setting we have found:

1. In the case of diagnostic radiology services, MA organizations are relying on the referral diagnosis for the radiology service as the actual diagnosis code. ***This diagnosis code is not acceptable as risk adjustment data because the diagnosis has not been confirmed.***
2. While most diagnostic radiology reports do indicate findings or an impression, ***these reports do not indicate a diagnosis.*** The radiologist typically sends a report to the referring physician, who then reviews the findings and documents a diagnosis based on those findings.
3. Therapeutic radiology services are delivered after a confirmed diagnosis is assigned; thus, a report for this type of service would normally reflect a confirmed diagnosis.

Given these findings, CMS suggests the following guidelines:

1. Do not send diagnostic radiology medical records for validation if other medical record documentation is available.
2. If a diagnostic radiology medical record is the only documentation of a diagnosis, then the MA organization should review the medical record to ensure that the documentation is sufficient to support an HCC diagnosis.
3. If an insufficiently documented radiologist medical record is submitted, then the HCC diagnosis will be discrepant.

CMS has eliminated diagnostic radiology as an appropriate risk adjustment physician specialty for dates of service occurring on January 1, 2005 and beyond.

Guidance for Nursing Home Resident Medical Records

Although CMS does not accept risk adjustment data from nursing home facilities, some beneficiaries who reside in a nursing home will have a nursing home medical record as the only source to support their diagnostic data (i.e., there is no other medical record that documents the diagnosis submitted for risk adjusted payment; the nursing home record is the record of last resort). Only in certain circumstances will CMS accept nursing home medical records for purposes of data validation. We will accept a medical record from a nursing home providing it is the only medical record for the enrollee that documents the diagnosis submitted for risk adjustment and:

1. The provider's encounter must have been face-to-face with the beneficiary;
2. The provider must be an acceptable physician data source for risk adjustment;
3. The medical record must clearly document the provider's signature and credentials; and
4. The beneficiary must be identified in the Minimum Data Set (MDS) as a long-term institutional resident.

Guidance for Problem Lists

Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

Medical Record Documentation Resources



ICD-9-CM Official Guidelines for Coding and Reporting, October 1, 2003 (Section IV is specific to ambulatory coding), <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>



ICD-9 Coding Clinic Guidelines



CMS 2004 Physicians and Medicare Advantage Risk Adjustment CD



American Health Information Management Association, <http://www.ahima.org/>



American Medical Association, <http://www.ama-assn.org/>



Bates Guide to the Physical Examination and History Taking, 7th Edition, Chapter 21 (The Patient's Record)



Fundamentals of Clinical Practice, Mengel, Holleman, and Fields (Eds.), Kluwer Academic/Plenum Publishers, Chapter 12 (Record Keeping and Presentation)



7.2.5 Medical Record Review (Slide 25)

CMS uses medical record review to validate risk adjustment payments. The process involves review of submitted medical record documentation by a certified coder. The reviewer validates the date of service and the diagnosis code identified by the MA organization on the medical record coversheet. Medical record review includes abstracting a diagnosis code when it is based on the accompanying medical record documentation.

During medical record review, the certified coder also checks for the following:

- Diagnosis code(s) supported by medical record documentation per *ICD-9 Coding Clinic Guidelines*.
- A provider signature and credentials for each note.
- Coversheet diagnosis against the medical record diagnosis.
- Date of service on coversheet and in medical record that are within data collection period.

7.2.5.1 Risk Adjustment Discrepancies (Slide 25)

To give a general understanding of the types of discrepancies that may be identified, the following descriptions are provided:

- Invalid
 - The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
 - The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
 - The medical record is missing provider signature and credentials.
- Missing
 - Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
 - Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.
- Coding Discrepancies
 - The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.

A risk adjustment discrepancy is identified when an HCC originally assigned to an enrollee on the basis of submitted risk adjustment data differs from the HCC assigned after data validation. A risk adjustment discrepancy may affect the final risk score for a beneficiary. Risk adjustment discrepancies that are identified by the IVC are referred to the SVC for confirmation. An example of a risk adjustment data discrepancy is provided below.

 **Example 2**

Example of a Risk Adjustment Discrepancy

Reported Diagnostic Data: 482.4 Staphylococcal Pneumonia (HCC 111)
Data Validation Findings: 482.3 Streptococcal Pneumonia (HCC 112)

The medical record documentation supports the code 482.3 streptococcal pneumonia, not 482.4 staphylococcal pneumonia. The factor associated with HCC 111 is .693. The factor associated with HCC 112 (the final HCC) is .202. If confirmed, this finding results in a risk adjustment discrepancy because the beneficiary HCC changed.

The medical record associated with this risk adjustment discrepancy will go to the SVC for a second medical record review and confirmation. Risk adjustment discrepancies confirmed by the SVC could result in a payment adjustment. (See *Payment Adjustment* and *Appeals* sections of this module.)

7.2.6 Risk Adjustment Data Validation Findings  **STAGE 4** (Slide 26)

The purpose of risk adjustment data validation is to improve risk adjusted payment integrity and accuracy. This is accomplished by identifying problems and communicating findings. CMS will continue to provide MA organization-specific (contract level) and summary level findings from the data validation process to selected MA organizations. MA organization-specific findings may include a contract response rate, the number of risk adjustment discrepancies, and the number of additional HCCs identified. CMS will make every effort to provide timely feedback.

7.2.7 Payment Adjustment  **STAGE 5** (Slide 27)

Again, the purpose of risk adjustment data validation is to ensure risk adjusted payment integrity and accuracy. Once a risk adjustment data discrepancy that affects payment has been identified by the IVC and confirmed by the SVC, the CMS CBC Director determines if a payment adjustment should be implemented. A payment adjustment may increase or decrease the risk adjusted payment, and it is the basis for appeals.

CMS' general approach to making payment adjustments is to first develop the criteria that will identify an MA organization for payment adjustment. For example, the criteria could include payment adjustment based on a "consistent pattern" of inaccurate data for previous and current payment years being validated. Consistent patterns may include:

- High risk adjustment discrepancy rate—in comparison to the national average risk adjustment discrepancy rate.
- High payment error rate—in comparison to the national average net payment error rate.
- Inaccurate risk adjustment data for 2 consecutive years based on validation findings.

7.2.8 Appeals **STAGE 6** (Slide 28)

An appeals process is implemented if an MA organization disputes a payment adjustment. The appeals process is conducted by the SVC. An expert coding panel reviews every appeal. The panel is typically comprised of a senior medical reviewer, a senior coder, and a physician. The physician assesses whether any clinical factors may change the outcome of the appeals determination.

Consistent with Medicare fee-for-service, an MA organization has one opportunity to challenge a payment adjustment. Once a payment adjustment has been made and appears on the Monthly Membership Report (MMR), the MA organization has 60 days to file an appeal.

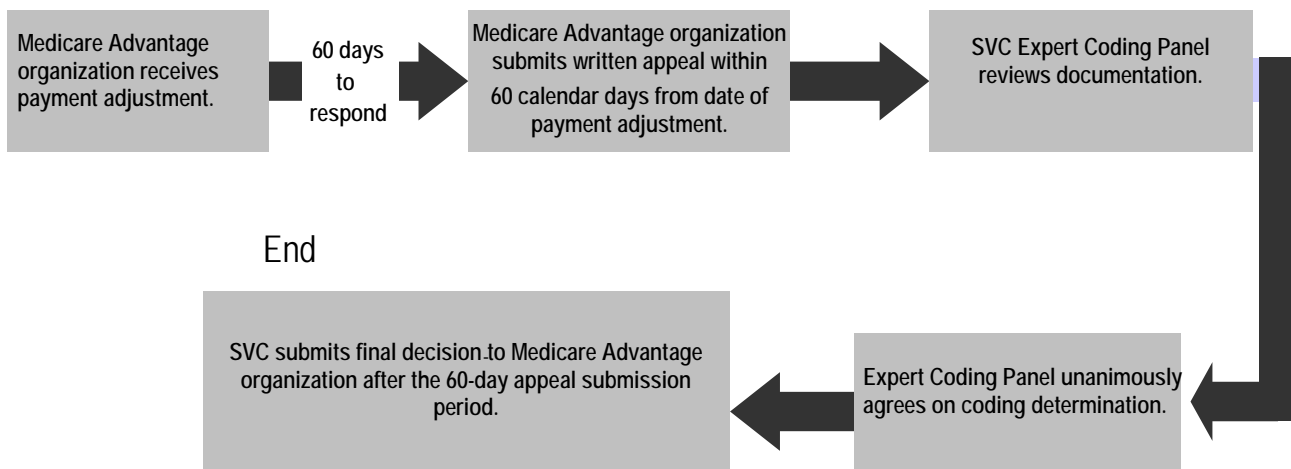
When submitting an appeal, an MA organization may offer a different interpretation of the ICD-9 code assignment based on *ICD-9 Coding Clinic Guidelines*. MA organizations may also provide additional medical record documentation to support their appeal. Thus, each appeal must include, at a minimum:

- A clearly documented reason for disagreement with the medical record review finding; and/or
- Additional medical record documentation to support the reason for appeal.

Figure 7B illustrates the timing of the appeals process.

Start

Figure 7B – Appeals Process Timeline



End

7.2.9 Correct Payment **STAGE 7** (Slide 29)

The conclusion of the appeals process determines the final outcome of risk adjusted payment for an MA organization. Based on the outcome of an appeal, the payment adjustment may stand (unchanged) or be reversed.

This concludes the Risk Adjustment Data Validation Process. **STAGES 1- 7**

7.3 Recommendations & Lessons Learned to Date (Slides 30-31)

Recommendations and lessons learned about the medical record request process that may assist contracts in planning and implementing their contract's activities include the following:

- **Conducting Independent (non-CMS) Data Validation Activities**

MA organizations may choose to undertake data validation activities independent of CMS' efforts. When this is the case, CMS encourages organizations to clearly emphasize to their providers that the activity is not a CMS sponsored activity. As a courtesy to providers, we ask that MA organizations limit to distribution of enrollee confidential health information to the minimum information necessary to accomplish the purpose of their activity. This means that an organization should not provide enrollee diagnoses data to providers who were not responsible for rendering specific treatment for enrollees. For example, if a provider submitted diabetes on a claim for an enrollee, the MA organization should only disclose diabetes to that provider and no other diagnoses as determined by other providers. In other words, the organization should not provide universal lists of enrollee diagnoses to multiple providers. Doing so, may raise concerns about the organization's compliance with the Privacy Rules.

If undertaking independent data validation activities, below are some additional considerations:

- Conduct ongoing internal processes to confirm the accuracy of risk adjustment diagnoses from providers.
 - Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
 - Use newsletters and CMS training tools to inform physicians about risk adjustment.
- **CMS-related Validation Activities**
 - Query your data based on the beneficiary list that is furnished by the IVC.
 - Establish communications with the providers prior to sending the medical record request.
 - Identify a contact person at the physician's office.
 - Send complete request information to providers.
 - Determine whether providers require payment in advance of sending medical records.
 - Follow up with the physician's office after the medical record request is sent.
 - Plan accordingly to ensure that you receive the medical records you need. It may require more effort to obtain medical records from—
 - Specialists
 - Non-contracted providers
 - Hospital outpatient or primary care provider settings.
 - Consider having the provider indicate the date of service and diagnosis code on the coversheet.
 - Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
 - Involve in-house quality assurance staff/medical record reviewers/medical director to identify the "one best medical record."
 - Ensure medical record documentation is signed (with physician credentials) and dated by an appropriate provider type.
 - Ensure medical record documentation is complete.
 - Submit medical records as you receive them from providers.
 - Use newsletters and CMS training tools to inform physicians about risk adjustment.
 - Adhere to the submission deadline.



7.4 Technical Assistance (Slide 32)

To improve the quality of risk adjustment data, CMS has technical assistance contractors available for any MA organization that needs help with CMS data validation processes, data completeness and accuracy, documentation requirements, and areas of concern identified by medical record review. Technical assistance may include site visits and teleconferences. To discuss your technical assistance needs, please contact the appropriate CMS staff member as identified in the *Current Validation Activities* section below.

7.5 CMS Data Validation Team Contacts (Slide 33)

Table 7D provides a synopsis of risk adjustment data validation activities by payment year and a listing of responsible CMS staff.

TABLE 7D – CMS STAFF

CMS CONTACT	CONTACT INFORMATION	ROLE
Lateefah Hughes	lateefah.hughes@cms.hhs.gov	Team Lead
Mary Guy	mary.guy@cms.hhs.gov	Project Officer CY 2005 CY 2007
Chanda McNeal	chanda.mcneal@cms.hhs.gov	Project Officer CY 2004 CY 2006

7.6 Next Steps

As risk adjustment data validation activities continue, CMS will consider other techniques for monitoring risk adjustment data submissions to improve the sampling selection and receipt of quality medical record documentation.