

# Encounter Data Work Group Summary Notes for Chart Reviews and Data Submission for Chart Audits: Key Findings and Recommendations

## Chart Reviews and Data Submission for Chart Audits Work Group 1 of 4

This report summarizes the findings of the Encounter Data Work Group Chart Reviews and Data Submission for Chart Audits conducted on December 15, 2010. Forty-eight organizations participated in this Work Group and included:

- Bravo Health
- Network Health
- Care Wisconsin
- WellPoint
- Inland Empire Health Plan
- Humana
- L.A. Care
- Scan Health Plan
- Senior Whole Health
- Blue Cross Blue Shield of Alabama
- NYC Health and Hospitals Corporation
- Tufts Health Plan
- Capital District Physicians Health
- Amerigroup Corporation
- MVP Health Care
- Highmark
- Physicians Health Choice
- Coventry Healthcare
- Group Health Cooperative
- Colorado Access
- Aetna
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of Florida
- Regence Group
- Freedom Health
- Citizens Choice Health Plan
- ArchCare
- Health Spring
- Health Alliance
- The Health Plan
- Promedica Health Systems
- BlueCross Blue Shield of New Jersey
- CalOptima
- Emblem Health
- Excellus BlueCross BlueShield
- Presbyterian
- AultCare
- Molina Healthcare
- WellCare
- Universal American
- Inter Valley Health Plan
- Security Health
- National PACE Association
- Blue Cross Blue Shield of North Carolina
- Universal Health Care
- America's Health Insurance Plans
- Capital Health Plan
- Mercy Health Plans
- CMS
- ARDX

The primary purpose of the Encounter Data Work Groups is to provide a forum for communication between the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage Organizations (MAOs), and Third Party Submitters to determine and discuss issues while creating possible solutions for final implementation of Encounter Data.

The goals for this series of sessions for Chart Reviews and Data Submission for Chart Audits include:

- Identifying data collection methods for chart review,
- Submitting chart review data using the required 5010 format, and
- Determining best practices for validating data.

The expected discussion topics for this session were:

- Methodologies for collecting and managing the data volume for chart reviews and chart audits,
- Risks associated with collection of adjudicated claims data only,
- Editing and reporting processes to handle increased volume of duplicate data,
- The 12-month timely filing rule and its application in the submission of retrospective chart review data,
- Explanation of current chart review processes with information on the timing and scope of chart reviews,
- Identification of the percentage of risk adjustment payments derived from chart review activities, and
- Description of methods for integrating chart reviews with the Encounter Data Process.

## Understanding Current Processes to Collect and Submit Chart Review Data

In order to understand the impact of collection and submission of chart review data for the participants, it is important to identify the process currently used to collect and submit chart review data, and also develop an understanding of the impact of these processes on the volume of data collected and affect of this data on the MAOs' payment. The following table displays collection and submission processes identified by participants of the work group and information regarding the impact of chart reviews on the volume of data collected and payments made to the plan based on this data. Any additional details or concerns discussed regarding the transition to collection and submission of chart review data while implementing encounter data are also identified.

## Encounter Data Work Group

### Chart Reviews and Chart Audits

December 15, 2010



Process Identified	Data Volume Impact (%)	Payment Impact (%)	Additional Details
<ul style="list-style-type: none"> <li>Chart reviews are conducted twice annually—once in the spring and again in the fall.</li> <li>One to three chart reviews are conducted per member.</li> <li>Chart reviews are requested from providers, coded, and submitted via the risk adjustment system (RAPS).</li> </ul>	5%	10%	<ul style="list-style-type: none"> <li>The process is conducted over a 3-6 month timeframe and includes retrospective chart reviews requested for new enrollees.</li> <li>50-60% of diagnoses submitted by the plan are obtained primarily from chart review data.</li> <li>About 40% of chart review data triggers HCCs that had not been previously reported.</li> </ul>
<ul style="list-style-type: none"> <li>Two major chart reviews are conducted per year. However, chart reviews are requested and received continuously throughout the year.</li> <li>Retrospective chart reviews are conducted by an outside vendor. Medical records are requested by the health plan. Coders then review the records and collect diagnosis codes.</li> <li>Two RAPS files are created and submitted to CMS on a monthly basis.</li> <li>A higher volume of chart reviews are submitted as sweep dates approach to ensure chart reviews are counted by that sweep date.</li> </ul>	N/A	N/A	<ul style="list-style-type: none"> <li>Noted by a small plan, Chart reviews are conducted on 20,000 of the 75,000 beneficiaries enrolled.</li> <li>The plan is able to distinguish between data that was submitted from a chart review and data that was submitted from an encounter using the member control number.</li> <li>Concerns:                             <ul style="list-style-type: none"> <li>All diagnosis codes reported on a claim are not received by the plan due to claims processing systems limitations.</li> <li>Home health assessments will be impacted significantly by submitting chart reviews from encounter data.</li> <li>Managing deletion of erroneously reported diagnosis codes on claims.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Chart reviews are conducted once per year for the prior year.</li> <li>The chart review process begins in June and continues until the sweep date.</li> </ul>	Less than 5%	Less than 5%	<ul style="list-style-type: none"> <li>Noted by a large plan with approximately 313,000 beneficiaries.</li> <li>Plan does not have a high percentage of diagnoses obtained from chart reviews that were not originally submitted on a claim.</li> </ul>
<ul style="list-style-type: none"> <li>Diagnosis codes obtained from chart review data are submitted within the year of the date of service and the following year up until the submission deadline.</li> <li>This process is valued because they obtain codes that trigger HCCs that would not have been captured otherwise.</li> </ul>	Less than 10% (diagnosis codes)	N/A	<ul style="list-style-type: none"> <li>The 12-month timely filing rules will significantly affect the chart review process. Chart reviews are typically performed on claims that are older than 12 months. As a result, they would not be able to submit a significant amount of their chart review data causing a loss in revenue.</li> </ul>
<ul style="list-style-type: none"> <li>Internal staff (nurse practitioners, etc.) conducts annual member visits and the goals of this plan are to keep members out of the hospital and clinics.</li> <li>Internal diagnosis codes are compiled and sent to RAPS year round.</li> <li>Reconciliation is ongoing but in July, denials from CMS are reviewed and the records are retro-audited.</li> </ul>	70% - 75% of diagnosis submitted come from chart reviews	N/A	<ul style="list-style-type: none"> <li>Plan specific characteristics:                             <ul style="list-style-type: none"> <li>Dual eligible Special Needs Program</li> <li>1,100-1,200 beneficiaries</li> </ul> </li> <li>Makes up a significant part of the companies capitation rate and is a primary concern for the implementation of EDS.</li> </ul>

# Encounter Data Work Group

## Chart Reviews and Chart Audits

December 15, 2010



Process Identified	Data Volume Impact (%)	Payment Impact (%)	Additional Details
<ul style="list-style-type: none"> <li>Chart reviews are conducted once per year since only 2 coders are on staff.</li> <li>Diagnosis codes are obtained retroactively by reviewing drug or DME data.</li> <li>A chart audit worksheet, coded "CA," is produced and submitted to RAPS.</li> <li>A vendor is used for data submission to RAPS. However, an internal data reporting staff member puts the chart review data obtained into an excel spreadsheet.</li> </ul>	70% (diagnosis codes)	20%	<ul style="list-style-type: none"> <li>Plan has About 20,000 enrollees total                             <ul style="list-style-type: none"> <li>Chart reviews are conducted on 20% of beneficiaries.</li> </ul> </li> <li>The chart review process has more revenue impact because most vendors submit only four diagnosis codes.</li> <li>There are limitations in some of the Electronic Health Record (EHR) systems providers use that do not allow more than 4 diagnoses to be submitted on the claim form.</li> </ul>
<ul style="list-style-type: none"> <li>Chart reviews are mostly conducted following sweep dates.</li> <li>Both retrospective and prospective chart reviews are conducted.                             <ul style="list-style-type: none"> <li>Plan reports a strictly senior population and uses a third party service of nurse practitioners who visit members' homes.</li> </ul> </li> <li>Chart audits are performed throughout the year—a high volume of chart audits are conducted to capture the information.</li> <li>Volume of chart review data is very high during sweep periods, as this is the only way data is obtained.</li> </ul>	N/A	10% or greater	<ul style="list-style-type: none"> <li>California has a capitated market, which causes a problem in getting encounter data because claims are paid prior to getting the encounters.</li> <li>Much of the data comes in before the encounters because there is a major lag of 3 months or more in receiving encounters.</li> <li>Data is received in an excel spreadsheet and then put into the ICE format (which is an alternative submission method that does not include all required 5010 elements) for submission to RAPS.                             <ul style="list-style-type: none"> <li>The ICE format consists of a professional and institutional form.</li> <li>The forms come from an IPA or MSOs and are not directly received from the provider. The ICE format is specific to California.</li> </ul> </li> </ul> <p>Clarification of ICE format utilization:</p> <ul style="list-style-type: none"> <li>The ICE format is utilized to obtain diagnosis codes however a small amount of data is obtained from the ICE format originally.</li> <li>The majority of encounter data is submitted on the 837 form from delegated groups.</li> <li>There is a systems limitation for the number of diagnosis codes that can be submitted by a provider.</li> </ul>
<ul style="list-style-type: none"> <li>Chart reviews are conducted continuously throughout the year.</li> <li>A third party vendor submits separate file for chart audit data and RAPS data, and additional diagnosis codes are tied back to the original claim.</li> </ul>	10%	20%	<ul style="list-style-type: none"> <li>Dual eligible-Special Needs Plan with 35,000 beneficiaries.                             <ul style="list-style-type: none"> <li>Chart reviews are conducted on 30% of members per year.</li> </ul> </li> <li>Concerns:                             <ul style="list-style-type: none"> <li>There is no original encounter/claim to link chart review data obtained.</li> <li>Some rural providers only submit 4 diagnoses codes due to systems limitations.</li> </ul> </li> </ul>

## Encounter Data Work Group

### Chart Reviews and Chart Audits

December 15, 2010



Process Identified	Data Volume Impact (%)	Payment Impact (%)	Additional Details
<ul style="list-style-type: none"> <li>Chart review audits are conducted 2 times per year.</li> </ul>	N/A	N/A	<ul style="list-style-type: none"> <li>Plan has 50,000 beneficiaries:                             <ul style="list-style-type: none"> <li>Chart reviews conducted on 60-70% of members.</li> </ul> </li> <li>50% of providers only submit 4 diagnosis codes.</li> <li>Concerns:                             <ul style="list-style-type: none"> <li>Deletion of erroneous diagnosis codes submitted by the provider.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Data is submitted to CMS through a self-built custom application that generates the RAPS format</li> <li>An external application maps data back to the HIC# and an internal ID number to distinguish between data obtained from chart reviews and data obtained from claims submissions.</li> </ul>	32% (diagnosis codes)	N/A	<ul style="list-style-type: none"> <li>Plan attempts to conduct chart reviews on 85-90% of members annually.</li> </ul>

### Options for Submission of Chart Review Data

The following are the options identified during the work group regarding submission of chart review and chart audit data.

#### Option 1: Utilization of the PWK01 Segment Report Type Code

CMS suggested the use of the PWK01 segment field for submission of chart review data. Participants of the work group were asked to provide comments and suggestions regarding the use of this option for submission of chart review data.

- This segment allows CMS to flag chart review data and report information back to the health plan.
- This option involves populating the PWK01 segment field with code '09' (currently used for progress reports) to flag data as chart review data.
- Use of this code would enable other edits, in which data is not available, to be suppressed.

#### Issues Identified:

- Suppressing certain edits creates problems with select types of visits and providers, like DME and ambulance services.
  - The challenge will be getting data from providers who had not previously submitted data since no face-to-face visits were conducted.
  - Participants do not want a separate process for submission of chart review data to CMS.
  - Participants identified that it would be a challenge to see this data as one encounter.
- A process would need to be established with working with deleted data and using the PWK01 segment. Currently, many deletes are conducted due to over-coding issues.
  - One of the options within the CAS segment field would be translated to the purpose of submitting a deletion.
- Some beneficiaries may change plans during the year and the new plan may not have the original encounter data in which to link the chart review data.

#### Resolutions Discussed:

Participants discussed the development of a process similar to the current RAPS submission process, which would only require the submission of five necessary data elements for chart review data.

#### Option 2: Utilization of the CAS Segment

Participant suggested the use of the Claims Level Adjustment Segment (CAS) with codes CR (correction and replace) or OA (delete) to identify chart review data. This option involves using the CR or OA code to make a correction or deletion and then re-submit the claim as the plan wants it to be finalized. Some plans may favor sending an adjusted encounter. It is presumed that pricing may be more accurate by using CAS, but it is uncertain if separate encounters are submitted, the level of accuracy in the pricing.

#### Issues Identified:

- Many plans are unfamiliar with the fee-for-service process and have limited understanding of the manner in which MAOs will mirror that process.

- Would the original claim be withdrawn and re-submitted with the adjustment to CMS? Will this be one continuous encounter?
- Matching chart review diagnoses to the original claim would be a significant effort because a manual data look-up would have to be conducted.
- Chart reviews do not always have the original encounter data available, therefore a replacement could not be conducted if the original encounter data was missing.
- If chart review data is submitted as an encounter, then the paid amount would be equivalent to zero since it would not be a true claim.
- There is a risk for complications when using a variety of vendors for changing claims data. The original data may be lost when submitting updated data.

### *Resolutions Discussed*

- Use of the CAS segment to submit a new claim would supersede the previously submitted claim.
- The new claim would be submitted as the finalized claim and would essentially overlay the original.
  - Submitting an adjustment would involve resubmitting the old claim (claim that needed to be adjusted) using the CR code and that claim would become the final encounter claim that is saved in the system.
  - This is the initial thought however, rules for submission of chart review data have yet to be firmly established and will be developed as work groups are conducted.
  - Example: If one new diagnosis code needs to be added to an original claim containing 4 diagnoses the claim should be re-submitted with all 5 necessary diagnosis codes using the CR function. This claim would then be identified as the finalized claim.

### **Option 3: Development of a Separate Format for Submission of Chart Review Data**

One participant suggested the use of a completely separate format from the 5010 in order to submit chart review data. This option has not been fully explored with the work group participants at this time. Participants were asked to establish further guidelines and more information on the use of a separate format, if it is a viable option for consideration with chart review data submission.

Due to time constraints of the work group this option was not fully explored and information regarding how a separate format for chart review data submission would be structured is needed for further research on utilization of this option for encounter data implementation.

### **Identification of Chart Review Data in the Reporting Process**

CMS asked participants to identify the value of distinguishing between chart review data and claims data as part of the reports returned to health plans following claims submissions.

#### *Responses:*

- Currently, plans are able to identify if data was obtained from a chart review or a claim following submission since the patient account identifier maps back to the encounter in the MAOs system.
- Health plans request reporting standards similar to what is currently reported (at a minimum). It is imperative to know what data was accepted, deleted, or rejected. Minimally, plans need detailed diagnosis information.

- It is valuable to distinguish between chart review data and claims data as some MAOs use this information to train and educate providers to be more accurate in their coding. It is ideal to have these types of data reported separately.

### Questions Addressed Throughout the Work Group

The following are additional questions discussed by participants during the Chart Review and Data Submission for Chart Audits Work Group.

#### Questions asked by Participants

**Q1: Will submission of chart review data be accepted on the 837 file format?**

**A1:** Chart review data must be submitted to CMS in the 5010 837 format.

**Q2: Using the 5010 837 format means there are certain fields that won't be available. What data is needed for risk adjustment?**

**A2:** CMS has not made a decision about how missing fields will be submitted. CMS must first obtain feedback from the health plans and then recommendations for submission of these fields will be developed as a group.

**Q3: What is the anticipated release date for the companion guide?**

**A3:** CMS has not yet published a companion guide. CMS is working to make decisions to complete the Companion Guide. In the mean time, on a weekly basis as decisions are made CMS will send information as decisions are made and communicate through the work groups.

**Q4: Can you confirm that one claim equals one encounter?**

**A4:** As of now we are going with the assumption that one claim equals one encounter.

**Q5: How should health plans respond to the work group discussion topics following close of the session?**

**A5:** Participants of the work group will be added to the distribution list for dissemination of updates or other information. Additional comments or questions can be submitted to [eds@ardx.net](mailto:eds@ardx.net).

**Q6: Could chart review data be submitted to CMS as a separate file from the health plan's system? Or would it have to be one large file combined with other claims data?**

**A6:** This depends on your business process flow. The 5010 format must be in tact but there is no rule currently regarding separation of chart review and claims data as it is submitted.

**Q7: Is CMS going to be requiring many more data fields than what is required on a basic claim?**

**A7:** No, there will not be more required data fields than what is required on a basic claim (5010) .

**Q8: How do plans delete and add codes at the same time?**

**A8:** There will be a workgroup on deletions and submissions. The details of options for submitting and/or correcting previously submitted data will continue to be discussed.

**Q9: Would CMS consider relaxing edits that are not necessary to pricing?**

**A9:** CMS is currently in the process of analyzing existing edits and determining which are appropriate to encounter data collection. There are no final decisions as of yet but this is being considered.

### Key Conclusions and Recommendations for Encounter Data Chart Reviews and Data Submission for Chart Audits Work Group

Based on the information discussed in the Chart Reviews and Data Submission for Chart Audits Work Group held on December 15, 2010, the following recommendations are provided to CMS to ensure successful implementation of the collection of encounter data.

#### *Recommendations*

- Although further exploration is needed of the appropriate segment to identify chart review data, it appears that the PWK01 element may be the best and most successfully implemented option.
- Further conversations with this work group will need to discuss in more detail needs of the reports that are beneficial to MAOs with the submission of chart review data within the encounter data system.

#### *Action Items and information needed from Participants*

The next Encounter Data Work Group will be held for Chart Reviews and Data Submission for Chart Audits on February 16, 2011.

By Wednesday December 22, 2010, work group participants should send the following items to [eds@ardx.net](mailto:eds@ardx.net):

- Additional details of the chart review process including how chart review data is collected and submitted to CMS.
  - Percentage of data coming from chart reviews (data impact).
  - Percentage of payment based on chart review data collected (payment impact).
- Information on systems limitations from both the providers and claims processing perspectives (ICE format limitations, etc)
- Suggestions/recommendations regarding the three options discussed for submitting chart review data to CMS:
  - PWK segment-Allows CMS to flag chart review data and report back to the health plan
  - CAS segment-Using the CR function for corrections or deletions and then re-submitting a finalized claim
  - Creation of a separate format for submission of chart review data-This option was not discussed thoroughly during the work group session and details are needed regarding structure of a separate format.