Risk Adjustment Data Validation Study
Frequently Asked Questions

MEDICAL RECORD SUBMISSION

Q1: Can medical groups gather all the medical records for the data validation and send them all at once?

A1: Please do not wait until you have all of your records to send them. Medical records should be submitted to SCAN for data validation as your organization receives them from your providers. You must select the "one best medical record" for each HCC being validated.

Q2: Does the provider have to mail the requested medical records or is that the responsibility of the medical group?

A2: Instruct your providers to submit all requested medical records for validation directly to your organization. Your medical group is responsible for submitting the medical records to SCAN via traceable carrier as soon as possible.

Q3: Does the medical group have to submit a medical record to support each ICD-9 code on the coversheet?

A3: No, the medical group has to submit a medical record to support each HCC. More than one ICD-9 diagnosis code can support a single HCC.

Q4: Only ONE record total is needed to support each HCC requested. Is this correct?

A4: Yes, this is correct. Your organization only has to submit the one best medical record to support each unique member HCC.

Q5: When we start to send our medical record documentation to you, what do you mean by a traceable carrier? Is United States Postal Service allowed if we get a trace number?

A5: A traceable carrier is one with mechanisms for your medical to track your package in case there is any problem with the delivery. SCAN requires a traceable carrier when shipping any Protected Health Information. The U.S. Postal Service has the ability to track your package and is considered a traceable carrier. Some other examples of traceable carriers are Federal Express, UPS, DHL, etc.

Q6: Can the provider use only a signature stamp for office encounters?

A6: Signature stamps WERE an acceptable form of medical record authentication in many states and with the Joint Commission of Accreditation of Hospitals (JCAHO), providing the physician has a current signature stamp authorization document on file. This document states that the physician attests that he/she is the only person allowed to use the signature stamp in medical record documentation and the signature stamp is securely stored to prevent unauthorized use. Essentially, other people (staff or non-staff) cannot stamp notes on behalf of the physician. As some states may still prohibit rubber stamp signatures, each MA organization must check the applicable state regulations with their legal counsel. CMS no longer allows signature stamps as of 3/28/08 for all Medicare Fee for Service claims. They have not yet prohibited signature stamps for MA, but physicians probably should not have two separate procedures for Medicare FFS and MA. If you are submitting notes with a signature stamp, please submit a copy of the physician attestation on file.

Q7: Is the typed signature on the report acceptable for office consult notes, discharge summary, and hospital consults?

A7: No. If the note is dictated, there must be a physical signature. If the note is from an electronic medical record, then the signature cannot be a typewritten name alone. It must indicate “signed by”, “electronically signed by”, “digitally signed by” or other wording indicative of a signature.

Q8: Are medical records containing dictated progress notes that are dated but not signed acceptable for medical record review?

A8: Medical record documentation should be signed and dated by the physician, and contain the beneficiary's name.However, if the record is an inpatient medical record and if there is sufficient signed documentation in the record to substantiate the diagnosis, the coder may use other signed documentation to appropriately code the member’s principal and secondary discharge diagnoses. The medical group will need to determine on a case-by-case basis if this is an appropriate record to substantiate the HCC.

Q9: If there are multiple dates of service for an HCC, why does the form state that only one record should be checked instead of multiple? Which one should be submitted?

A9: The coversheet lists all dates of service and ICD-9 CM codes that were submitted by your medical group for each member HCC. Although there may be multiple dates of service for a given member HCC, you should submit a medical record for only one date of service or

discharge. As an option, you may submit an "in lieu of" medical record from an appropriate visit/discharge for a date of service that was not submitted to SCAN as long as it's intended to support the selected HCC.

Q10: In your instruction materials in section titled "The Medical Record," you list chart components that the medical group "should include" for validation of each HCC. For inpatient medical records, are you requiring submission of all those components listed or only those documents that provide clear documentation of the applicable diagnoses? My understanding from the training was that documentation submitted should clearly reflect the member and the documentation of the diagnosis for the date of service; you did not want/need the whole inpatient record.

A10: For inpatient stays - If you are submitting a medical record to be reviewed as an inpatient stay, we strongly encourage medical groups to submit the entire medical record for the discharge that you select. The term "should include" was intended to be informational. For example, a medical admission may not have any pathology reports. The medical record coders would generally need the entire record to review/code the principal diagnosis and any secondary diagnoses.
For outpatient hospital visits and practitioner office visits - Please submit the medical record documentation for the one service/visit date that you select.

Q11: Can we use a highlighter to mark the areas of the medical record we think support the ICD-9-CM code?

A11: Yes, please note, however, that the medical record coders will review the record and abstract codes based on established coding guidelines, not based on highlighted areas of the chart.

Q12: How are data from skilled nursing facilities (SNFs) captured?

A12: Medical records from SNFs are only acceptable if the physician encounter submitted to RAPS occurred during the beneficiary stay at the SNF. In other words, there must have been a physician encounter submitted to CMS for the date that the physician visited the beneficiary in the SNF.
In some instances, a SNF medical record would contain the associated physician encounter information and is the only form of documentation available to support an HCC. When this occurs, the medical record is responsible for indicating on the cover sheet, the corresponding date of service in the SNF record for the physician encounter submitted to SCAN. If no physician encounter was submitted from the SNF stay, the SNF medical record would not be an acceptable form of documentation

for medical record review. We recommend that you send documentation from a SNF only if there are no other forms of documentation available to support a beneficiary HCC.

Q13: Our medical group received a medical record with an unsigned practitioner visit. Can we go back to the physician and have him/her sign the record?

A13: Medical records should be signed by the practitioner on a timely basis. Going back and obtaining a signature months after the service date is unacceptable. Please submit another signed record to substantiate the HCC.

Q14: The coversheet has a range of dates for PHYSICIAN or OUTPATIENT service dates. Do I need to submit the record for all dates?

A14: No, please submit a medical record for the one service date that substantiates the HCC. Write on the coversheet the one service date that your medical group selected.

Q15: Are practitioner visits during a hospital admission acceptable as "PHYSICIAN" records? If yes, what coding rules will apply to these records?

A15: If a member has an inpatient hospital discharge that supports the HCC, it is usually best to select the inpatient discharge and submit the entire inpatient medical record for coding. However, if the entire inpatient medical record cannot be obtained, the organization can submit medical record documentation from an inpatient physician visit for review and it would be reviewed in accordance with the Diagnostic Coding and Reporting Guidelines for Outpatient Services. When submitting these forms of documentation please note the following: In the outpatient setting, coders do not code diagnoses documented as "probable" "suspected," questionable," or "rule out" but rather coders code the condition to the highest degree of certainty for that encounter/visit (i.e., symptoms, signs, abnormal rest results.) This limited documentation may not support the HCC. Acceptable inpatient physician visit medical records are: inpatient history and physical examinations, progress notes, consultation reports, and discharge summaries. When submitting medical record documentation from an inpatient physician visit, the organization has two options:

1. Select a service date from the stored risk adjustment data listed in Section 3A of the coversheet (i.e., RAPS data) for a PHYSICIAN visit. The RAPS record most likely was for the physician claim for inpatient visit services. Be sure that the record you are submitting exactly matches the date of the selected service date. For example, the coversheet is

checked with a service date of 9/5/2003 through 9/5/2003 and a signed inpatient physician consultation report dated 9/5/2003 is attached for review.

2. Submit an “in lieu of” medical record by completing Section 3B of the coversheet for a PHYSICIAN visit. Be sure that the record you are submitting exactly matches the date of the selected service date. For example, Section 3B of the coversheet has a service date of 10/3/2003 through 10/3/2003 and a signed inpatient physician admission history and physical examination report dated 10/3/2003 is attached for review.

Should the coversheet not indicate that the documentation was intended to support a PHYSICIAN visit, the record would be considered as an inpatient stay; thus rendering the stay invalid or insufficient to code.

Q16: If a plan discovers the medical record does not support the Member's HCC, does SCAN want a Corrective Action Plan submitted along with the medical record or would you (SCAN) prefer a brief note attached to the Medical Record Coversheet & medical record? Or, can the plan submit a deletion to SCAN for the date of service (*) that equated to this HCC being assigned to our Member?

A16: No, do not submit a Corrective Action Plan to SCAN. We recommend you exhaust all your efforts to locate the one best medical record to support the HCC being validated. If you have in fact confirmed that no medical record to support the Member's HCC exists from the various provider types (hospital inpatient, hospital outpatient and physician data), please wait until the appeals process has been completed. Then, SCAN will submit a deletion to CMS for the date of service that equated to this HCC being assigned to your member. On the coversheet, please check Section 1 "No medical record is submitted to support this member and HCC." You must submit the coversheet to SCAN, and indicate in Section 4 the reason why no medical record will be submitted.

Q17: If the discharge date is in 2008 but the admission is in 2007, can a medical group submit a signed and dated History and Physical as an in lieu of "physician" record when the History and Physical was done in 2002?

A17: No, since the service date is in 2007, and the date on the physician claim for this service would be in 2007, the History and Physical examination (submitted as an in lieu of "PHYSICIAN" record) would not be a valid record for the CY2008 SCAN RADVS. However, since the

discharge date was in 2008, the inpatient stay record (submitted as an "INPATIENT" record) would be a valid record.

Q18: For a medical record that SCAN indicated is unsigned, the medical facility or physician office has stated that standard practice in their office does not include dictation being signed by the physician. If we are able to obtain a signature for this particular office visit, would the medical record support the HCC?

A18: CMS' position is that medical records should be signed by the practitioner on a timely basis. Going back and obtaining a signature months after the service date is unacceptable to CMS. Therefore, we request that the medical group obtain another signed visit to support the HCC.

Q19: If my organization already submitted a medical record to SCAN and I now have a better record to support the HCC, can I resubmit a corrected coversheet and the new record?

A19: No, your initial submission to SCAN is the one that will be accepted for this validation.

HCC/DIAGNOSIS SPECIFIC

Q1: If the HCC level that has been requested for validation is part of a hierarchy, (for example, HCC 19 - Uncomplicated Diabetes), there is a possibility that the medical record review may actually support a higher HCC. If this is the case, should the 'In Lieu of' section be used to document this? If this is the case, the HCC to be validated is already populated, should this be crossed out and the proposed new HCC level be written in below it?

A1: No, in this example, we are validating HCC 19 which is based on data from the RAPS database. The medical record that you submit must support the HCC that is intended for validation (in this case HCC 19). MA medical groups should not alter any of the pre-populated RAPS data on the medical record request coversheet. You may choose to send a medical record corresponding to the dates of service in one of the RAPS records for HCC 19 or you could use the "in lieu of section" of the coversheet to submit another medical record that would still support HCC 19.

Q2: For each member on the data validation list, all HCCs based on data sent to date are requested for validation. If a new condition is found during the medical record review, can this or should this be sent in addition to the requested HCCs?

A2: Do not submit medical records for new conditions. If the medical group finds new conditions based on the organization's medical record review, your organization could submit the new diagnosis data to SCAN to support the conditions. The data submission period is still open. New conditions that are identified by our coders during the validation medical record review will be compared to all data submitted for an member following our selection process to determine the extent to which the conditions are actually new (i.e., never submitted to CMS by the MA organization for payment). The CY 2008 risk adjustment data validation is only validating data already submitted to CMS at the time of the selection process.

Q3: If there are multiple dates of service, each supporting the same HCC, do we need to obtain records for each date of service?

A3: No, the medical group should select the "one best medical record" to support an HCC. The one best record may correspond to a date of service submitted to CMS and shown in the RAPS dataset, or it may correspond to a medical record for which information was not submitted to CMS and does not appear in the data submitted to CMS. In the latter of the two scenarios, the medical group may submit this

record as an ‘in lieu of’ record and indicate so in the coversheet section 3B. In any case, staple the coversheet for the HCC to the medical record that supports it.

Q4: What if there is one medical record that supports multiple HCCs?
A4: One medical record can support more than one HCC. Staple the coversheet for each HCC to the medical record that supports it. Do not copy the same medical record for each HCC. For each HCC being supported by the medical record, the respective coversheet must indicate the dates of service selected to support the HCC.

Q5: Is there any available data on mapping ICD-9 codes to the HCC level? This could make the medical record retrieval process more efficient.
A5: Yes, there is available data on the CMS website (http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp). The file labeled Risk model diagnosis codes includes the mapping from diagnosis code to HCC, titled “current model diagnoses”. This document is a helpful reference point in mapping ICD-9 codes to their respective HCCs.

Q6: The diagnosis selected to be verified for a particular patient is an invalid diagnosis code, how should we proceed?
A6: We are validating HCCs that were generated from diagnosis codes that were submitted for risk adjustment payments. If you identify an invalid diagnosis code (based on the date submitted) or a code that does not support the HCC being validated, please complete and return the coversheet to SCAN. Please check the appropriate box in Section 1 indicating that you are not submitting a medical record and complete Section 4 on the coversheet.

Q7: One of the charts we were given had code 250.50 (Diabetes with Ophthalmic manifestations). Our nurse spoke to the ophthalmologist when reviewing this chart because the only documentation was that the patient had diabetes and needed glasses. The ophthalmologist stated if a patient has diabetes and has anything wrong with their eyes or vision this is the code he uses. I thought eye problems had to be related to the diabetes. Can we use 250.50 for any eye problems or vision problems as long as the member is diabetic?
A7: The answer is no to ophthalmologist. The medical record documentation may say "with diabetes", however, this does not necessarily mean that the condition is due to diabetes. The physician must identify a direct relationship by documenting statements such as "due to", "caused by” or "secondary to” before diabetic complication (250.5X diabetic with ophthalmic manifestation) codes are assigned.

DIAGNOSTIC REPORTS

Q1: The only supporting diagnosis we have for the HCC is from a chest x-ray. Is this an acceptable submission? If not, what should we do?

A1: No. Radiology services are not acceptable for risk adjustment purposes.

Q2: What do I do if the only diagnosis for a given HCC and patient, is a lab claim? Can a radiology or pathology report alone be sufficient for Medical Record Review?

A2: Laboratory claims and all other claim forms or superbill forms are not acceptable documentation. Pathology and other laboratory reports present the actual results of the laboratory test and generally do not have a documented diagnosis and physician signature. When a prior or subsequent physician visit medical record is reviewed, our coders can find that the diagnosis on the claim for the laboratory service was a "rule out" diagnosis. We suggest that you check your claims system for claims/encounters for this member on dates close to the laboratory test date. If there are such claims, request the records from the PCP or other practitioner visits for dates just before and after the laboratory test date to see if perhaps the diagnosis was documented but not coded by the practitioner's office. The practitioner visit medical records can be submitted as an “in lieu of” medical record. See the above response to Question 1 regarding radiology reports.

Q3: If the only documentation in the chart of an old MI is on an EKG, can we use ICD9 code 412 and submit it as a physician visit?

A3: Every medical record is different. In some instances, an EKG report with the diagnosis documented on the report and a physician signature is acceptable documentation to code a diagnosis of 412 (old myocardial infarction).

ELECTRONIC COPIES

Q1: We have electronic medical records containing admission notes, discharge summary and consult notes that we can print off our system. These medical records are signed electronically by the physician. If this is the one best medical record, will CMS accept what we have printed/copied off our system?

A1: An electronic medical record that is authenticated by the physician is perfectly acceptable. A medical record with only admission notes, discharge summary and consultation notes generally is not sufficient to code an inpatient medical record. The coder will abstract all diagnoses supported by the information in this record; if the information is not sufficient for the coder to make a determination of diagnoses, then the record will be classified as insufficient to code rendering HCC discrepant. The above information also applies to hardcopy medical records.

Q2: Are electronic signatures acceptable?

A2: Electronic signatures by the actual provider of services are an acceptable form of authentication. There must be an "electronic signature" authentication indicated on the medical record. Systems should be designed for authentication after each entry for a date of service is typed and reviewed, not just upon logging into the system. Examples of acceptable electronic signatures include: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," Finalized by," "Validated by," – followed by the practitioner's name.

EXTENSIONS

Q1: Will SCAN grant any extensions on data submission to SCAN for the medical record review?

A1: No extensions are planned at this time. We recommend that you continue all efforts to obtain medical records from your providers.

RISK ADJUSTMENT DATA VALIDATION MEDICAL RECORD REQUEST AND SUBMISSION PROCESS GUIDANCE

The following guidance reflects recurring problems that were identified upon receipt of medical records submitted by MA medical groups. To better assist you with the requirements of the medical record submission process, please take into consideration the following:

1. Do not submit medical records for dates of services that are outside of the data collection period. The data collection period for the CY 2008 data validation consist of dates of services that occurred between January 2008 and October 31, 2008.
2. All submitted documentation must be signed by a practitioner. Electronic signatures are acceptable, but there must be indication of the electronic signature or authentication by the practitioner.
3. If you select an inpatient discharge to substantiate an HCC or HCCs we strongly encourage submitting the entire medical record (i.e. progress notes, physician orders, admission history and physical, discharge summary, diagnostic test reports, etc.) Do not just submit parts of the record that may state the diagnosis (e.g., do not just submit a discharge summary as an inpatient record.)
4. The medical record must contain the date indicated for review by the MA organization on the coversheet (in either section 3A or 3B). If you are submitting documentation for a physician visit that is part of an inpatient record, make sure that the visit date that you select has an associated physician note on the same date in the medical record.
5. If one medical record substantiates more than one HCC selected for review, attach each HCC coversheet to the respective medical record. Do not make multiple copies of the same medical record.
6. Do not submit medical records for multiple outpatient or physician visits for a given HCC. Submit only the “one best record” to support the member HCC for a face-to-face visit that occurred within the data collection period.
7. Do not submit loose documentation and documentation with only paper clips for physician office and hospital outpatient visits. 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 is hard to do with large inpatient medical records. If necessary, please rubber band the coversheet to the record.
8. Do not submit copies of prescriptions to be reviewed as a form medical record documentation.

9. Do not submit blank coversheets. Complete and submit all coversheets, even if you are not submitting a medical record. If you are unable to submit medical record(s), you must complete the following sections of the coversheet for each member HCC:
    a. Section 1- No medical record submitted to support this member and HCC
    b. Section 4 - Provide the reason that the medical record could not be submitted
    c. Section 5 - Contact person
10. Do not check multiple visit dates on a single coversheet. You should only check the date of service and corresponding provider for which the medical record is intended to support.
11. Do not clip records for multiple members together. Keep records for different members separate.
12. Do not submit more than one coversheet for a given HCC. If you submit more than one coversheet for one HCC, the first coversheet received will be used for the validation.