Presentation Objectives

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

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Risk Adjustment Data Validation

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

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Risk Adjustment Data Validation: New Approaches

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

2007 RADV Project Parameters

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

Risk Adjustment Data Validation

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

Risk Adjustment Data Validation Guiding Principle

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

Risk Adjustment Discrepancy

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

Medical Record Review Overview

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

Risk Adjustment Data Validation Process

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

Sampling

STAGE 1

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

Medical Record Request

STAGE 1

Three segments

- Request
- Submission (MAO Response)
- Receipt

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Request Process (continued)

STAGE 1

Request

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

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Request Process (continued)

STAGE 1

Submission (MAO Response)

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

Request Process (continued)

STAGE 1

Submission (MAO Response)

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

Request Process (continued)

STAGE 1

Submission (MAO Response)

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

Request Process (continued)

STAGE 1

Submission (MAO Response)

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

Request Process (continued)

STAGE 1

Receipt

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

Medical Record Review

STAGE 2

GOOD DOCUMENTATION = ACCURATE PAYMENTS

Visit

Document Visit

Submit and Obtain Risk Adjusted Payment

Assign Diagnosis Code

Medical Record Review (continued)

STAGE 2

Requirements for Documentation Submitted for Medical Record Review

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

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Medical Record Review (continued)

STAGE 2

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

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Medical Record Review (continued)

STAGE 2

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

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Medical Record Review (continued)

STAGE 2

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

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Medical Record Review (continued)

STAGE 2

Types of Acceptable Physician Signatures and Credentials	
Hand-written signature or initials, including credentials	• *Mary C. Smith, MD; or MCS, MD*
Signature stamp, including credentials	• Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	• Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by") • Must be password protected and used exclusively by the individual physician

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Medical Record Review (continued)

STAGE 2

Types of Unacceptable Physician Signatures and Credentials	
TYPE	**UNACCEPTABLE unless…**
Typed name	• Authenticated by the provider
Non-physician or non-physician extender (e.g., medical student)	• Co-signed by acceptable physician
Provider of services' signature without credentials	• Name is linked to provider credentials or name on physician stationery

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Medical Record Review (continued)

STAGE 2

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

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MRR Findings and Contract-Level Payment Adjustments

STAGE 3

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

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Documentation Disputes

STAGE 4

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

Post Documentation Dispute- Payment Adjustment

STAGE 5

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

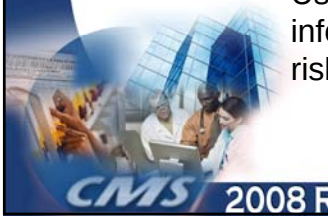
Appeals

STAGE 6

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

Recommendations & Lessons Learned

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



Recommendations & Lessons Learned to Date (continued)

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

CMS Data Validation Team

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

EVALUATION

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

THANK YOU!