CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Risk Adjustment for EDS & RAPS Webinar

Thursday,

September 29, 2016

Agenda

- Introduction
  - Session Guidelines
  - Upcoming User Group calls
- EDS Filtering Logic
- MAO-004 Report Fields
- Model Implementation
- National Provider Identifier (NPI)
- Top EDPS Reject Edits Prevention/Resolution
- EDS Report Restoration
- Q & A

Introduction

Session Guidelines

- This is a one hour webinar session for MAOs and other entities submitting data to the Encounter Data System.
- There will be opportunities to submit questions via the webinar QA feature.
- For questions regarding content of this webinar, submit inquiries to the CMS Encounter Data mailbox at: EncounterData@cms.hhs.gov.
- Today's webinar slides are posted on the CSSC Operations website under *Medicare Encounter Data>User Group*. The Q&As will be posted in the coming weeks at the same location.
- Please refer to http://tarsc.info for the most up to date details regarding Encounter Data training opportunities.

Upcoming Encounter Data and Risk Adjustment User Group Calls

- CMS plans to hold monthly user group calls to address topics related to risk adjustment data (EDS and RAPS data submissions)
- Next Session: October 20, 2016
- The topics and dates will be posted on http://tarsc.info

CMS Encounter Data Filtering Logic

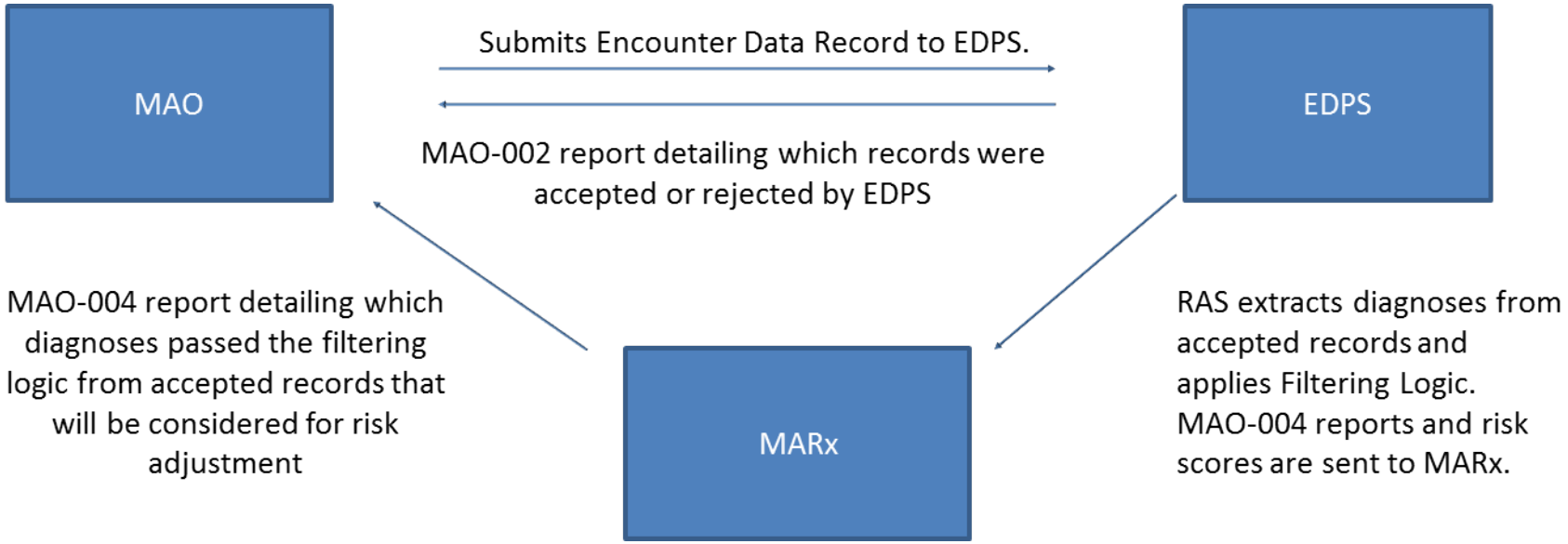
CMS Encounter Data Filtering Logic Background

- When CMS calculates beneficiary risk scores, it uses diagnoses from the prior year, whether they were submitted by a FFS provider, or by a plan.
- For a diagnosis to be eligible for risk adjustment, it must be documented in a medical record from an acceptable provider type (hospital inpatient, hospital outpatient, or professional) and the result of a face-to-face visit. The objective of these rules is to ensure that we only use reasonably definitive diagnoses to predict costs. CMS has further established rules regarding which inpatient and outpatient facilities, and which professional encounters, are acceptable sources for risk adjustment-eligible diagnoses.

CMS Encounter Data Filtering Logic Background (continued)

- Historically, Medicare Advantage Organizations (MAOs) have done their own filtering and submitted to CMS risk adjustment eligible diagnoses in a minimum data set to the RAPS. Therefore, CMS has not needed to filter diagnoses submitted by MAOs in order to calculate risk scores.
- In submitting encounter data, unlike in RAPs data, MAOs are required to submit the full breadth of information regarding services furnished to a beneficiary. CMS must identify those diagnoses that meet risk adjustment rules.

Overview of the Encounter Data Filtering Process



CMS Encounter Data Filtering Logic

- The CMS filtering logic will extract (i.e., filter) diagnoses from all Institutional Outpatient, Institutional Inpatient, and Professional encounters that are submitted and accepted by the Encounter Data System (EDS), with dates of service in the applicable data collection year. For example, for payment year 2015, CMS would select the most recent version of an encounter data record with dates of service from 1/1/2014 to 12/31/2014.
- For Risk Adjustment, CMS only considers the most recently accepted record. If a replacement encounter is submitted for the original, the diagnoses on the replacement encounter will be the only diagnoses considered for risk adjustment. If a void encounter is submitted for the original, the diagnoses on the original encounter will not be considered for risk adjustment.

CMS Encounter Data Filtering Logic (continued)

- For accepted institutional encounter data records, CMS will determine whether or not diagnoses are from a risk adjustment acceptable facility. CMS will use the Type of Bill Code for Inpatient and Outpatient encounter data records to determine if the diagnoses are from an acceptable source.

Institutional Inpatient Acceptable Type of Bills	Medicare Bill Type Code	Label (first 2 digits)
	11X	Hospital based or Inpatient (Part B only) or home health visits under Part B
	41X	Hospital Outpatient
Institutional Outpatient Acceptable Type of Bills	12X	Hospital based or Inpatient (Part B only) or home health visits under Part B
	13X	Hospital Outpatient
	43X	Religious Nonmedical (Outpatient)
	71X	Rural Health Clinic
	73X	Free-standing Clinic
	76X	Community Mental Health Center (CMHC)
	77X	Clinic FQHC Federal Qualified Health Center
	85X	Special Facility Critical Access Hospital (CAH)

CMS Encounter Data Filtering Logic (continued)

- For accepted Professional and Institutional Outpatient encounter data records, CMS will evaluate accepted lines on the record to determine if the CPT/HCPCS codes are on the acceptable Medicare Risk Adjustment CPT/HCPCS list (also referred to as the "Medicare CPT/HCPCS list"). If there is an acceptable CPT/HCPCS code on at least one accepted line in the record, CMS will accept all of the header diagnoses on that record.
- If there are no acceptable CPT/HCPCS codes on any of the lines on the record, then CMS will not consider any of the diagnoses on the record for risk adjustment.
- All diagnoses from Institutional Inpatient encounter data records with acceptable TOBs will be considered for risk adjustment regardless of the procedures performed during the encounter.

CMS Encounter Data Filtering Logic (continued)

- For each payment year, CMS will publish a preliminary Medicare CPT/HCPCS code list at the start of the data collection period. This list may be updated quarterly with a final list published in the fourth quarter of each data collection year.
- CMS will review the new, revised, and deleted CPT/HCPCS codes at the beginning of each quarter. If CMS determines that a new or revised CPT/HCPCS code could result in a risk adjustment eligible diagnosis, that CPT/HCPCS code will be added to the Medicare CPT/HCPCS code list.
- All CPT/HCPCS codes that are determined to be eligible at any point in the data collection period will remain eligible for the entire data collection period.

CMS Encounter Data Filtering Logic (continued)

CMS applies risk adjustment rules when developing its criteria for inclusion and exclusion of CPT and HCPCS codes for the Medicare Risk Adjustment CPT/HCPCS code list. A selected list of the criteria is listed below:

- Procedures that indicate a face-to-face visit with a physician or other qualified health professional (QHP) from which a definitive diagnosis could be attained. Procedures done by technicians or non-QHPs are excluded.
- Physician planning time codes (e.g., for operative or therapeutic radiation procedures) that would likely include diagnoses related to the planned procedure.
- Chronic care management codes that would likely include diagnoses. Procedure codes that are used for quality reporting and functional limitation reporting (not primary source for diagnoses if unaccompanied by allowable CPT code on another service line).

CMS Encounter Data Filtering Logic (continued)

- Diagnostic testing codes if they also include a non-diagnostic procedure/treatment
- Face-to-face procedures for device evaluations that include diagnoses from ongoing conditions that might not otherwise be recorded
- Special ophthalmological services where the ophthalmologist is both the ordering physician and the professional who can diagnose based on the findings
- Procedure codes that correspond to diagnostic radiology/lab/pathology or testing procedures are excluded because the resulting diagnosis would appear on a separate claim by the ordering physician/QHP

CMS Encounter Data Filtering Logic (continued)

Chart review records allow plan sponsors to submit encounter data records that reflect their reviews of medical records (called “chart review” records). These records allow a plan sponsor to:

1. Submit additional diagnoses that were not submitted when the encounter was reported, but were later found to be associated with the encounter through a chart review.
2. Delete diagnoses via linked chart review that had been submitted on an encounter, but were later found to be unsupported by the medical record.

CMS Encounter Data Filtering Logic (continued)

Chart review records will be filtered according to the same methodology as encounter data records.

1. CMS will select chart review records with “through” dates in the data collection period.
2. Added diagnoses will be filtered according to the same methodology as non-chart review encounter records.
3. If a risk adjustment eligible diagnosis is deleted through a chart review record, it will no longer be considered as eligible for risk adjustment.

Overview of MAO-004 Report with Recent Changes

Definitions

Phase I MAO-004 Reports: These are the reports the MAOs have been receiving since December 2015

Phase II MAO-004 Reports: These are the reports the MAOs will be receiving in the fall of 2016 with the revised template.

Revised MAO-004 Header Record Changes

Phase 1

#	Field Name	Field Length	Starting Position	Ending Position	Format & Comments
11	Submission Interchange Number	30	80	109	• Alpha Numeric • Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)

Phase 2

#	Field Name	Field Length	Starting Position	Ending Position	Format & Comments
11	Filler	30	80	109	Spaces

Revised MAO-004 Detail Record Changes

Phase 1

#	Item	Length	Starting Position	Ending Position	Format & Comments
11	Replacement Encounter Switch	1	75	75	• Alpha Numeric • Encounter Replacement switch will identify if there was a replacement received.

Phase 2

#	Item	Length	Starting Position	Ending Position	Format & Comments
11	Encounter Type Switch	1	75	75	• Alpha Numeric • This field can take on 9 different values: "1" = original encounter, "2" = Void to an original Encounter, "3"= Replacement to an original Encounter, "4" = Linked Chart Review, "5"= Void to a Linked Chart Review, "6"=Replacement to a Linked Chart Review; “7”=Unlinked Chart Review; “8”=Void to an unlinked chart review; “9”=Replacement to an unlinked chart review

MAO-004 Report Details Section

Phase 1

#	Item	Length	Starting Position	Ending Position	Format & Comments
25	Diagnosis Code	7	160	166	• Alpha Numeric • ICD-9 codes will be accepted prior to the ICD-10 implementation date. Only ICD-10 codes will be accepted starting with ICD-10 implementation date.
26	Diagnosis ICD	1	167	167	• Alphanumeric • ICD code for Diagnosis (9 or 0)
27	Delimiter	1	168	168	• Alphanumeric • Uses the * character
28	Diagnoses codes	324	169	492	• Alphanumeric • Additional Diagnoses codes up to 36 including the ICD codes and the * delimiters
29	Filler	8	493	500	• Alphanumeric • Spaces

MAO-004 Report Details Section (continued)

Phase 2

#	Item	Length	Starting Position	Ending Position	Format & Comments
25	Diagnosis Code	7	160	166	• Alpha Numeric • ICD-9 codes will be accepted prior to the ICD-10 implementation date. Only ICD-10 codes will be accepted starting with ICD-10 implementation date.
26	Delimiter	1	167	167	• Uses the * character
27	Diagnosis ICD	1	168	168	• Alphanumeric • ICD code for Diagnosis (ICD9=9 or ICD10=0)
28	Delimiter	1	169	169	• Uses the * character
29	Add or Delete Flag	1	170	170	• Alphanumeric • This will flag a diagnosis if it is an add or delete. A=Add, D=Delete. Original encounters which Add diagnoses, and Replacements that effectively Add or Delete diagnoses, shall be flagged with A or D accordingly. Replacements that have no effect on the diagnoses submitted in the Original encounter are not reported again in the MAO-004 report in the submission month of the Replacement, as the diagnoses in the Original submission stand as originally submitted.
30	Delimiter	1	171	171	• Uses the * character
31	Diagnoses codes	288	172	459	• Alphanumeric • This field represents up to 11 (for Professional) or up to 24 (for Institutional) occurrences of the diagnosis codes along with the corresponding Diagnosis ICD and Add or Delete flag (field #25-30 values).
32	Filler	41	460	500	• Alphanumeric • Spaces

PY 2017 CMS-HCC Model Implementation Revisions

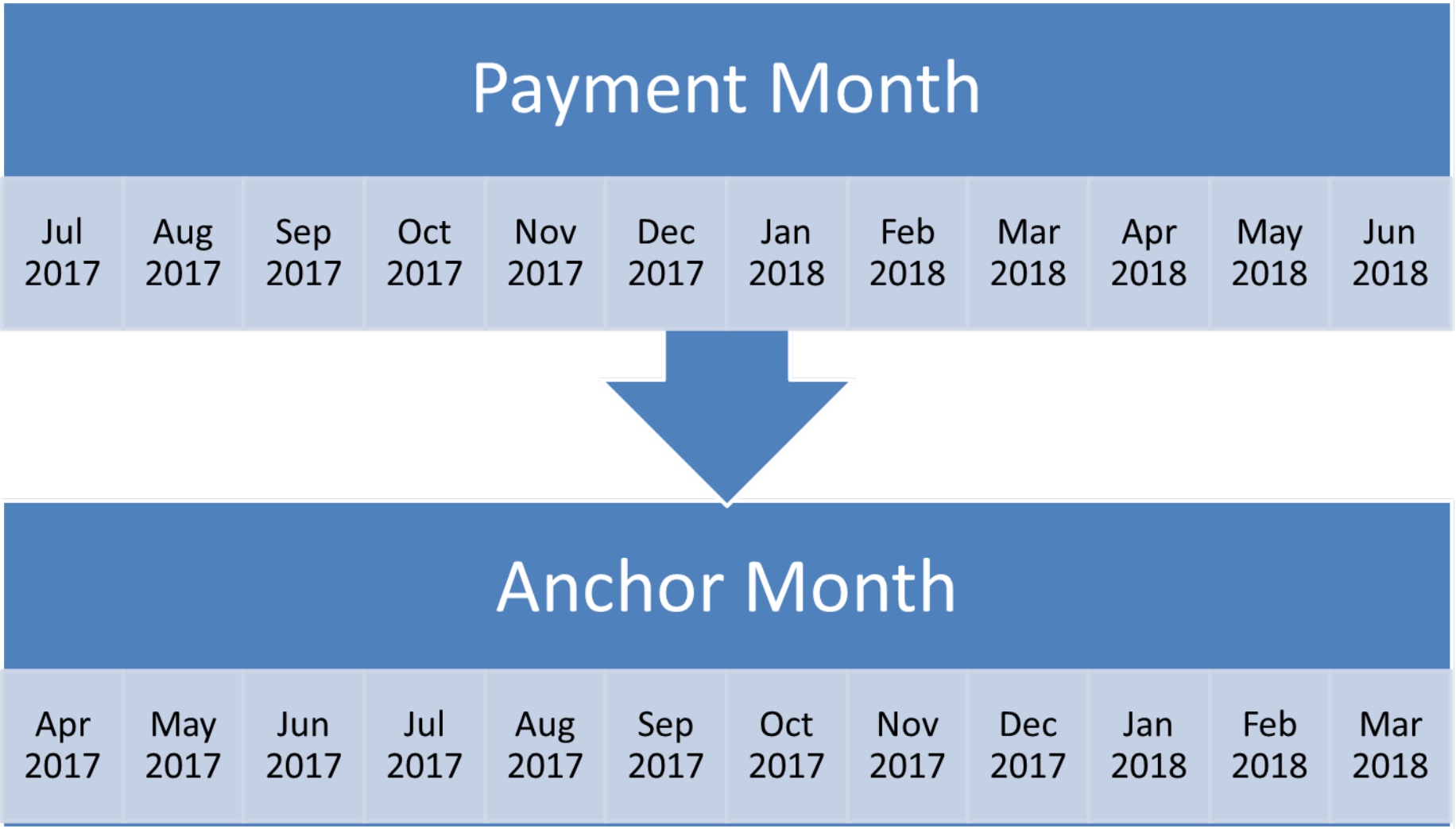
2017 HCC Model Revisions

- CMS released an HPMS memo on June 10, 2016, describing our initial approach to implementing the new risk adjustment model that we are implementing in 2017.
- In response to comments we will be making some operational changes to the implementation of the 2017 HCC model.
- We anticipate that these changes will take effect mid-2017.
- The key change will involve a revision to the “anchor month” approach of determining Medicaid status.
- Additional changes will occur to the frequency of the Medicaid Status Report.

Anchor Month Changes

- Commenters were concerned about CMS's use of only two anchor months to determine the appropriate community risk scores throughout the payment year, and recommended that CMS use more recent data throughout the year.
- Starting with the July 2017 payment, as part of a monthly process, we will utilize a rolling anchor month to determine prospective Medicaid status. This will allow payments to reflect more recent dual status.
- We will use the third month prior to the payment month as the anchor month for each payment month.
- As a reminder, anchor months are used throughout the payment year to determine which dual status to use when choosing the appropriate community risk score for a payment month.

New Anchor Months



MMR Fields

- Several commenters stated that they rely on monthly updates to the dual status reflected in fields 39 (Current Medicaid Status) and 84 (Dual Status Code) for benefit management purposes. These commenters are concerned that by using these fields to reflect only two months of the year, that they will no longer be able to track their members dual status.
- We note that, with the move to using rolling anchor months for payment, the dual status reported in these fields will again reflect rolling monthly dual status, similar to what we do today.

Additional Notes

- Some commenters requested that we “true up” the dual status with the payment month before final reconciliation.
- With the use of rolling anchor months, CMS believes that we will come closer to paying correctly across the payment year. Therefore, CMS will not be “truing up” the dual status with the payment month before final reconciliation.
- CMS will use the rolling anchor months throughout the year, including for retroactive adjustments, such as retroactive enrollments, and changes in a beneficiary’s status at mid-year from LTI to community.

Medicaid Status Report Update

- As we discussed in the June memo, we are developing a report that will inform plans of their enrollees' monthly Medicaid status.
- This report will show the Medicaid status for each payment month in the report, as of the run date of the report, not the anchor month.
- As a result of industry feedback we have decided to run this report on a more regular basis.

National Provider Identifier (NPI)

National Provider Identifier (NPI)

- The NPI is a 10-digit, intelligence-free, unique numeric identifier and must be used in lieu of legacy provider identifiers.
- The EDS requires the use of a valid NPI for submission and processing.
- When submitting encounters with providers that are not “atypical” providers – i.e., providers who have NPIs – plans must include the providers’ actual NPIs.
- An “atypical” provider is defined as an individual or business that bills for services rendered but does not meet the definition of a healthcare provider according to the NPI Final Rule 45 CFR 160.103 (e.g., non-emergency transportation providers, Meals on Wheels, personal care services, etc).

Default NPIs for Atypical Providers

- Default NPIs were established to assist with EDS submission when the provider is considered to be “atypical.”

SYSTEM	PAYER ID	DEFAULT NPI VALUE
Institutional	80881	1999999976
Professional	80882	1999999984
DME	80887	1999999992

- CMS is seeing a high volume of default NPIs from some organizations for HCPCs that should have valid NPIs.
- CMS may be reaching out to your organization if your volume is an outlier.

Top EDPS Reject Edits Prevention / Resolution

Error Code 00800 – Parent ICN Not Allowed for Original

- An original, non-chart review encounter data record should not contain a linked ICN.

Scenario: Southwest Health Plan submitted an original, non-chart review encounter data record for Samuel Anderson. This record contained a reference to ICN 4561234561233. The EDPS rejected the record because an original, non-chart review encounter data record should not contain an ICN. The original encounter should be resubmitted without the ICN.

Error Code 98325 – Service Line(s) Duplicated

- Verify encounter was not previously submitted and/or the service line does not contain the exact same data elements as a previously submitted service line on the same encounter.

  Note: *The EDPS will bypass edit logic for 98325 when modifier 59, 62, 66, 76, 77, and/or 91 is submitted on one (1) of multiple service lines containing the exact same data elements.*

Scenario: Sanford Health Systems submitted an encounter data record on 6/15/2015 for a service provided by Skye Medics for a leg prosthetic. Sanford Health submitted a replacement encounter to CMS to correct the office contact information and received error code 98325 because none of the data elements validated by the EDPS duplicate logic were changed from the previously submitted encounter. To correct the office point of contact only, Sanford Health Systems would need to void the previously submitted encounter and submit a new original encounter.

Error Code 02240 – Beneficiary Not Enrolled in MAO for DOS

- Verify that the beneficiary was enrolled in your contract during dates of service (DOS) on the encounter data record. Encounter data records should only be submitted for DOS in which the beneficiary is enrolled in your contract.

Scenario: Gabrielle Boyd was admitted to Faith Hospital for an appendectomy on 6/11/2012 and was discharged on 6/14/2012. Faith Hospital submitted the claim for the hospital admission to Adams Healthcare. Adams Healthcare adjudicated the claim and submitted an encounter to the EDS on 7/12/2012. Ms. Boyd's effective date with the Adams Healthcare contract was 7/1/2012. The EDS returned an MAO-002 report to Adams Healthcare with edit 02240 because Ms. Boyd was not enrolled in the contract for the DOS on the encounter data record.

Error Code 02256 – Beneficiary Not Part C Eligible for DOS

- Verify beneficiary was enrolled in Part C for DOS listed on the encounter. Encounters should not be submitted for beneficiaries not enrolled with the contract for the DOS on the received claim.

Scenario: On 7/4/2012, Gail Williams has severe chest pains and goes to the emergency room for a chest x-ray at Underwood Memorial Hospital. At the time of the emergency room visit, Ms. Williams only has Part A Medicare coverage, and her Part C Medicare coverage is effective 8/1/2012. AmeriHealth submits an encounter data record to the EDS, which is rejected with edit 02256, because Ms. Williams is not covered under Part C Medicare for the DOS.

Error Code 02125 – Beneficiary DOB Mismatch

- Verify that date of birth (DOB) populated on the encounter matches DOB listed in CMS systems. The EDPS will accept these encounters within plus or minus two (2) years of beneficiary's birth year.

  Note: *CMS anticipates that the change in this edit will be short-term and expects plan sponsors to improve their submission of DOBs.*

Scenario: Watchman Health submitted an encounter data record to the EDS for Texas Joe, listing Mr. Joe's DOB as 9/8/1965. The CMS systems listed Mr. Joe's DOB as 9/8/1956. The EDS returned the MAO-002 report to Watchman Health with edit 02125 due to the conflicting dates of birth beyond the two (2)-year variance.

Error Code 00265 – Correct/Replace or Void ICN Not in EODS

- Replacement or void encounter data record submitted with an invalid ICN. Verify accuracy of ICN on the returned MAO-002 report.

Scenario: Chance Medical Services submitted an encounter data record to the EDS and received an MAO-002 report with an accepted ICN of 123456789. The encounter data record required an adjustment (void or replacement). Chance Medical Services submitted a replacement encounter data record using ICN 234567899. The replacement encounter was rejected because there was no original record in the EDS for this ICN with the same Submitter ID.

Error Code 00760 – Adjusted Encounter Already Void/Adjusted

- Submitter has previously voided an encounter data record and is attempting to replace the same voided encounter. Submitter should review returned MAO-002 reports to confirm processing of the voided encounter data record prior to resubmission of the replacement.

Scenario: On 8/20/2012, Pragmatic Health submitted a replacement encounter data record for ICN 123456789 to correct a CPT code. However, Pragmatic Health had already submitted a void for the same ICN on 8/18/2012, but had not yet received the MAO-002 report by 8/20/2012. Pragmatic Health received edit 00760 on a subsequent MAO-002 report because the EDPS had already processed the void encounter data record submitted on 8/18/2012.

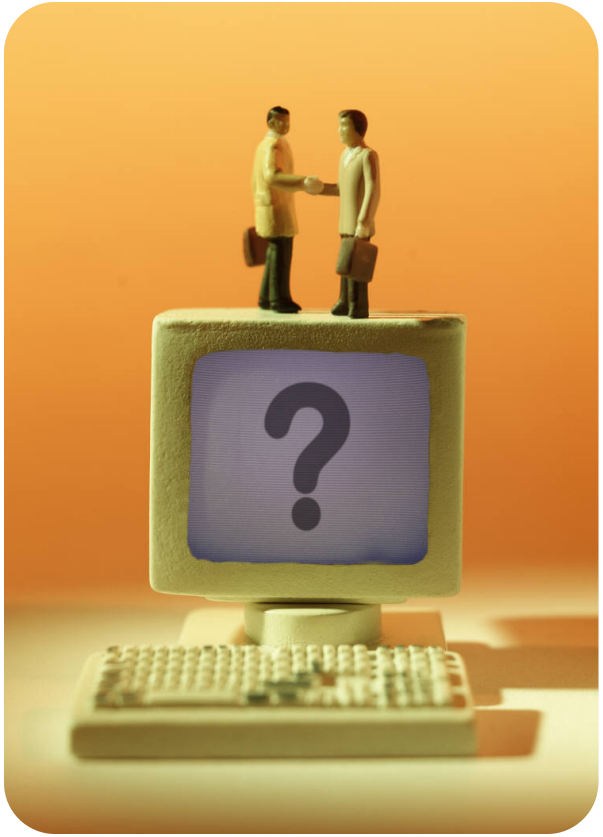
Encounter Data System (EDS) Report Restoration

Report Restoration

- 999 and 277CA Acknowledgement Reports will not be restored if the files are older than 20 days.
- MAO Reports will not be restored if the files are older than 60 business days.
- Requests for more than 200 files, per request, will not be accepted.

  Note: Plan sponsors and submitters can send multiple requests for report restoration over a span of time. CMS recommends that MAOs and other entities monitor their files and submit requests appropriately, and CMS reserves the right to deny requests that manipulate the guidelines.

Questions & Answers



Closing Remarks

Resources

Resource	Resource Link
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
Customer Support and Service Center (CSSC) Operations	http://www.csscoperations.com csscoperations@palmettogba.com
EDS Inbox	encounterdata@cms.hhs.gov
Risk Adjustment Mailbox	riskadjustment@cms.hhs.gov
Technical Assistance Registration Service Center (TARSC)	http://www.tarsc.info/
Washington Publishing Company	http://www.wpc-edi.com/content/view/817/1
Medicare Advantage and Prescription Drug Plans Communications User Guide	http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

Resources (*continued*)

Resource	Link
CMS 5010 Edit Spreadsheet	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/
RAPS Error Code Listing and RAPS-FERAS Error Code Lookup	http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~Edits?open&expand=1&navmenu=Risk^Adjustment^Processing^System||
EDFES Edit Code Lookup	https://apps.csscoperations.com/errorcode/EDFS_ErrorCodeLookup
EDPS Error Code Look-up Tool	http://www.csscoperations.com/internet/cssc3.nsf/DocsCat/CSSC~CSSC%20Operations~Medicare%20Encounter%20Data~Edits~97JL942432?open&navmenu=Medicare^Encounter^Data|||

Contact Us

- Additional questions may also be submitted following the webinar to:

EncounterData@cms.hhs.gov

or

RiskAdjustment@cms.hhs.gov

- Questions submitted to other CMS mailboxes will be forwarded to the risk adjustment or encounter data mailboxes as appropriate.

Evaluation

A formal request for evaluation feedback will be sent at the conclusion of this session.

Please take a moment to note any feedback you wish to give concerning this session.

Your Feedback is Important.

Thank You!

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