Payment Year 2018
Medicare Advantage Contract-Specific Risk Adjustment Data Validation (RADV)

Audit Methods and Instructions

(CMS Website Version)

November 14, 2024

Table of Contents

1 Purpose

This document communicates the Centers for Medicare & Medicaid Services' (CMS) audit methods and instructions to a Medicare Advantage Organization (MAO) selected for a payment year (PY) 2018 contract-specific RADV audit.[1] The MAO should closely review this document and referenced attachments to understand the full scope and requirements for the audit.

2 Background

Section 1853(a)(1)(C) of the Social Security Act requires that CMS risk-adjust payments made to MAOs. Risk adjustment strengthens the Medicare Advantage (MA) program by ensuring that appropriate payments are made to MAOs based on the health status and demographic characteristics of their enrolled beneficiaries. MAOs submit enrollees' diagnosis data[2] to CMS until the final risk adjustment data submission deadline to receive risk adjusted payments from CMS. CMS published information about how PY 2018 MA risk adjusted payments were calculated—including risk adjustment factors and hierarchical condition categories (CMS-HCCs)—in the Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information (April 3, 2017).[3]

CMS conducts RADV audits pursuant to 42 C.F.R. § 422.310(e), which requires MAOs to submit a sample of medical records (MRs) from face-to-face encounters to CMS for validation of risk adjustment data. Contract-specific RADV audits are CMS' main corrective action to identify overpayments made to MAOs when there is a lack of documentation in MRs to support the diagnoses reported by MAOs for risk adjusted payments.[4] For each MA contract-specific RADV audit for PYs 2018, CPI will define a sample unit and sampling frame, select a sample of enrollees from within the sampling frame, and extrapolate audit results to the sampling frame.

Each MA contract-specific RADV audit includes:

- Planning: CMS defines a sample unit, sampling frame, and sample selection method.
- Initiation: CMS sends an Audit Notice and provides audit methods and instructions.

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[1] In the past, CMS referred to a MA contract-level RADV audit (now referred to as a contract-specific RADV audit) using the acronym CONXX, where XX referred to the two-digit payment year. This acronym may still be used in CMS systems for a limited time until CMS can make terminology updates.

[2] Risk adjusted payments to MAOs for a given PY are required to be substantiated by diagnoses documented in MRs from face-to-face encounters with dates of service in the year prior to the PY (i.e., data collection year).

[3] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/announcement2018.pdf

[4] A CMS contract-specific RADV audit focuses on the health conditions (i.e. diagnoses) self-reported by an MAO for the purpose of receiving risk adjusted payments, not on confirming other data/factors from CMS' systems of records that impact payments.

- MR Submission: The MAO submits MRs to CMS during a MR submission window for enrollees selected in the audit sample.
- Analysis and Issuance of an Audit Report Package: CMS analyzes the output from MR reviews, calculates payment errors, and issues an Audit Report Package to the MAO.[5]

3 Important Dates to Remember

The following are important dates to remember for the PY 2018 MA contract-specific RADV audit:

- MR submission window opens: November 14, 2024
- Hardship Exception Request Deadline: March 3, 2025
- MR Submission Deadline (window closes): April 21, 2025

4 Statistical Sampling Methodology

This section describes the sampling frame, sample unit definition, sample design, and sample selection method for this audit.

4.1 Sampling Frame

Note: The points of contact for each MA contract selected for audit in PY 2018 will receive a version of this document that contains only one of two versions (A or B) of this Sampling Frame section based on the sampling frame used for their audit.

Version A
CMS defined the sampling frame for this MA contract-specific RADV audit by identifying enrollees that:

1. Were continuously enrolled in the audited MA contract from January of the data collection year (2017) through January of the payment year (2018)
2. Were enrolled in Medicare Part B coverage for all 12 months during the data collection year (2017)
3. Had at least one risk adjustment diagnosis in the International Classification of Diseases, Clinical Codes with a 2017 date of service that led to at least one CMS-HCC assignment for the payment year (2018)
4. Were not in an End Stage Renal Disease status from January of the data collection year (2017) through January of the payment year (2018)
5. Were not in a hospice status from January of the data collection year (2017) through January of the payment year (2018),

[5] MAOs have appeal rights pursuant to 42 C.F.R. § 422.311(c).

6. Were not part of any OIG audit or other pertinent settlement that included data from January of the data collection year (2017) through January of the payment year (2018), and
7. Were ranked in the top decile of PY 2018 RADV eligible enrollees in RADV eligible MA contracts by one or both of CPI's PY 2018 MA improper payment prediction models,[6] and therefore predicted to have the greatest reduction in their risk score as a result of a RADV audit.

Version B

CMS defined the sampling frame for this MA contract-specific RADV audit by identifying enrollees that:

1. Were continuously enrolled in the audited MA contract from January of the data collection year (2017) through January of the payment year (2018)
2. Were enrolled in Medicare Part B coverage for all 12 months during the data collection year (2017)
3. Had at least one risk adjustment diagnosis in the International Classification of Diseases, Clinical Codes with a 2017 date of service that led to at least one CMS-HCC assignment for the payment year (2018)
4. Were not in an End Stage Renal Disease status from January of the data collection year (2017) through January of the payment year (2018)
5. Were not in a hospice status from January of the data collection year (2017) through January of the payment year (2018),
6. Were not part of any OIG audit or other pertinent settlement that included data from January of the data collection year (2017) through January of the payment year (2018), and
7. Had all of their Encounter Data System (EDS) CMS-HCCs, based on diagnoses submitted by the audited MAO to the EDS, only derived from linked or unlinked chart review records.[7]

4.2 Sample Unit Definition

The sample unit is an MA contract enrollee that meets the sampling frame criteria.

4.3 Sample Selection Method

CMS selected a statistically valid random sample of 35 enrollees from the sampling frame by:

[6] Types of entities that could have been selected for contract-specific RADV audits included Coordinated Care Plans (CCPs), local Health Maintenance Organizations (HMOs), local preferred provider organizations (PPOs), Regional PPOs, Provider-Sponsored Organizations (PSOs), Special Needs Plans (SNPs) Demonstrations, Medical Savings Accounts (MSAs) Contracts, Private Fee for Service Contracts, and Employer/Union Only Direct Contract PFFS plans.

[7] A linked chart review is a chart review that is linked to a previously accepted encounter data record, allowing CMS and other oversight entities to identify the specific item or service that is associated with a risk-adjustment-eligible diagnosis. An unlinked chart review is a chart review that adds diagnoses to the encounter data without identifying the encounter data record associated with the diagnoses.

1. Establishing a seed number using a random number generator[8]
2. Sorting enrollees (i.e., sample units) included in the sampling frame by CMS' unique identifier for each enrollee, and
3. Using statistical software tool to perform simple random sampling (without replacement) method to randomly select 35 enrollees.[9]

5 Audit Initiation

CMS initiates an MA contract-specific audit by sending the MAO an Audit Notice. Upon receiving the letter, the MAO should begin taking steps to assign points of contact (POCs), review available audit sample data, and begin gathering MRs.

5.1 Audit Notice

CMS sends an Audit Notice to the Chief Executive Officer (CEO) and Medicare Compliance Officer (MCO) to initiate the MA contract-specific RADV audit. The letter provides important information about the audit, including the opportunity to establish and/or update the points of contact (POCs) for the audit and links to important documents.

5.2 Points of Contact

The CEO and/or MCO may establish POCs to help their organization comply with audit requirements throughout the audit lifecycle. A maximum of seven individuals, including the CEO and MCO, may be designated as POCs. POCs' contact information must be provided to CMS on the POC Form (see Attachment 1). Once the form is completed, only the CEO or MCO may submit the POC Form to RADVCONTechSupport@radvcdat.com. A separate POC Form must be submitted for each contract if multiple contracts for an MAO are selected for an audit.

Designated POCs will receive an email from RADVCONTechSupport@radvcdat.com. The email will instruct POCs to use the CMS secure RADV system, the Central Data Abstraction Tool (CDAT), to register and access sensitive RADV audit data. Information about the RADV audit is only provided to designated POCs. The sooner POC Forms are submitted, the sooner POCs will be able to register and access CDAT.

5.3 Enrollee Data List

CMS will make an enrollee data list (EDL) available in the audited MA contract's secure portal within CDAT to communicate the enrollees and hierarchical condition categories (CMS-HCCs) selected for audit. A POC for the MAO should access the EDL as soon as it is available to give the MAO the maximum amount of time available to gather and submit the necessary MRs for the audit.

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[8] The seed number was generated using the SAS CALL routine random number generator.

[9] The software tool used was the SAS PROC SurveySelect function. Note that if the audited MA contract has fewer than 35 enrollees identified in the sampling frame, then all enrollees are included in the RADV audit sample.

The EDL is a Microsoft Excel file with three worksheets (or tabs):

1. Data Dictionary (DD) – Describes each column in the EDL.
2. Sampled Enrollee List – Includes the sampled enrollees, CMS-HCCs, and associated diagnosis codes that the MAO submitted to the Risk Adjustment Processing System (RAPS) and/or Encounter Data Processing System (EDPS) for which the MAO must submit MRs to CMS via CDAT.
3. Sampling Frame – Includes identifiers for all enrollees included in the sampling frame and a flag indicating which enrollees are selected in the sample, for reference only.

6 MR Requirements and Submission Instructions

The audited MAO must submit at least one valid MR and MR coversheet to CMS to substantiate each audited CMS-HCC included in the EDL. A valid MR for RADV purposes is a legibly signed and dated medical record that documents diagnoses and services provided during a face-to-face visit and conducted by an appropriately credentialed provider within the designated data collection period. The signature on the medical record must be the signature of the credentialed provider that conducted the face-to-face visit.

The MAO must submit MRs and MR coversheets within CDAT while the MR submission window is open. For instructions on how to submit an MR and MR coversheet within CDAT, review the *CDAT User Guide* in the Plan Library within CDAT. The MAO must request MRs from hospitals and physicians/practitioners that provided services to enrollees and documented diagnoses associated with enrollees' audited CMS-HCCs during the appropriate data collection period.[10] The data collection period for PY 2018 is January 1, 2017, through December 31, 2017.

For each sampled enrollee, the MAO can submit a maximum number of MRs equal to five times the number of audited CMS-HCCs. For example, if a sampled enrollee has two audited CMS-HCCs in the EDL, the maximum number of MRs an MAO can submit for that enrollee is 10 MRs (2 CMS-HCCs * 5). An MAO may submit these 10 MRs in any combination for the two audited HCCs.

The MR submission process includes two parts, MR intake and diagnosis code abstraction. Each MR submitted to CMS for RADV purposes will be reviewed during the MR intake process to ensure it is valid. Only valid MRs and acceptable MR coversheets will move forward to the diagnosis code abstraction step of the RADV audit. See Appendix A for a list of reasons (i.e., reason codes) why a MR (and its associated MR coversheet) can be deemed invalid.

6.1 Completing the MR Coversheet

This section includes guidance for completing the MR coversheet during the submission process in CDAT. For step-by-step instructions for accessing an electronic version of the MR coversheet template, please refer to the *CDAT User Guide* in the CDAT Plan Library. Hardcopy or "printable" coversheets are

[10] 42 C.F.R. §422.310(d)(3)

not provided. The MR coversheet allows CDAT users to submit documents (MR only or MR and attestation [MR+ATT]) or confirm no documents (No MR) for a specific sampled enrollee and audited CMS-HCC. The system will allow only the MR file to be uploaded as a PDF file to a coversheet.

The MR coversheet template displays submission information in five sections:

Section I: MA Contract Information. Displays the Contract Name, Current Contract ID, and Sample Year Contract ID for the selected enrollee.

Section II: Enrollee Information. Displays details about the selected enrollee, including the Enrollee ID, Medicare Beneficiary Identifier (MBI), Date of Birth (DOB), Last Name, and First Name. Note: When completing the submission process, the MAO must ensure the enrollee on the coversheet matches the enrollee on the MR. Submitting a MR for the wrong enrollee may lead to a Protected Health Information (PHI)/Personally Identifiable Information (PII) issue and will result in an invalid submission.

Section III: Document to be Attached. Indicates the type of MR uploaded. The uploaded file should contain one MR only. When completing the MR coversheet in CDAT, the MAO is required to select a document type for the submission. The document type determines which coding guidelines (Inpatient or Outpatient) should be applied.

- **One Physician Specialist/Hospital Outpatient Record:** This type of record is submitted for one date of service and can be a physician office visit; a standalone hospital outpatient visit (for example, an emergency room visit or outpatient procedure report); a standalone document from an inpatient stay (Consult, Progress Note, History & Physical, Emergency Room or Operative Report); a Health Risk Assessment (HRA); or a visit with a physical therapist, occupational therapist, or speech language pathologist (not occurring in an inpatient setting). For an outpatient record, enter the one date of service documented in the record. A credentialed provider's documentation, such as a progress note or a consult form, can be added to this record and submitted as an outpatient record as long as the date of service is within the data collection period and the MR has a valid signature and credentials.
- **One Hospital Inpatient Record:** This type of record can be a full inpatient hospital record or an inpatient rehabilitation record and must include both an admission date and a discharge date. Enter a date range using both admission date and discharge date documented in the record. The discharge data must be in the data collection year for the MR to be accepted as an inpatient record.

Section IV: Designated CMS-HCCs for this MR. This section displays which audited CMS-HCC(s) is designated for this MR. A MR with multiple CMS-HCCs will have each CMS-HCC on a separate row with the accompanying ICD codes for each. All the enrollee's audited CMS-HCCs are available for designation on each MR coversheet. Note: If the MR documents more than one of the audited CMS-HCCs for the enrollee, the MAO should select all applicable CMS-HCCs when completing the MR coversheet and submit the MR only once. The MAO should avoid submitting the same MR multiple times for the same or different CMS-HCC(s).

Section V: File Content/Coding Guidelines. This includes Provider Type (Inpatient or Outpatient), Admission and Discharge Dates for Inpatient Record, and Date of service for Outpatient Record.

CMS includes pre-populated MA contract information and enrollee identifiers. All other information is supplied by the MAO.

The MR coversheet should be completed according to the *CDAT User Guide* and reviewed for accuracy prior to submitting in CDAT. The following information should be verified prior to submitting each coversheet:

1. MR coversheet is correctly labeled "CY 2018 Contract-Level RADV" on all pages.
2. All data fields in Section I contain data.
3. All data fields in Section II contain enrollee data that matches the name on the MR submitted. The birth date may be used as a secondary identifier for common shortened names if it is present on the MR. MAOs can note on the coversheet reasons that explain any name variance.
4. Section III, IV, and V are populated as directed with at least one CMS-HCC indicated. If any unusual format or population issues are noted, the automated intake process may be routed to a manual process for confirmation.
5. Year of Review field must be "2017". For a hospital inpatient record, the Discharge Date Year of Review field is populated with "2017". For a physician/specialist/hospital outpatient/observation record, the Year of Review field is populated with "2017".
6. All fields in the MR Submission Information section (File Name, Submitted By, and Submission Date) must contain data.
7. On page 2, the MR coversheet displays the ICD-10-CM codes that correspond to the audited CMS-HCCs selected within Section IV of the MR coversheet.

6.2 Preparing the MR File

The MAO must submit MR documentation for each audited CMS-HCC. To do so, the MAO must create a MR file that contains one MR and, if applicable, one completed CMS-generated attestation. Please note that if the MAO intends for the MR documentation to substantiate more than one audited CMS-HCC for the enrollee, then it must indicate all applicable CMS-HCCs on the MR coversheet and submit the MR only once to validate multiple CMS-HCCs. The MAO should avoid submitting the same MR documentation multiple times. The MAO must attach each MR file to an electronic MR coversheet for submission into CDAT. An MR file submitted to CDAT cannot exceed 100MB.

Although CMS does not review MRs based on the naming convention, CMS encourages the MAO to name the MR file using the following:

1. Use the enrollee ID as provided in the sample list (e.g. 12345678)
2. Include the model number[11] for 2017 dates of service (e.g., V22), and

[11] CMS updates the MA payment system periodically to map diagnosis codes to categories of diagnoses. With each release of reclassification, a new version of the CMS-HCC model is finalized. One of the CMS-HCC model numbers used for the clinical services provided in payment year 2018 should be identified in the coversheet.

3. Include one CMS-HCC in your naming convention (e.g., HCC017)

In this example, the file name would be: 12345678_V22_HCC017. The MAO should avoid duplicate file names when submitting multiple MRs for the same CMS-HCC(s). Use unique file names for each MR. If multiple MRs are submitted for the same set of CMS-HCCs, add a Version number at the end (_v1, _v2).

MRs lacking the necessary provider signature and/or credentials require a signed attestation to be considered valid and eligible for RADV review. If a completed CMS-generated attestation is submitted, it must appear on the first page of the MR file. For additional information on the CMS-generated attestation, see Section 6.4. If applicable, the MAO should prepare each MR file containing one completed CMS-generated attestation and one MR in a PDF format.

6.3 Checking the MR File before Submission

After the MR file has been prepared according to these instructions, the MAO must complete the MR coversheet and upload the MR file in CDAT following instructions in the *CDAT User Guide*. When attaching the MR file to the MR coversheet in CDAT, the MAO must identify the type of record being submitted. If "One Physician Specialist/ Hospital Outpatient Record" or "One Observation Record" is selected, only outpatient coding guidelines will apply. If "One Hospital Inpatient Record" is selected, only inpatient coding guidelines will apply. Ensure the conditions in the inpatient MR are documented and authenticated by an acceptable risk adjustment physician specialty.

Check the MR file to ensure that:

- The MR contained in the file corresponds with the MR coversheet for which it is being submitted.
- It does not contain multiple MRs.
- All text and images are legible.
- It does not exceed 100MB

All MR coversheets and associated MR files must be submitted by the MR Submission Deadline (see Important Dates to Remember). The MAO will receive feedback on the validity of submitted MRs via the Intake Feedback Report in CDAT.

6.4 MR Attestation

MRs submitted for this audit that do not contain physician/practitioner signatures or credentials (i.e. Physician Assistant) will result in errors under the MR review process. If a MR lacks the necessary physician/practitioner signature and/or credentials, CMS allows the MAO to submit a CMS-generated attestation form (PDF file) with the MR. CMS-generated attestations are accepted only for physician and hospital outpatient MRs (i.e., not for inpatient hospital MRs).

A CMS-generated attestation must be signed by a physician/practitioner who attests responsibility for conducting and documenting the health services in the accompanying physician or outpatient MR that the MAO submits. By signing and documenting credentials on the attestation and identifying the date of service, physicians/practitioners are attesting to the MR entry being submitted for this audit.

CMS-generated attestations will be accepted only for MRs that the MAO indicates on the coversheet and should be coded accordingly. Attestations are only acceptable for physician/outpatient sites for dates of service between January 1 to December 31, 2017.

Elements of the CMS-generated attestation are pre-populated by CMS (e.g., name, date of birth, Medicare identifiers, contract name and ID) for data integrity purposes. Because it contains PHI/PII, this document will only be made available to the MAO's POCs via the plan portal within CDAT.

For point-and-click instructions on how to submit a CMS-generated attestation form in CDAT, the MAO should review the *CDAT User Guide*.

CMS reviews each submitted attestation form for validity. Attestations will be found valid if they meet the following criteria:

1. Attestation is a CMS-generated attestation form only.
2. The CMS-generated attestation is completed in its entirety, signed, and dated by the physician/practitioner who provided those services.
3. The completed fields include the printed physician/practitioner's name, the date of service of the MR to which they are attesting, the physicians/practitioner's specialty or credential (i.e. Physician Assistant), and the signature and date by the physician/practitioner that conducted the face-to-face visit.

Attestations will be deemed invalid if one (or more) of the following conditions is true:

1. The CMS-generated attestation Form is altered
2. The attestation is Incomplete
3. Date of service on the attestation form does not match the MR
4. Enrollee name does not match both coversheet and MR
5. Entire Inpatient Record (Attestations are accepted only for physician and hospital outpatient MRs. Inpatient records that indicate a specific date of service and progress note are considered outpatient records and can include an attestation)
6. The attestation form is not CMS-generated (only a CMS Generated Attestation Form is acceptable)
7. Unacceptable provider credentials
8. Unacceptable signature(s), including an attestation that is signed by someone other than the physician/practitioner with or without explanation (retired, expired, Power of Attorney, etc.)

Valid attestations move forward through the MR intake process to the diagnosis code abstraction process. Attestations that are deemed invalid will result in an error and the associated MR will be considered invalid.

7 MR Intake and Feedback Process

CMS reviews all submitted MR files and coversheets during the MR intake process to determine which ones are valid and invalid. Each submitted MR file and coversheet combination are assigned a unique Coversheet ID. While the MR submission window is open, if a MR file and coversheet combination is determined to be invalid, the MAO may submit another one to replace it. Accordingly, CMS encourages the MAO to get submissions in as early as possible. CMS continues the MR intake process until all submissions are reviewed.

CMS will provide daily feedback about each submitted MR file and coversheet throughout the MR intake process. An MAO's POC may access an Intake Feedback Report (IFR) within CDAT. The IFR provides the status of intake processing for each MR submitted during the MR submission window.[12] Once intake processing is complete for a given MR, the IFR is updated to indicate if the MR passed all intake validity checks. If it did not, then the IFR will list the reason(s) why it did not pass. Instructions for how to access the IFR are included in the Plan Library within CDAT. The IFR will be available to the MAO's POCs throughout the audit lifecycle.

Only MR files and coversheets that pass all MR intake checks and are determined to be valid will be forwarded to the diagnosis code abstraction process. Only valid MRs are eligible to be used as a basis for medical record review determination appeal, if applicable.

8 Hardship Exception Request Process

CMS recognizes there may be extraordinary circumstances preventing an audited MAO from providing MRs to CMS and complying with audit requirements. Examples of extraordinary circumstances include natural disasters and seizure of MRs by law enforcement. An MAO experiencing an extraordinary circumstance may request a hardship exception for: (1) the MA contract-specific RADV audit, (2) an audited enrollee(s), and/or (3) an audited CMS-HCC(s).

A hardship exception request for an MA contract must include the RADV Audit Number (RAN) for the contract, which was communicated in the Audit Notice, and a justification for the request.

A hardship exception request for an audited enrollee(s) or CMS-HCC(s) must include a completed *Hardship Exception Request Form* (see Attachment 2), which requires a justification for each audited enrollee and/or CMS-HCC for which the MAO is seeking a hardship exception. Note that the *Hardship Exception Request Form* is also available for download in the CDAT Plan Library.

The justification for a hardship exception request should include a detailed description of the incident/issue preventing the collection of a MR(s) to support an audited CMS-HCC(s). The supporting documentation should contain the relevant information for CMS to fully understand the incident/issue, such as any communications related to the incident and proof of the incident (e.g., copy of an insurance

[12] The IFR within CDAT does not provide the results of diagnosis coding abstraction activities. Instead, CMS will provide diagnosis coding abstraction results when it issues an Audit Findings Report at the end of an audit.

claim receipt by the provider, police report, or news article). Do not include any PHI within your hardship request. Any request that contains PHI will immediately be rejected by CMS.

All hardship exception requests and supporting documentation should be submitted to radv@cms.hhs.gov. Please include "PY18 Hardship Exception Request" in the subject line. The email may come from the approved Point of Contact (POC) but should carbon copy the Medicare Compliance Officer (MCO) or CEO.

CMS will review each hardship exception request on a case-by-case basis and a submission does not guarantee approval by CMS. If approved, the hardship exception request is valid only for a specific RADV audit.

We encourage an audited MAO to begin requesting and submitting MRs as soon as possible to not have delays in collecting MRs from health care providers prevent the timely submission of MRs to CMS. CMS does not consider the following scenarios to be justification for granting a hardship exception: record retention issues, health care providers not responding to a request, issues related to lost records, retired health care providers, and human resource issues.

All hardship requests must be submitted to CMS as soon as possible and no later than the Hardship Exception Request Submission Deadline (see Important Dates to Remember).

9 Diagnosis Code Abstraction

From all valid MRs that pass MR intake, CMS abstracts diagnosis codes in accordance with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Guidelines for Coding and Reporting[13], and *Coding Clinic for ICD-10-CM and ICD-10-PCS*[14] quarterly newsletters published by the American Hospital Association's Central Office on ICD-10-CM and ICD-10-PCS. CMS' affirmation of the Coding Clinic as the official source of coding information is noted in the Federal Register, Vol. 74, No. 165, at pgs. 43,784, 43791-98, Thursday, August 27, 2009. An MAO submitting MRs to substantiate audited CMS-HCCs must also follow these guidelines and newsletters; instructions in this document; requirements set forth in Chapter 7 of the *CMS Medicare Managed Care Manual;* and all requirements set forth in Medicare regulations, Parts C and D contracts, and Electronic Data Interchange Agreements.

Each submitted valid MR may be subjected to up to three rounds of review by certified MR coders. An initial MR review to abstract ICD-10-CM codes is conducted on all submitted valid MRs. MRs that do not substantiate the one or more audited CMS-HCCs for which they were submitted will undergo a second review. A physician review is conducted on each MR where there is disagreement between the first and second medical review about whether, or to what degree, an audited CMS-HCC(s) is discrepant (see

[13] ICD-10-CM Coding Guidelines: https://www.cms.gov/medicare/coding-billing/icd-10-codes

[14] Coding Clinic Advisor: https://www.codingclinicadvisor.com/aha-central-office

below for information on what makes a coding review discrepant). Physician review is the last step in the MR diagnosis code abstraction process.

10 Payment Error Calculation Methodology

RADV audits confirm the presence of diagnoses that map to CMS-HCCs in MR documentation submitted by an MAO. A risk adjustment discrepancy is identified when an original CMS-HCC(s) used for payment for a sampled enrollee, based on diagnosis code data self-reported by an MAO, differs from the CMS-HCC(s) assigned after MR diagnosis code abstraction is completed by CMS through the RADV audit process. Risk adjustment discrepancies are aggregated for sampled enrollees to determine the average change in sampled enrollees' risk scores as a result of the RADV audit, which is then used to estimate an overpayment amount for collection for the sampling frame using a statistically valid extrapolation technique.

Detailed information about MA risk adjustment and enrollee risk score calculation is published each year by CMS.[15] Risk adjustment models and supporting data and documentation are available for PY 2006 through the present. All enrollee risk score calculations during a RADV audit use the published model for the relevant PY, including the relevant normalization, coding intensity adjustment, and frailty factors (if applicable). CMS will use the most recently available data from CMS systems of records and post-RADV results of audited CMS-HCCs to calculate payment errors for sampled enrollees and estimate the payment error for the sampling frame.[16]

10.1 Payment Error Calculation for Sampled Enrollees

CMS calculates the "RADV enrollee total payment error" for each enrollee selected in the RADV audit sample by completing the following steps:

1. Running the sampled enrollee's diagnosis codes that are abstracted by CMS from valid MRs submitted by the MAO for RADV[17], and other necessary data for the enrollee sourced from CMS systems of records, through the relevant PY's MA payment model to determine the "RADV enrollee risk score".[18]

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[15] https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents. These documents comprise the Medicare Advantage (MA), and Medicare+Choice (M+C) advance notices of methodological changes; announcements issued with MA or M+C rates; and special reports.

[16] Data from CMS systems of records that contributes to MA payment error calculations may include items such as the following: Medicare Beneficiary Identifier (MBI), Health Insurance Claim Number (HICN), Date of Birth, Sex, Original Reason for Entitlement Code (OREC), and Medicaid Dual Status.

[17] No payment error will be calculated for any sampled enrollees and/or audited CMS-HCCs for which CMS has approved a Hardship Exception.

[18] If CMS abstracts a diagnosis code (that maps to a CMS-HCC) that was not previously submitted by the MAO for risk payment prior to the data submissions deadline(s), and such a diagnosis code was found in a valid MR that substantiates any manifestation of an audited CMS-HCC in the RADV audit sample (i.e., even if a MR only

2. Calculating "RADV monthly enrollee risk payment amounts" by multiplying the "RADV enrollee risk score" after normalization, adjustment, and blending (if applicable) by the appropriate county rate for months in which the sampled enrollee was covered by the plan and not in an End Stage Renal Disease (ESRD) or hospice status.
3. Summing the "RADV monthly enrollee risk payment amounts" and applying all other relevant payment components[19] and adjustments to determine the "RADV Enrollee Risk Payment Amount".
4. Calculating "RADV enrollee monthly payment error" by subtracting each month's "RADV monthly enrollee risk payment amount" from the "original monthly payment amount" that was previously received by the MAO.
5. Summing the "RADV enrollee monthly payment error" amounts for the PY to determine the "RADV enrollee total payment error".

Note that the "RADV enrollee monthly payment error" amount can be positive, $0, or negative.[20] When positive, an overpayment condition exists related to the sampled enrollee.

10.2 Use of Extrapolation to Estimate Overpayment Amount for the Sampling Frame

Extrapolation is expected to be the standard practice beginning with CMS RADV audits of MA contracts from PY 2018.[21] In rare circumstances, however, CMS may use its discretion to not utilize extrapolation, such as when the original number of enrollees identified in the sampling frame is less than 30[22] or when unforeseen circumstances (e.g., MRs for sampled enrollees are destroyed in a natural disaster and are

substantiates a lower manifestation of an audited CMS-HCC), then CMS will include the "additional CMS-HCC" when calculating a specific RADV sampled enrollee's "RADV enrollee risk score". Note, however, that the crediting of "additional CMS-HCCs" during a RADV audit can only offset overpayment amounts and can never result in additional risk adjustment payments to an MAO since this would circumvent the final risk adjustment data submission deadlines described at 42 C.F.R. § 422.310(g)(2)(ii). An MAO is not permitted to appeal determinations made by CMS during a RADV audit regarding whether to give credit for additional CMS-HCCs. *See* 79 Fed. Reg. 29932 (May 23, 2014).

[19] Other relevant payment components include rebates, premiums, and other factors.

[20] In rare instances when CMS decides not to extrapolate to estimate total payment error for the sampling frame, if a net underpayment condition exists when the "RADV enrollee monthly payment error" amounts for all sampled enrollees are summed, then the net underpayment amount will be capped at $0.

[21] 88 Fed. Reg. 6650 (Feb. 1, 2023)

[22] When the original number of enrollees in the sampling frame is less than 30 and CMS is auditing all CMS-HCCs (for those original enrollees) for which the MA contract received risk adjusted payments, CMS will audit the entire sampling frame without the use of extrapolation.

not otherwise available) disturb the statistical validity of the audit sample.[23] When extrapolation is utilized, CMS will extrapolate the estimated payment error only to enrollees within the sampling frame.

For this MA contract-specific RADV audit, CMS intends to use extrapolation to estimate an overpayment amount for collection. More specifically, this will be accomplished by:

1. Calculating the average change in risk score ($\overline{\Delta R}$) for the sampled enrollees, where n represents the number of sampled enrollees and ΔR_i represents the change in risk score for a sampled enrollee:

$$\overline{\Delta R} = \frac{1}{n}\sum_{i=1}^{n} \Delta R_i$$

2. Deriving the variance ($s^2_{\Delta R}$) of the change in risk score for each sampled enrollee:

$$s^2_{\Delta R} = \sum_{i=1}^{n} \frac{(\Delta R_i - \overline{\Delta R})^2}{n-1}$$

3. Calculating the estimate of the variance of the average change in risk score ($VAR(\overline{\Delta R})$) for the sampling frame, where N represents the number of enrollees in the sampling frame:

$$VAR(\overline{\Delta R}) = \left(\frac{N-n}{N}\right)\frac{s^2_{\Delta R}}{n}$$

4. Computing the lower bound of the 90 percent confidence interval (δ) of the change in risk score:

$$\delta = \overline{\Delta R} - 1.645\sqrt{VAR(\overline{\Delta R})}$$

5. Multiplying the calculated lower bound of the change in risk score by the sum of county rates in the sampling frame to obtain an estimated payment error for the sampling frame, where c_i represents the county rate for an enrollee in the sampling frame of the audited MA contract:

$$PE = \sum_{i=1}^{N} \delta c_i = \delta \sum_{i=1}^{N} c_i$$

[23] In instances where hardship exception requests are approved by CMS and the total number of enrollees remaining in the sample falls below 30, CMS will not use extrapolation.

11 Audit Report Package

When CMS completes the MA contract-specific RADV audit, it posts an Audit Report Package in the audited MA contract's secure portal within CDAT and notifies the MAO's POCs via email. An Audit Report Package includes a letter and Excel workbook with audit results that will provide detailed feedback about each sampled enrollee and audited CMS-HCC. CMS will also provide a help document(s) to assist an MAO in understanding the contents of the Audit Report Package.

12 RADV and the Requirement to Report and Return Plan-Identified Overpayments

In accordance with 42 CFR 422.326, an MAO is required to report and return any plan-identified overpayments within 60 days of being identified. However, as a contract selected for a CMS PY 2018 RADV audit and in accordance with 42 CFR 422.326(d), please suspend the reporting of overpayments to the Risk Adjustment Overpayment Reporting (RAOR) module in the Health Plan Management System (HPMS) and the submission of data corrections in RAPS and/or EDPS for PY 2018 for enrollees included in this audit's sampling frame (which includes the sampled enrollees) until further notice. For plan-identified overpayments related to enrollees in the subject MA contract that are not included in the sampling frame for this RADV audit, your organization is required to report any plan-identified overpayment to CMS in accordance with 42 CFR 422.326.

13 CMS Email Support Resources

The POCs associated with an audited MA contract may request technical support regarding use of the CDAT system by sending an email to the CDAT Technical Support Email Box at RADVCONTechsupport@radvcdat.com.

Individuals with general questions about CMS' MA contract-specific RADV audits may send an email to radv@cms.hhs.gov.

Appendix A: Invalid MR Reason Codes[24]

INV1 –Wrong Record/No name. The MR name and identifying information is completely different from the name on the MR coversheet (sampled beneficiary CMS- HCC). Validity Check Question: *Does the MR correctly identify the sampled beneficiary?*

INV2 – Missing signature. The MR submitted is not signed. Note that an attestation is not a consideration for this invalid reason code, the only consideration is if the MR has a signature. Validity Check Question: *Is the MR signed?*

INV3 – Name variation. The name on the MR is similar but does not match the MR coversheet. Validity Check Question: *Is the name on the MR an acceptable variance of the name of the sampled beneficiary?*

INV4 – Date missing. The date of service is missing entirely or partially complete (e.g. month/day only). Validity Check Question: *Is there a complete date of service on the MR?*

INV5 – Invalid medical record source. The medical record source is not on the acceptable sources of data list.[25] Data from hospital inpatient facilities, outpatient facilities, and physician office visits are the only valid data sources for RADV. Invalid sources include hospice, home health, lab only, super-bill, and non-face to face encounters. Validity Check Question: *Is the MR from a valid source?*

INV7 – Credentials missing. The MR is signed but there is no credential in the signature and no credential (MD, DO, NP) or specialty reference (Renal, Cardiology, PCP, Hospitalist, Attending, etc.) for the one specific physician/practitioner named on the document (heading, defined provider type in signature line).[26] Validity Check Question: *Are you able to confirm an acceptable credential or specialty (e.g., MD, PA, DPM, Cardiology, Internal Medicine)?*

INV14 – Date outside data collection period. The MR date of service is not within the data collection period.[27] Validity Check Question: *Is the date on the MR within the data collection period?*

INV17 – **Something other than a MR is attached.** The submission includes a coversheet, but the attached document is not a MR. Validity Check Question: *Is acceptable MR documentation included?*

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[24] Some invalid reason codes used in CMS RADV audits in the past have been discontinued, which is why there may be gaps between enumerated reason codes.

[25] Acceptable Sources of Data for PY2018 are located in Chapter 7 of the CMS Medicare Managed Care Manual, Table 22: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c07.pdf.

[26] Acceptable Physician Specialty Types for PY2018 are located in Chapter 7 of the CMS Medicare Managed Care Manual, Table 19: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c07.pdf.

[27] Valid Inpatient MRs must have a discharge date within the data collection period.

INV20 – Miscellaneous INV. There is a MR issue that hasn't already been identified in any of the INV questions. Validity Check Question: *Is the record free from invalid issues not otherwise addressed through existing INV checks?*

Attachment 1: Points of Contact Form

This attachment is incorporated by reference. Please see the document, *Attachment 1 - Points of Contact Form*, that accompanied the Audit Notice in HPMS.

Attachment 2: Hardship Exception Request Form

This attachment is incorporated by reference. Please see the document, *Attachment 2 - Hardship Exception Request Form*, that accompanied the Audit Notice in HPMS.