CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 118 **Date: September 19, 2014**

Transmittal 116, dated February 28, 2014, is being rescinded and replaced by Transmittal 118, dated September 19, 2014, to change the effective and implementation dates for ICD-10. All other information remains the same.

SUBJECT: Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010

I. SUMMARY OF CHANGES: The Medicare Managed Care Manual is updated to be consistent with CMS policies and instructions that have been issued about:

- conversion from ICD-9 to ICD-10 for reporting diagnoses and procedures, and
- conversion of ASC X12 formats from version 4010 to version 5010.

In addition references to Medicare carriers and intermediaries in the three chapters that require update for these changes are updated to refer to Medicare Administrative Contractors (MACs), which have replaced carriers and intermediaries. References to carriers and intermediaries in other chapters will be updated in future revisions.

NEW/REVISED MATERIAL

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: January 1, 2012 (for ASC X12 5010)

IMPLEMENTATION DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: January 1, 2012 (for ASC X12 5010)

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	7/40/Role and Responsibilities of Plan Sponsors
R	7/70.1/Calibration of the CMS-HCC Risk Adjustment Models
R	7/70.5.1/Model Similarities
R	7/120/Operations

R	7/120.1.1/Sources of Data
R	7/120.2.2/Format
R	7/120.2.3/Diagnosis Cluster
R	7/120.2.4/Valid Diagnosis Codes
R	7/120.2.6/Health Insurance Portability and Accountability Act (HIPAA)
R	7/130/Glossary of Terms
R	8/40.4.2/Rules for Payment of "Significant Cost" NCDs and LCBs
R	8/40.4.3/Special Rules for the September 2000 NCD on Clinical Trials
R	8/40.4.4/Category B Investigational Device Exemption (IDE) Trials
R	8/50/Adjustment to MA Payments Under the CMS-HCC Risk Adjustment Models
R	8/70.3.1/ CMS' Payments to Hospice Programs
R	16-B/50.2.1.3/Expanded Alternative Verification Methodology

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual
Chapter 7 – Risk Adjustment

40 - Role and Responsibilities of Plan Sponsors
(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

MA organizations, PACE organizations, 1876 Cost HMOs/Competitive Medical Plans (CMPs), and starting in 2012, Health Care Prepayment Plans (HCPPs) like the United Mine Workers of America Health and Retirement Funds, must submit risk adjustment data, as required by CMS.

This section provides a high-level checklist of plan requirements. Detailed information about risk adjustment data collection, submission, reporting, and validation are outlined in later sections within this chapter.

Risk Adjustment Data Submission Requirements – Plan Sponsors (Medicare Advantage Organizations (MAOs), PACE organizations, and 1876 Cost HMO/CMPs) must:

- Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.

- Implement procedures to ensure that diagnoses are from acceptable data sources. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians. Plan sponsors are responsible for determining provider type based on the source of the data.

- Submit the required data elements from acceptable data sources according to the coding guidelines.

- Submit all required diagnosis codes for each beneficiary and submit unique diagnoses at least once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clusters.

    - For Part B-only beneficiaries enrolled in a plan, the plan sponsor must submit diagnosis codes under the same rules as for a beneficiary with both

Parts A and B. The plan should also submit *diagnosis* codes for Part A services provided under a non-Medicare contract.

If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible.

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of diagnosis codes on an ongoing basis.

- Once CMS calculates the final risk scores for a payment year, plan sponsors may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had an impact on the final payment. Plan sponsors must inform CMS immediately upon such a finding.

70.1 - Calibration of the CMS-HCC Risk Adjustment Models

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The CMS-HCC risk adjustment model is used to adjust payments for Part C benefits offered by MA plans and PACE organizations to aged/disabled beneficiaries. The CMS-HCC model includes both diseases and demographic factors. There are separate sets of coefficients for beneficiaries in the community, beneficiaries in long term care institutions, and new enrollees. The CMS-HCC model was first used for payment in 2004 and has been recalibrated two times since then (2007 and 2009).

When CMS recalibrates the CMS-HCC risk adjustment model, it uses data from fee-for-service (FFS) claims, using one year's diagnoses to predict the following year's expenditures. When developing the model, CMS consulted with a panel of outside clinicians to review the *diagnosis* codes in order to group them with other clinically similar *diagnosis* codes. These diagnosis groupings were then mapped to condition categories based on similar clinical characteristics and severity, and cost implications. Both the panel of clinicians and analyses of cost data informed the creation of condition categories.

Coefficients for condition categories were estimated by regressing the total expenditure for Medicare Parts A and B benefits for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (e.g., age/sex group, Medicaid status, disability status).

While all *diagnosis* codes are mapped to a condition category, not all condition categories are included in the model used in payment. The decision to include a condition category in the model is based on each category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that don't predict costs well – because the coefficient is small, the t-value is low, the number of beneficiaries with a certain condition is small so the coefficient is unstable, or the condition does not have well specified diagnostic coding – are not included in the model.

In a final step, hierarchies were imposed on the condition categories, assuring that more advanced and costly forms of a condition are reflected in the risk score.

In order to use the risk adjustment model to calculate risk scores for payment, CMS creates a relative factor for each demographic factor and HCC in the model. CMS does this by dividing all the dollar coefficients by the average per capita predicted expenditure for a specific year (i.e., the "denominator year"). See Table 3 below for a list of data years and denominator years in each version of the risk adjustment model. The relative factors are used to calculate risk scores for individual beneficiaries, which will average 1.0 in the denominator year for the FFS population.

Each time the risk adjustment model is recalibrated, the relative factors can change. Changes in the dollar coefficients resulting from the regression – the marginal cost attributable to an HCC – can change relative to the average cost. For example, the coefficient for diabetes can increase, reflecting higher costs for the disease; but if the average cost for Medicare beneficiaries has increased even more than for diabetes, then the relative cost of diabetes will decrease. This decrease in relative cost will be reflected in a decrease in the relative factor, even though the costs associated with diabetes have increased.

Although recalibrated models retain an average 1.0 risk score, individual beneficiaries' risk scores may change, as may plan average risk scores, depending on each individual beneficiaries' combination of diagnoses.

Table 3. Data Years and Denominator Years

Payment Years	Diagnoses Year	Costs Year	Denominator Year
2004, 2005, 2006	1999	2000	2000
2007, 2008	2002	2003	2005
2009, 2010, 2011	2004	2005	2007

70.5.1 - Model Similarities

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The CMS-HCC and the CMS RxHCC risk adjustment models are constructed and calibrated using the same methodology and many of the same data sources.

Source of diagnoses: Individual ICD diagnosis codes, both for the calibration of the models, and to calculate risk scores for payment, are taken from FFS claims and MA-reported diagnosis data.

***Regression model to predict expenditures*:** The models for continuing enrollees and new enrollees are calibrated using a multiple regression analysis of actual expenditures. Both models predict benefit costs for which the plans are responsible for covering. The CMS-HCC model predicts full Part A and B Medicare expenditures. The RxHCC model predicts those expenditures for which Part D sponsors are responsible, i.e., drug costs excluding cost sharing amounts for which the enrollee or the government is responsible for paying. This RxHCC model is sometimes referred to as the plan liability model, to distinguish it from the total spending model, which has been calibrated for analytic purposes only.

Additive and hierarchical model: The two models generate enrollee risk scores by adding relative risk weights for individual risk markers that have been assigned to the beneficiary. This allows more than one disease to impact the final risk score. Both of the models use diagnostic hierarchies. Hierarchies prevent multiple diagnoses in the same disease group from inappropriately increasing the risk score. In this way, someone with metastatic cancer and breast cancer receives credit only for the former, rather than both. This is clinically appropriate and lessens the impact of variations in diagnosis coding completeness.

***Used to adjust capitated payment amounts*:** Risk adjustment is intended to adjust capitated payment amounts to pay plans fairly and accurately, thereby decreasing incentives for health plans to avoid enrolling sicker beneficiaries. Both of these models adjust standardized payments for the underlying health status of the beneficiaries enrolled in the plan. The RxHCC model adjusts the monthly Part D direct subsidy. The CMS-HCC model adjusts Part C monthly payments to Medicare Advantage plans and PACE organizations.

Risk scores are relative and reflect the standard benefit: Each beneficiary's risk score is calculated to estimate that specific beneficiary's expected costs, relative to the average beneficiary. For each model, a risk score of 1.0 reflects the Medicare-incurred expenditures of an average beneficiary. An RxHCC risk score of 1.0 indicates the beneficiary is expected to incur the average liability amount for prescription drugs when covered by the standard Part D Medicare benefit. A CMS-HCC risk score of 1.0 indicates the beneficiary is expected to incur the average Medicare program expenditure for Parts A and B services.

120 - Operations

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS requires Medicare Advantage plans to collect hospital inpatient, hospital outpatient, and physician risk adjustment data and submit the data to CMS at least quarterly for calculation of the risk score for use in the payment calculation and payment reconciliation. Each quarterly submission should represent approximately one-fourth of the data a plan submits during a data collection year.

Once plans have collected the data and verified the data came from an acceptable data source, the plans submit the data using the Risk Adjustment Processing System (RAPS) format and provide the five required data elements in the cluster. Table 12 lists the five required elements and a description for each.

Table 12. Five Required Data Elements/Descriptions

Required Data Element	Description
Health Insurance Claim (HIC) Number	Beneficiary identification number issued by the Railroad Retirement Board (RRB) or the Social Security Administration (SSA).
Diagnosis code	*International Classification of Diseases (ICD)* codes are used to describe the clinical reason for a patient's treatment.
Service from date	The dates of service define when a beneficiary received medical treatment from a physician or medical facility. For outpatient and physician services, the From Date and Through Date may be identical. For inpatient services, these dates are usually different from each other, and reflect the dates of admission to and discharge from a facility.
Service through date	
Provider type	The types of providers, for the purpose of risk adjustment, MA organizations must collect data from are: • Hospital Inpatient facilities • Hospital outpatient facilities • Physicians

Plans submit the five data elements in the RAPS format (or the Direct Data Entry, an online data entry application for the RAPS format) to the Front End Risk Adjustment System (FERAS) for initial edit checks. FERAS transmits files successfully passing the initial edit checks to RAPS for detailed editing and processing.

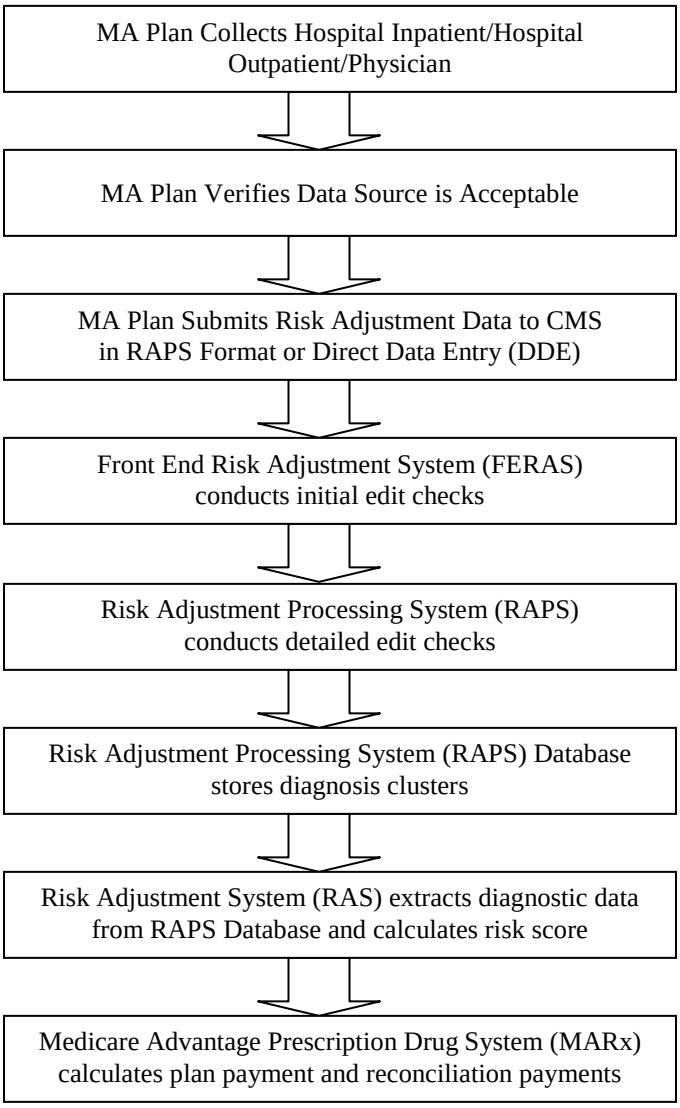
The FERAS and RAPS systems generate Transaction Reports describing the status of the transaction and any errors that occurred during processing. RAPS also provides Management Reports that identify the disposition of the submitted data so plans can verify their data and project their payment.

Finalized diagnosis clusters are stored in the RAPS database and used for calculation of risk scores. The Risk Adjustment System (RAS) extracts the diagnostic data from the RAPS database to calculate risk scores by executing the CMS-HCC payment model.

RAS sends the risk scores to the Medicare Advantage Prescription Drug System (MARx) for use in calculation of plan payments and payment reconciliation.

Figure 2 illustrates the risk adjustment collection, submission, and payment process.

Figure 2. Operations Overview



120.1.1 - Sources of Data

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS requires that MA organizations collect data for the purposes of risk adjustment from the following provider types:

- Hospital inpatient facilities
- Hospital outpatient facilities

- Physicians

Unacceptable Data Sources

It is important for MA organizations to note that regardless of the type of diagnostic radiology bill (outpatient department or physician component), the diagnostic data associated with these services are not acceptable for risk adjustment. Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and is, therefore, not assigned in the medical record documentation from diagnostic radiology services alone.

Excluded Providers

Medicare will not pay for items or services rendered to beneficiaries and recipients by an excluded provider or by entities owned or managed by an excluded provider. Therefore, MA organizations should not submit risk adjustment data if it was submitted by an excluded provider. Providers are excluded for the following reasons: a program related crime, patient abuse or neglect, health care fraud in any health care program, and convictions relating to controlled substances.

The HHS monthly exclusion notification can be found at http://oig.hhs.gov/fraud/exclusions.asp.

Hospital Inpatient

A hospital inpatient service is one provided by a hospital during which a patient is admitted to the facility for at least one overnight stay. Table 13 identifies covered and non-covered facilities with regard to risk adjustment diagnoses data collection.

Table 13. Hospital Inpatient Sources of Diagnostic Data

RAPS Provider Type	Covered Facilities	Non-Covered Facilities*
Hospital Inpatient	Short-term (general and specialty) Hospitals Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) Long-term Hospitals Rehabilitation Hospitals Children's Hospitals Psychiatric Hospitals Medical Assistance Facilities/ Critical Access Hospitals	Skilled Nursing Facilities (SNFs) Hospital Inpatient Swing Bed Components Intermediate Care Facilities Respite Care Hospice

*These are examples of non-covered facilities and not a comprehensive list.

NOTE: When submitting hospital inpatient data, MA organizations must make a distinction between the principal diagnosis and other diagnoses. Section 120.2 Submission and Flow of Risk Adjustment Data covers the details of submitting data.

Hospital Outpatient

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization.

Table 14 identifies covered and non-covered hospital outpatient facilities. MA organizations should refer to this table with regard to risk adjustment data collection.

Table 14. Outpatient Sources of Diagnostic Data

<table>
<tr><th>RAPS Provider Type</th><th>Covered Facilities</th><th>Non-Covered Facilities*</th></tr>
<tr><td rowspan="4">Hospital Outpatient</td><td>Short-term (general and specialty) Hospitals
Medical Assistance Facilities/Critical Access Hospitals
Community Mental Health Centers 1**
Federally Qualified Health Centers 2/ Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) **
Long-term Hospitals
Rehabilitation Hospitals
Children’s Hospitals
Psychiatric Hospitals
Rural Health Clinic (Free-standing and Provider-Based) 3**</td><td>Free-standing Ambulatory Surgical Centers (ASCs)
Home Health Care
Free-standing Renal Dialysis Facilities</td></tr>
<tr><td colspan="2">Non-Covered Services</td></tr>
<tr><td>Laboratory Services
Ambulance
Durable Medical Equipment
Prosthetics</td><td>Orthotics
Supplies
Radiology Services</td></tr>
</table>

* These are examples of non-covered facilities and are not to be considered a comprehensive list.

** Facilities use a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

1. Community Mental Health Centers (CMHCs) provide outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at an inpatient facility.

2. Federally Qualified Health Centers (FQHCs) are facilities located in a medically underserved area that provide Medicare beneficiaries with preventive primary medical care under the general direction of a physician.

3. Rural Health Clinics (RHCs) are Medicare certified facilities that are located in a rural, medically underserved area that provide ambulatory primary medical care under the general direction of a physician.

Determining Whether Facilities Are Acceptable for Risk Adjustment – MA organizations are responsible for ensuring that data collected and submitted to CMS are acceptable for the risk adjustment process. However, the NPI does not convey information regarding the type of facility or provider specialty, so a new code called the "taxonomy code" can be used to help identify types of providers. Both the legacy provider number and the taxonomy code can be used in determining the appropriateness of the covered hospital entities for the purposes of risk adjustment data collection. Table 15 illustrates the steps MA organizations may use to identify the provider numbers or taxonomy codes for facilities.

Table 15. Determining Covered Hospital Entity Provider Numbers

Situation	Issue	Action
Situation 1	The CCN or taxonomy code is identified.	Determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data.
Situation 2	An in-network provider submitted a claim but did not include any provider number or taxonomy code.	Obtain the provider number or taxonomy code and then determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data. NOTE: All network providers are required to have provider numbers or taxonomy codes; therefore, do not submit risk adjustment data for this provider until these numbers are obtained.
Situation 3	An out-of-network provider submits a claim without a provider number.	Plans must obtain a provider number or taxonomy code.

National Provider Identifier – MA organizations should verify that diagnoses are collected from Medicare certified hospitals/facilities and that data from all Medicare certified network hospital/facilities include the associated Medicare provider identifiers (NPI and taxonomy code; or the legacy provider number). They should also verify that the Medicare certified hospitals/facilities providing the data are from acceptable facilities and services. As stated above, plans may use either the Medicare provider numbers or the taxonomy code to determine if facilities and services are acceptable for risk adjustment.

Plan sponsors may wish to create a system for checking if the data are from acceptable facilities and for acceptable services. They may check the legacy provider number against the provider number ranges or check the taxonomy code against the taxonomy code ranges, both of which identify what type of service has been rendered.

- If using the legacy provider number, please note that it has six characters.
    - The first two characters are numerals and represent the state/territory as illustrated in Table 16.

Table 16. Provider Number State Assignments

State	Code	State	Code	State	Code
Alabama	01	Kentucky	18	Oklahoma	37
Alaska	02	Louisiana	19	Oregon	38
American Samoa	64	Maine	20	Palau	N/A
Arizona	03	Maryland	21	Pennsylvania	39
Arkansas	04	Massachusetts	22	Puerto Rico	40
California	05	Michigan	23	Rhode Island	41
Colorado	06	Minnesota	24	South Carolina	42
Connecticut	07	Mississippi	25	South Dakota	43
Delaware	08	Missouri	26	Tennessee	44
District of Columbia	09	Montana	27	Texas	45
Florida	10	Nebraska	28	Utah	46
Georgia	11	Nevada	29	Vermont	47
Guam	65	New Hampshire	30	Virgin Islands	48
Hawaii	12	New Jersey	31	Virginia	49
Idaho	13	New Mexico	32	Washington	50
Illinois	14	New York	33	West Virginia	51
Indiana	15	North Carolina	34	Wisconsin	52
Iowa	16	North Dakota	35	Wyoming	53
Kansas	17	Ohio	36		

- The third character may be a numeral or a letter. Provider numbers with a **U, W, Y, Z, 5,** or **6** in the third character indicate that the service was provided in a swing bed component of a hospital or a skilled nursing facility, which, are not covered entities. The last three characters are numerals unique to the facility.

- If using the taxonomy code, the bill type will be needed to identify if the service was provided by a non-covered entity such as a swing bed component of a hospital or a skilled nursing facility.

As an additional check, refer to Tables 17 and 18, which provide the only acceptable ranges for hospital facilities. The tables reflect the range of legacy provider numbers for risk adjustment covered hospital entities. Risk adjustment data are not acceptable when received from facilities with numbers outside the ranges.

NOTE: Skilled nursing facilities, home health care, and hospital inpatient swing bed components are not covered entities for risk adjustment data.

Table 17. Hospital Inpatient Covered Entities

Type Of Hospital Inpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Religious Non-Medical Health Care Institutions	XX1990-XX1999	TOB 4XX
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

Table 18. Hospital Outpatient Covered Entities

Type Of Hospital Outpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899	282N00000X

Type Of Hospital Outpatient Facility	Provider Number Range	Taxonomy Code/ Type of Bill (TOB)
	XXS001-XXS899 XXT001-XXT899	273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Community Mental Health Centers	XX1400-XX1499 XX4600-XX4799 XX4900-XX4999	TOB 76X
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions	XX1800-XX1999	TOB 73X for FQHC TOB 4XX for RNHCI
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X
Rural Health Clinics, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999	TOB 71X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

The implementation of the NPI did not change the valid Hospital Inpatient and Outpatient facilities for submission of risk adjustment data nor eliminate the process for receiving and verifying information from Medicare health care providers that are in network. Institutional providers that currently bill Medicare using more than one legacy identifier in order to identify subparts of their facility are required to submit a taxonomy code on all of the claims they submit to Medicare.

The Health Care Provider Taxonomy Code Set website, http://www.wpc-edi.com/codes/taxonomy, serves as a reference to types of facilities and taxonomy codes.

The American Hospital Directory website, http://www.ahd.com/freesearch.php3, serves as a reference for hospital provider numbers.

Physician

The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all diagnoses that are in the risk adjustment model and rendered as a result of a physician visit must be collected by the MA organization. This includes data collected from non-network as well as network physicians.

Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).

Only those physician specialties and other clinical specialists identified in Table 19 are acceptable for risk adjustment.

Table 19. Acceptable Physician Specialty Types
Payment Year 2011 (dates of services 2010)

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	26	Psychiatry	67	Occupational Therapist
2	General Surgery	27**	Geriatric Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	28	Colorectal Surgery	72*	Pain Management
4	Otolaryngology	29	Pulmonary Disease	76*	Peripheral Vascular Disease
5	Anesthesiology	33*	Thoracic Surgery	77	Vascular Surgery
6	Cardiology	34	Urology	78	Cardiac Surgery
7	Dermatology	35	Chiropractic	79	Addiction Medicine
8	Family Practice	36	Nuclear Medicine	80	Licensed Clinical Social Worker
9**	Interventional Pain Management (IPM)	37	Pediatric Medicine	81	Critical care (intensivists)
10	Gastroenterology	38	Geriatric Medicine	82	Hematology
11	Internal Medicine	39	Nephrology	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	40	Hand Surgery	84	Preventive Medicine
13	Neurology	41	Optometry	85	Maxillofacial Surgery
14	Neurosurgery	42	Certified Nurse Midwife	86	Neuropsychiatry
15	Speech Language Pathologist	43	Certified Registered Nurse Anesthetist	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	44	Infectious Disease	90	Medical Oncology
17**	Hospice And Palliative Care	46*	Endocrinology	91	Surgical Oncology
18	Ophthalmology	48*	Podiatry	92	Radiation Oncology
19	Oral Surgery	50*	Nurse Practitioner	93	Emergency Medicine
20	Orthopedic Surgery	62*	Psychologist	94	Interventional Radiology
22*	Pathology	64*	Audiologist	97*	Physician Assistant
24*	Plastic And Reconstructive Surgery	65	Physical Therapist	98	Gynecologist/Oncologist
25	Physical Medicine And Rehabilitation	66	Rheumatology	99	Unknown Physician Specialty

* Indicates that a number has been skipped.
** Added effective January 1, 2010 dates of service

120.2.2 - Format

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

In accordance with CMS' 2008 Call Letter, MA organizations must submit risk adjustment data electronically using one of two formats to enable CMS to more efficiently process the data at CSSC and ensure appropriate payment under the risk adjustment payment models. MA organizations must submit data electronically using either the RAPS format or the Direct Data Entry (DDE) option. Both of these formats are used for all provider types.

Table 20 describes each field of the current RAPS file layout.

- The shaded fields in the table represent where the RAPS Return File provides new information after data processes through RAPS.

There are two diagnosis cluster error fields because MA organizations can receive up to two errors on any diagnosis cluster.

Table 20. RAPS File Layout

RAPS RECORD AAA – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	File-level information that identifies the submitter. This field should always be populated with "AAA."
2	4-9	Required	Submitter ID	Identifies the submitter and should be populated with the six-digit alphanumeric SH# assigned by CSSC.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. This file name may not be repeated within a 12-month period.
4	20-27	Required	Transaction Date	Specifies the date that the file was submitted to Palmetto and formatted as CCYYMMDD.
5	28-31	Required	Production Test Indicator	Must be populated with "PROD" or "TEST." Submission test data proceeds through the entire process.
6	32-512	Spaces	Filler	Must be populated with 481 spaces. The "Filler" field allows for additional fields in the future.

RAPS RECORD BBB – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Batch-level information that identifies the MA organization is populated with "BBB."
2	4-10	Required	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one. This is a numeric field.
3	11-15	Required	Plan Number	Identifies the MA organization and should be populated with the five-digit alphanumeric contract assigned by CMS. (H#, R#, etc.).
4	16-512	Spaces	Filler	Must be populated with 497 spaces. The "Filler" field allows for additional fields in the future.

Table 20. RAPS File Layout (Continued)

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Detail-level information that identifies the beneficiary information. This field should always be populated with "CCC."
2	4-10	Required	Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field. Limited to 1,000,000 per day.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the sequence number, or will remain blank if no errors were detected in the sequence number.
4	14-53	Optional	Patient Control Number	This optional field may be used by the MA organization to identify the claim submitted. The field allows up to 40 alphanumeric characters.
5	54-78	Required	HIC	The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces, not zeros, in unused spaces.
6	79-81	RAPS RETURN	HIC Error Code	This should be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the HIC number, or remains blank if no errors were detected in the HIC number.
7	82-89	Optional	Patient DOB	This optional field may be populated with the patient's date of birth and is used to verify that the correct beneficiary identification was submitted. If the field is populated, it must be formatted as CCYYMMDD, and CMS edits this field against the information on file at the MBD. If no DOB is submitted, fill with spaces.
8	90-92	RAPS RETURN	DOB Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error with DOB, or remains blank if no errors were detected in the DOB.

Table 20. RAPS File Layout (Continued)

RAPS RECORD CCC – DETAIL LEVEL (CONTINUED)				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
9	93-412	DIAGNOSIS-CLUSTER (10 occurrences)		The following 8 fields (9.0-9.7) may be repeated 10 times in the same "CCC" record with one diagnosis per cluster. Each diagnosis cluster must contain 32 characters or spaces. Plans must not skip clusters when submitting active diagnosis codes. If there are less than 10 diagnosis clusters the remaining clusters are space filled. If there are more than 10 diagnoses, a new "CCC" record must be established.
9.0		Required	Provider Type	This 2-digit alphanumeric field identifies the site of service provided (01,02,10,20).
9.1		Required	From Date	For hospital inpatient this describes the admission date. For physician and hospital outpatient this describes the date of service. Must be formatted as CCYYMMDD.
9.2		Required	Through Date	For hospital inpatient this describes the discharge date. For physician and hospital outpatient this may be left blank and the system will fill with the "From Date." Must be formatted as CCYYMMDD.
9.3		Conditional	Delete Indicator	This field allows the MA organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. Enter a "D" or space.
9.4		Required *when ICD-9-CM is used*	Diagnosis *Code or Filler*	This field is populated with the three-to five-digit ICD-9-CM diagnosis code. The decimal is implied and should not be included (e.g., 42732). *Fill with spaces when ICD-9-CM is not used. Left justify.*
9.5		*Required when ICD-10-CM is used*	Diagnosis Code *or* Filler	*This field is populated with the three-to seven-digit ICD-10-CM diagnosis code. The decimal is implied and should not be included (e.g., 4273432).* *Fill with spaces when ICD-10-CM is not used. Left justify*
9.6		RAPS RETURN	Diagnosis Cluster Error 1	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
9.7		RAPS RETURN	Diagnosis Cluster Error 2	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
19	413-437	RAPS RETURN	Corrected HIC number	This field must be submitted with spaces. If the MA organization has submitted an outdated HIC, upon return, this field is populated with the most current HIC number and the "HIC Error" field contains an information error code.

RAPS RECORD CCC – DETAIL LEVEL (CONTINUED)				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
20	438-512	Spaces	Filler	Must be populated with 75 spaces. The “Filler” field allows for additional fields in the future.

Table 20. RAPS File Layout (Continued)

RAPS RECORD YYY – BATCH TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
1	1-3	Required	Record ID	Batch trailer information should be populated with "YYY."
2	4-10	Required	Sequence Number	A 7-digit numeric character identifying the batch submitted. Must match the "BBB" record.
3	11-15	Required	"H" Number	"H" number assigned by CMS to identify the MA organization. Must match the "H" number in the corresponding "BBB" record (i.e., the "BBB" record with the same sequence number).
4	16-22	Required	CCC Record Total	This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001). Limited to 1,000,000 per day.
5	23-512	Spaces	Filler	Must be populated with 490 spaces. The "Filler" field allows for additional fields in the future.

RAPS RECORD ZZZ – FILE TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
1	1-3	Required	Record ID	File Trailer Information should be populated with "ZZZ."
2	4-9	Required	Submitter ID	Identifies the submitter and must match the 6-digit alphanumeric SH# in the AAA record.
3	10-19	Required	File ID	10-digit alphanumeric character identifying the specific file submitted. Must match the File ID in the "AAA" record.
4	20-26	Required	BBB Record Total	This field should total the number of batches in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001).
5	27-512	Required	Filler	Must be populated with 486 spaces. The "Filler" field allows for additional fields in the future.

Data must be submitted as described in the tables above. When data is entered improperly, the plan receives errors as the data is processed through FERAS or RAPS. If errors are discovered in FERAS, the file will be returned to the plan. Job aids with list of FERAS and RAPS error codes are available at http://www.csscoperations.com. Once at the web site, select "Training Information," then select the latest "Risk Adjustment Training Information" link, and then select "Job Aides."

120.2.3 - Diagnosis Cluster

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The diagnosis cluster contains the core information regarding each diagnosis submitted by an MA organization. The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- Delete Indicator
- Diagnosis Code

A maximum of 10 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above. If any of these attributes are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur.

ICD-9-CM Diagnosis Codes - International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment *for inpatient discharges before the ICD-10 implementation date and for outpatient and physician services before that date*. Diagnosis codes describe the patient's medical condition, not the service performed. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations.

ICD-10-CM will be used for inpatient discharges and for outpatient and physician services on or after the ICD-10 implementation date. ICD-10-CM codes are 3-7 digit codes.

Service From and Through Dates – Defines the start and end dates for a provided service. The correct submission format for the "From" and "Through" dates of service is CCYYMMDD. The "Through Date" defines the data used in the data collection year for risk adjustment purposes. Table 21 describes the "From" and "Through" dates.

Table 21. From and Through Dates

PROVIDER TYPE	FROM DATE	THROUGH DATE
Hospital Inpatient	Admission Date	Must have a through date and must be the discharge date
Hospital Outpatient	Exact date of patient visit or the first date service began for a series of services	Exact date of patient visit or the last date of service for a series of services
Physician		

Hospital Inpatient dates of service must reflect the final bill. Interim bills are not acceptable for risk adjustment data.

MA organizations may submit several occurrences of the same diagnosis in one cluster with a 31-date span. The "From" date will reflect the first occurrence and the "Through" date will reflect the final occurrence within the 31 days.

Delete Indicator – To delete a diagnosis, for correction purposes, that has been stored in the RAPS database, a "D" is entered. If not correcting a diagnosis, then a space is entered.

Provider Type – For risk adjustment purposes, MA organizations are responsible for collecting data from the acceptable data sources (hospital inpatient, hospital outpatient, and physician) and determining the provider type based on the source of data.

Type of Bill (TOB), which is coded on *the encounter record* during the collection of hospital data, may be used to assist in translating the correct provider type.

Table 22 lists the acceptable sources of data, provider types, provider type codes, TOB.

Table 22. Provider Type and Code

Source of Data	Provider Type	Provider Type Code	Type of Bill
Hospital Inpatient	Hospital Inpatient Principle Diagnosis	01	111 or 11Z
Hospital Inpatient	Hospital Inpatient Other Diagnosis	02	111 or 11Z
Hospital Outpatient	Hospital Outpatient	10	131, 13Z, 141 or 14Z
Physician	Physician	20	N/A

120.2.4 - Valid Diagnosis Codes

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Valid diagnosis codes are those that are published for the fiscal years pertaining to the CMS-HCC risk adjustment model in use for a particular payment year. Current model diagnosis codes are codes that CMS accepts as valid, and are also included in the current version of the CMS-HCC model; only these diagnosis codes affect the risk score in a particular payment year. Future model diagnosis codes are codes that are currently valid, but are not included in the current version of the CMS-HCC model and, therefore, do not count toward the risk score.

A current model diagnosis code must meet the following criteria:

1. The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC), Prescription Drug (CMS-RxHCC) or End Stage Renal Disease (CMS-HCC ESRD) risk adjustment models.

2. The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.

3. The diagnosis must be collected according to the risk adjustment data collection instructions.

A list of current and future *diagnosis* codes for the CMS-HCC, ESRD, and RxHCC risk adjustment models for any given payment year includes published National Center for Health Statistics (NCHS)/CMS codes that are valid for the payment year. The list is posted on the CMS website at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage

Figure 3 provides a snapshot of the required diagnoses for a given payment year.

Figure 3. Example of Required Current and Future Model Diagnoses

Revised September 30, 2008

ICD-9-CM Codes, CMS-HCC and RxHCC models

ICD-9-CM Code	ICD9_Description	Diagnosis Code Effective Date	CMS-HCC Model Category	RxHCC Model Category	CMS-HCC Model Calendar Year 2004 Payment	CMS-HCC Model Calendar Year 2005 Payment	CMS-HCC Model Calendar Year 2006 Payment	CMS-HCC Model Calendar Year 2007 Payment	CMS-HCC Model Calendar Year 2008 Payment	CMS-HCC Model Calendar Year 2009 Payment	RxHCC Model Calendar Year 2006 Payment	RxHCC Model Calendar Year 2007 Payment	RxHCC Model Calendar Year 2008 Payment	RxHCC Model Calendar Year 2009 Payment
0031	Salmonella Septicemia	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
00322	Salmonella Pneumonia	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
00323	Salmonella Arthritis	1/1/1991	37	39	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
00324	Salmonella Osteomyelitis	1/1/1991	37	39	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0064	Amebic Lung Abscess	1/1/1991	112	112	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0066	Amebic Skin Ulceration	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0074	Cryptosporidiosis	10/1/1998	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0201	Cellulocutaneous Plague	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0202	Septicemic Plague	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0203	Primary Pneumonic Plague	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0204	Secondary Pneumon Plague	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0205	Pneumonic Plague Nos	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0212	Pulmonary Tularemia	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0220	Cutaneous Anthrax	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0221	Pulmonary Anthrax	1/1/1991	112		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0223	Anthrax Septicemia	1/1/1991	2		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
0310	Pulmonary Mycobacteria	1/1/1991	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
0311	Cutaneous Mycobacteria	1/1/1991		159	No	No	No	No	No	No	Yes	Yes	Yes	Yes
0312	Dmac Bacteremia	10/1/1998	5	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
03283	Diphtheritic Peritonitis	1/1/1991	31		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No

ICD-9-CM Codes, Future models only

ICD-9-CM Code	*ICD9_Description*	*Diagnosis Code Effective Date*
003	OTH SALMONELLA INFECTION*	1/1/1991
0030	SALMONELLA ENTERITIS	1/1/1991
0032	LOCAL SALMONELLA INFECT*	1/1/1991
00320	LOCAL SALMONELLA INF NOS	1/1/1991
00321	SALMONELLA MENINGITIS	1/1/1991
00329	LOCAL SALMONELLA INF NEC	1/1/1991
0038	SALMONELLA INFECTION NEC	1/1/1991
0039	SALMONELLA INFECTION NOS	1/1/1991
004	SHIGELLOSIS*	1/1/1991
0040	SHIGELLA DYSENTERIAE	1/1/1991
0041	SHIGELLA FLEXNERI	1/1/1991
0042	SHIGELLA BOYDII	1/1/1991
0043	SHIGELLA SONNEI	1/1/1991
0048	SHIGELLA INFECTION NEC	1/1/1991
0049	SHIGELLOSIS NOS	1/1/1991
0065	AMEBIC BRAIN ABSCESS	1/1/1991
008	INTESTINAL INFECTION NEC*	1/1/1991
0080	E. COLI ENTERITIS*	1/1/1991
00800	INTEST INFEC E COLI NOS	1/1/1991

120.2.6 - Health Insurance Portability and Accountability Act (HIPAA)

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Effective October 16, 2003, when HIPAA transaction standards became mandatory, all electronic claims/encounters sent from providers/physicians to MA organizations (health plans) constitute a HIPAA covered transaction. Any MA organization that receives an electronic claim/encounter from a provider/physician must use the *current applicable ASC* X12 837 format.

MA organizations cannot request that a physician resubmit data previously submitted (same patient, same diagnosis) using a different format (e.g., HCFA 1500) if the physician initially submits data in *ASC X12 professional* format for purposes of risk adjustment data collection.

In accordance with Final Rule 45 CFR Part 152, effective March 17, 2009, CMS adopted X12 Version 5010 for HIPAA transactions. The final rule mandates covered entities MA organizations (health plans) comply no later than January 1, 2012.

130 - Glossary of Terms

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Beneficiary Demographic Input File - Contains beneficiary demographic data captured from Common Medicare Environment. The demographic data is used by the Risk Adjustment System (RAS) to calculate a beneficiary's risk score and to determine payment.

Beneficiary Diagnosis Input File - Contains beneficiary diagnosis data captured from Risk Adjustment Processing System (RAPS) and National Medicare Utilization Database (NMUD). The diagnosis data is used by the Risk Adjustment System to calculate a beneficiary's risk score and to determine payment.

Common Medicare Environment (CME) – Tables sourced from the Medicare Beneficiary Database (MBD) and the Enrollment Database (EDB) that provide beneficiary demographic and enrollment data.

Connect: Direct - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. This connection involves mainframe-to-mainframe connection with a submission response from FERAS.

Data Collection Period - The 12 month period from which CMS uses diagnoses submitted by MA organizations to calculate a beneficiary's risk score.

Data Submission - The process in which MA organizations submit required data elements to CMS for risk adjustment purposes.

Data Validation - The process of validating that enrollee diagnosis codes submitted for payment by MA organizations are supported by the medical record documentation.

Diagnosis Cluster - Core information submitted by MA organizations for each diagnoses submitted. The following are included: provider type, from date of service, through date of service, delete indicator, and diagnosis code.

Dialysis Status - CMS risk adjusts payments for a beneficiary using the CMS-HCC dialysis model when we are notified that the beneficiary is receiving dialysis.

Direct Data Entry (DDE) - An electronic data exchange between providers and health plans where health plans enter RAPS data directly into an online screen for processing.

Disabled Status - Demographic factor for beneficiaries who became eligible for Medicare based on a disability.

Disease Hierarchy - *International Classification of Diseases Clinical Modification (ICD-9-*CM *or ICD-10 CM as applicable)* diagnosis codes that address multiple levels of severity for a disease with varying levels of associated medical costs.

Dual Eligible - An MA eligible individual who is also entitled to Medical Assistance under a State Plan under Title XIX (Medicaid). A chart describing the various categories of individuals who are collectively known as dual-eligibles can be found at: https://www.cms.gov/MedicareEnRpts/Downloads/Buy-InDefinitions.pdf.

Electronic Data Interchange (EDI) Agreement - An agreement MA organizations have with CMS to follow provisions for submitting risk adjustment data through one of CMS' accepted types of electronic connections.

End Stage Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Enrollment Database (EDB) – A data repository that contains Medicare entitlement information for beneficiaries entitled to Medicare.

File Transfer Protocol (FTP) - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. The connection uses modem-to-modem (i.e., dial up) or lease line connection with a submission response from FERAS.

Frailty Adjuster - Predicts Medicare expenditures of community populations with functional impairments that are unexplained by the risk adjustment methodology alone.

The frailty adjuster is included as part of risk adjusted payments for PACE organizations and, through 2011, for certain demonstration organizations. Beginning in 2012, certain Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are eligible to receive frailty adjustment.

Front End Risk Adjustment (FERAS) - Performs the initial file editing for risk adjustment data submitted by Medicare Advantage and Medicare Advantage-Prescription Drug plans and transmits files to the Risk Adjustment Processing System (RAPS).

Full Risk - Medicare beneficiaries that have 12 months of Part B coverage during the data collection period.

Gentran - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. Gentran users are issued a mailbox and it is used as a vehicle to transmit and receive reports on RAPS data sent to CMS.

Health Plan Management System (HPMS) - CMS information system used by Medicare Advantage and Prescription Drug plans to upload bid, Plan Benefit Package, and marketing information, and is used by CMS to send information to plans.

Hierarchical Condition Category (HCC) - Groupings of clinically similar diagnoses in each risk adjustment model. Conditions are categorized hierarchically and the highest severity takes precedence over other conditions in a hierarchy. Each HCC is assigned a relative factor which is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.

Health Insurance Portability and Accountability Act (HIPAA) - Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data and contained health insurance reforms intended to promote access and portability of insurance coverage. The implementation of HIPPA improved the use of electronic data exchange in the national health care system.

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) Codes - 3 to 5-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. *ICD-9-CM codes are used for inpatient discharges before the implementation date of ICD-10, and for outpatient and physician services before that date.*

***International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) Codes** - 3- to 7-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted*

reimbursement from CMS to MA organizations. ICD-10-CM codes are used for inpatient discharges on and after the implementation date of ICD-10, and for outpatient and physician services on and after that date.

Long-term Institutionalized (LTI) Status - CMS identifies whether a Medicare beneficiary is in a long term institution for both model development and risk score calculation purposes. CMS considers a beneficiary as having long term institutional status if they have been in an institution for 90 days or more. CMS obtains this information from the Minimum Data Set (MDS), which stores dates of 90-day assessments reported by nursing homes.

Low-income Subsidy (LIS) - Provides financial assistance for beneficiaries who have limited income and resources; individuals eligible for this low-income subsidy will receive assistance with paying for their monthly premium, yearly deductible, prescription coinsurance and copayments and coverage in the gap.

Medicaid - Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.

Medicare Advantage Prescription Drug (MARx) System - Receives beneficiary level risk adjustment factors from RAS for use in Part C and Part D payment calculations.

Medicare Beneficiary Database (MBD) – A data repository that contains eligibility and enrollment data for Medicare beneficiaries.

Minimum Data Set (MDS) - A part of the Resident Assessment Instrument (RAI) developed by CMS to assist Medicare/Medicaid certified nursing homes in developing a comprehensive care plan for each resident.

Minimum Data Set (MDS) Long Term Institutional File - Identifies beneficiaries that resided in a long term institution for 90 days or more, which classifies them as long term institutional (LTI) beneficiaries. The file is used to identify Medicare beneficiaries that reside in LTI for risk adjustment purposes.

National Medicare Utilization Database (NMUD) - Contains Medicare claims data, including diagnostic data submitted by fee-for-service providers for beneficiaries new to Medicare Advantage with less than 12 months of risk adjustment data. The diagnostic data stored in NMUD is translated to the risk adjustment format.

National Provider Identifier (NPI) - The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization.

New Enrollee - A Medicare beneficiary who has less than 12 months of Part B entitlement during the data collection period.

Normalization Factor - Factor used to correct population and coding changes between the data years used in model calibration and the payment year.

Original Reason for Entitlement Code (OREC) - A demographic factor added to the risk score for beneficiaries 65 years of age or older who were originally entitled to Medicare due to disability. The factor varies based on the age and sex of the beneficiary.

Post-Graft (Functioning Graft) - A beneficiary is in post-graft status when they have received a kidney transplant or kidney/pancreas transplant at least three months ago and did not return to dialysis status since the transplant. There is a separate segment of the CMS-HCC ESRD model for people who have functioning kidney grafts.

Principal Inpatient Diagnostic Cost Group (PIP-DCG) - The PIP-DCG model was a precursor to the CMS-HCC risk adjustment model CMS used the PIP-DCG model from 2000-2003. In this model, CMS used diagnoses from hospitalizations to identify a particularly ill and high cost subset of beneficiaries for whom CMS will make higher payments in the next year. The system recognized admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

Program of All-Inclusive Care for the Elderly (PACE) - A unique capitated managed care benefit for frail and elderly individuals provided by a public entity or private entity. PACE features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Reconciliation - The CMS process of updating beneficiaries' statuses and processing the resulting payment adjustments.

Risk Adjustment Processing System (RAPS) – An application that stores diagnoses data submitted by MA Organizations. Upon completion of the initial file processing, FERAS sends the risk adjustment data to RAPS to perform low level edits to the file header and record.

Risk Adjustment System (RAS) – A system used to calculate a beneficiary's risk score from enrollment and diagnosis data received from Common Medicare Environment (CME), National Medicare Utilization Database (NMUD) system and Risk Adjustment Processing System (RAPS). After the risk scores are calculated in RAS, they are sent to MARx to use in calculating beneficiary level prospective payments.

Special Needs Plan (SNP) - An MA coordinated plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more severe or disabling chronic conditions, as set forth at 42 CFR 422.4(a)(1)(iv) of the MA regulation, and provides Part D benefits under 42 CFR Part 423.

Taxonomy Code - An external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute, Accredited Standards Committee health care transaction.

Transplant Status - A Medicare beneficiary is in Transplant Status for the three months commencing with a kidney transplant.

Medicare Managed Care Manual
Chapter 8 - Payments to Medicare Advantage Organizations

40.4.2 - Rules for Payment of "Significant Cost" NCDs and LCBs
(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Before Adjustments to Annual MA Capitation Rate Are Effective. Before the contract year when the MA capitation rates have been adjusted to take into account the significant cost NCD or LCB, the following rules apply to such services.

1. Medicare payment for the service or benefit is:

   - In addition to the capitation payment to the MA organization; and
   - Made directly by the fee-for-service contractors to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.

2. Costs for NCDs or LCBs for which CMS *MACs* will not make payment and are the responsibility of the MA organization are defined in §90.2 of Chapter 4.

3. Costs for NCDs or LCBs for which CMS fee-for-service contractors will make payment are:

   - Costs relating directly to the provision of services related to the NCD or LCB that were non-covered services prior to issuance of the NCD or LCB; and
   - A service that is not included in the MA capitation rate.

After Adjustments to the Annual MA Capitation Rates Are in Effect. When CMS makes an adjustment to capitation rates, or other payment adjustments, to account for the cost of the NCD or LCB, the MA organization is required to assume risk for the costs of that service or benefit as of the effective date of the adjusted capitation rates.

40.4.3 - Special Rules for the September 2000 NCD on Clinical Trials
(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS will make payments for MA enrollees on a fee-for-service basis for covered clinical trial costs under the September 2000 NCD. This policy is in effect until further notice. In CY 2000, CMS determined that the cost of covering these new benefits was not included in the 2001 MA capitated payment rates, and since this cost met the threshold for "significant cost" under 42 CFR 422.109(a), Medicare paid for covered clinical trial services outside of the capitated payment rate. CMS continues the policy of making payments on a fee-for-service basis for covered clinical trial items and services provided MA enrollees until further notification, because the capitation rates have not been appropriately adjusted to account for costs of this NCD, as required under §1853(c)(7) of the Social Security Act (the Act).

Medicare *MACs* made payments on behalf of MA organizations directly to providers of covered clinical trial services, on a fee-for-service basis.

Payment for covered clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans is determined according to the applicable fee-for-service rules, except that MA enrollees are not responsible for meeting either the Part A or Part B deductible (i.e., the deductible is waived). The MA enrollees are liable for the coinsurance amounts applicable to services paid under their plan rules (which may be the Medicare fee-for-service rules).

40.4.4 - Category B Investigational Device Exemption (IDE) Trials

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Medicare Advantage organizations should not confuse clinical trial coverage under the September 2000 NCD with Medicare's policy on IDE (Investigational Device Exemption) coverage. Category B IDE trials have been covered, at contractor discretion (within CMS's rules and guidelines), since November 1, 1995, under 42 CFR 405.201 to 405.215. Category B IDE costs are included in the Medicare Advantage (MA) payment rates. Therefore, these claims are not paid on a fee-for-service basis by *MACs*. The MA organizations can apply plan rules, including prior authorization rules, when determining whether to cover an enrollee's participation in a Category B IDE trial.

50 - Adjustment to MA Payments Under the CMS-HCC Risk Adjustment Models

(Rev.118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The 1997 BBA and later legislation required CMS to adjust per-beneficiary capitation payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status instead of just demographic characteristics such as age, sex, and Medicaid eligibility. Risk adjustment using diagnoses provides more accurate payments for MA organizations, with higher payments for enrollees at risk for being sicker, and

lower payments for enrollees predicted to be healthier. CMS gradually implemented risk adjustment models from 2000 through 2005, on the following schedule.

Aged/disabled enrollees

- From 2000 through 2003, CMS implemented the PIP-DCG risk adjustment model based only on inpatient diagnoses.

- Effective January 1, 2004, CMS implemented the CMS-HCC models based on diagnoses from inpatient, outpatient, and physician settings.

ESRD enrollees

- From 2002 through 2004, CMS applied age/sex factor adjustments to ESRD State rates.

- Effective January 1, 2005, CMS implemented the ESRD CMS-HCC models based on diagnoses from inpatient, outpatient, and physician settings, and distinguishing dialysis, transplant, and functioning graft statuses.

In selecting the CMS-HCC risk adjustment models, the goal was to select clinically sound models that improve payment accuracy while minimizing the administrative burden on MA organizations. The aged/disabled and ESRD CMS-HCC models are revisions of the Hierarchical Condition Category (HCC) model originally developed by Health Economics Research, Inc. The CMS-HCC models function by categorizing International Classification of Diseases codes into disease groups called Hierarchical Condition Categories (HCCs). Each HCC includes diagnosis codes that are related clinically and have similar cost implications. The CMS-HCC models are prospective in the sense that they use diagnosis information from a base year to predict costs for the next year. Models of this type are largely driven by the costs associated with chronic diseases, and they capture the systematic risk (costs) associated with Medicare populations.

The CMS-HCC models are selected significant disease models because they incorporate a limited subset of ICD diagnosis codes. In the aged/disabled models these codes are placed into approximately 70 disease groups. The ESRD models have approximately 67 disease groups, depending on the subpart of the model.

The CMS-HCC risk adjustment model consists of a set of risk factors (relative cost factors) for each HCC and each demographic characteristic in the model. When the diagnosis codes for a particular beneficiary are input to the model, the output is a risk score that reflects the beneficiary demographic characteristics and combination of HCCs associated with the beneficiary for the data collection year. The beneficiary's risk score for a year is a measure of expected health status.

To further improve payment accuracy, CMS developed separate models for different populations with different cost patterns than the general Medicare population:

Full risk models predict future costs using both diagnostic data and demographic characteristics. Full risk models for aged, disabled, and functioning graft beneficiaries are estimated separately for community and long-term institutional settings. The full risk model applied to ESRD dialysis and transplant enrollees does not distinguish community versus institutional settings.

New enrollee models are applied to MA enrollees with less than 12 month of Part B eligibility. These models predict future costs using only demographic characteristics, not diagnoses, because CMS does not have the latter information for these beneficiaries. Specifically, for purposes of risk adjustment new enrollees are newly-eligible disabled or age-in beneficiaries with less than 12 months of Medicare entitlement during the data collection year.

Table 2 below lists the CMS-HCC models used to calculate risk scores for MA plans. The factors for each HCC model can be found on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

Table 2. CMS-HCC Risk Adjustment Models

Enrollee Type	**Model**
Aged & Disabled	Full-Risk Community Model
	Full-Risk Long-term Institutionalized Model
	New Enrollee Model
ESRD Dialysis (Also applies to those in transplant status.)	Full-risk Dialysis Model
	New Enrollee Dialysis Model
ESRD Transplant Status	Special Payment Factors
`Functioning Graft	Full-Risk Community Model
	Full Risk Long-term Institutionalized Model
	New Enrollees - apply aged/disabled model

Risk Scores Adjust Payments. Beneficiary risk scores are used to adjust each plan's base payment rate for member health status, the first step in determining the per-person per-month payment to MA organizations, PACE organizations and certain demonstrations. See §60 on payment calculation rules for MA plans.

CMS uses demographic and diagnostic information from original Medicare and from all MA organizations a beneficiary may have joined (taken from diagnostic data submitted by the organizations) to determine the appropriate risk score for each beneficiary. The

risk score is computed for each beneficiary for a given year and applied prospectively. The risk score generally follows the beneficiary for one calendar year. Since all Medicare beneficiaries have risk scores (including new enrollees), information is immediately available for payment purposes as beneficiaries join an MA organization or move among organizations. When an MA organization forwards beneficiary enrollment information to CMS, CMS then sends the organization the appropriate risk scores for the beneficiary, as well as the resultant payment.

Risk Adjustment Participant Guide and Model Software. See the Participant Guide, available at http://www.csscoperations.com/new/usergroup/july2006_regtrn/raps-participant-guide_081606.pdf for details on the CMS-HCC risk adjustment models and for guidance on data submission and CMS payments to MA organizations (including the fee-for-service normalization factor applied in the payment calculation). The risk model diagnosis codes and CMS-HCC model software are available on the CMS Web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

70.3.1 - CMS' Payments to Hospice Programs

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The hospice is paid through the original Medicare program, subject to the usual rules of payment, for hospice care furnished to the Medicare enrollee. See the Medicare Claims Processing Manual, Chapter 11 on Hospice on the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html

Section 40.2.2(B) of Chapter 11 notes that Medicare hospices will bill the *A/B MAC (HH)* for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage.

Original Medicare pays physicians, providers and suppliers for other Medicare-covered services furnished to enrollees who have elected hospice. "Other services" refer to non-hospice A/B services that are not related to the terminal illness.

For other Part B services furnished to enrollees who have elected hospice, original Medicare will also pay the MA organization to the extent a claim has been reassigned to the MA organization. Under §1861(u) of the Act, Part A claims from "providers of services" cannot be reassigned.

The MA organization is responsible for making available to its members who have elected hospice all Medicare-covered non-hospice services and also any non-hospice services that are not Medicare-covered, but that are offered as supplemental benefits under the plan. For example, services provided by an attending physician to an MA enrollee who has elected hospice are considered non-hospice services, if the physician is

not employed or contracted by the enrollee's hospice program, and may be reimbursed by original Medicare.

Since an MA organization cannot bill *an A/B MAC (A),* nor can an *A/B MAC (A)* make payments to MA organizations, below are examples of how MA organizations may choose to handle billing for non-hospice ("other") services by contracted providers:

- The MA organization can authorize the provider (e.g., hospital or physician) or supplier to bill the *MAC* directly. (In such a situation, the MA organization might also choose to incorporate rate adjustments in contracts to account for the provision of non-hospice services by providers and suppliers that bill original Medicare directly.)

- In the case of physician and supplier services, the MA organization may direct them to submit claims for non-hospice services to the MA organization. The MA organization would bill the *A/B MAC (B)* and make payments to the physicians/suppliers.

Under original Medicare (and thus under the MA program during hospice elections), the beneficiary is responsible for certain cost sharing for hospice services:

- Co-pay for Part B drugs and biologicals: No more than $5 for each drug and other similar products for pain relief and symptom control.

- Co-pay for a respite care day: 5 percent of the payment that Medicare makes for a respite care day, not to exceed the hospital inpatient deductible.

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50.2.1.3 - Expanded Alternative Verification Methodology
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MA organizations that have experienced and documented an inordinate delay in getting a timely response from beneficiaries' existing providers and that have a CMS-approved Pre-enrollment Qualification Assessment Tool may develop and submit an expanded alternative verification methodology that meets CMS recommended practices for CMS approval. We reiterate our preference that C-SNPs contact enrollees' existing providers and obtain confirmation of the targeted chronic condition prior to enrollment. However, plans documenting a pattern of delayed response from providers and that have CMS approval to use their Pre-enrollment Qualification Assessment Tool may submit an expanded alternative verification methodology to the CMS mailing address provided in section 50.2.1.1 above.

CMS will review and approve proposals contingent on the following:

The C-SNP uses the CMS-approved Pre-enrollment Qualification Assessment Tool, described in section 50.2.1.1, to identify and enroll beneficiaries reporting the target chronic condition(s), and obtains confirmation that the enrollees have the qualifying condition from their existing providers (licensed physicians, nurse practitioners, psychiatrists, or clinical psychologists authorized to diagnose per State law) within the first month of enrollment.

If the C-SNP is unsuccessful in obtaining confirmation from the existing provider within the first month of enrollment, the C-SNP notifies the enrollees within the first seven days of the second month of enrollment that disenrollment will occur at the end of the second month if the target condition is not confirmed. During this time, the C-SNP must continue to attempt to contact the enrollees' existing providers, but may simultaneously use any of the following alternatives to confirm the chronic condition:

Schedule and complete a visit with a new provider (licensed physicians, nurse practitioners, psychiatrists, clinical psychologists authorized to diagnose per State law) from the plan's provider network.

Obtain and review a copy of a diagnostic lab or radiology report authenticated by a provider licensed by the respective State to interpret the test that documents the chronic condition or is uniquely diagnostic for the condition.

Obtain and review a copy of an active prescription label or prescription receipt displaying the enrollee's identifying information, the medication name, and its indication for use, which must exactly match the enrollees' qualifying condition.

Obtain and review a copy of a medical or pharmacy claim displaying the enrollee's identifying information that specifies the ICD or CPT code exactly matching the enrollees' qualifying condition and authenticated by a State-licensed provider.

For those beneficiaries who have been Medicare-eligible for a minimum of 12 months, obtain and review a copy of a monthly risk adjustment model output report indicating the enrollee has a designated HCC score that exactly matches the qualifying condition.