RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help Medicare Advantage (MA) organizations, providers, physicians, and third party submitters locate information specific to risk adjustment.

The purpose of this Resource Guide is to identify and supply resources that will simplify and clarify both the terminology and the processes employed in the submission of risk adjustment data. An emphasis is given to recent, policy-relevant material.

This Resource Guide is a helpful tool for those who need a quick reference for technical concepts, or for those who need to provide employees with an introductory presentation to the risk adjustment data process. Where possible and appropriate, "screen shots" of important resources on the Internet have been included. These pages may also be utilized as a suitable visual aid for risk adjustment data instructors to enhance their presentation.

The information listed in the Resource Guide is arranged in seven sections:

- RISK ADJUSTMENT ACRONYMS AND TERMS
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- CSSC WEB RESOURCES
- CSSC REFERENCE DOCUMENTS
- CODING RESOURCES
- APPLICATION FOR ACCESS

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Henry Thomas: henry.thomas@cms.hhs.gov
Lateefah Hughes: lateefah.hughes@cms.hhs.gov
Sean Creighton: sean.creighton@cms.hhs.gov

CUSTOMER SERVICE AND SUPPORT CENTER (CSSC) – http://www.csscoperations.com
The CSSC website provides "one-stop shopping" for MA organizations regarding risk adjustment data submission needs. Visit www.csscoperations.com to register for email updates from the CSSC. The updates will serve as notification that new or updated information has been added to the website.

CSSC Contact Information
877-534-2772 (toll-free)
csscoperations@palmettogba.com

LEADING THROUGH CHANGE, INC. (LTC, INC.)
For general questions about training and Risk Adjustment User Groups, please email Leading Through Change, Inc. at RARegistration@medicaretraining.net.

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RISK ADJUSTMENT ACRONYMS AND TERMS

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RISK ADJUSTMENT ACRONYMS AND TERMS

ACRONYM	TERM
AAPC	American Academy of Professional Coders
ACR	Adjusted Community Rates
ACRP	Adjusted Community Rate Proposal
ADS	Alternative Data Sources
ADL	Activities of Daily Living
AGNS	AT&T Global Network Services
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI X12 837	Variable Length File Format for Electronic Submission of Encounter Data
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act 1999
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement and Protection Act of 2000
CAD	Coronary Artery Disease
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Refined Hierarchical Condition Category Risk Adjustment Model
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSSC	Customer Service and Support Center
CVD	Cerebrovascular Disease
CWF	Common Working File
CY	Calendar Year
DCP	Data Collection Period
DDE	Direct Data Entry
DHHS	Department of Health & Human Services
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DOB	Date of Birth
DoD	Department of Defense
DOS	Dates of Service
DRG	Diagnosis Related Group
DX	Diagnosis
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
ET	Eastern Time
FERAS	Front-End Risk Adjustment System
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
GUI	Graphical User Interface
H#	MA Organization CMS Contract Number
HCC	Hierarchical Condition Category
HCFA 1500	Medicare Part B Claim Filing Form
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set

ACRONYM	TERM
HHS	Department of Health and Human Services
HIC#	Health Insurance Claim Number (Beneficiary Medicare ID#)
HICN	Health Insurance Claim Number (Beneficiary Medicare ID#)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICN	Internal Claim Number
IP	Internet Protocol
IVC	Initial Validation Contractor
JCAHO	Joint Commission on Accreditation of Health Care Organizations
LTC	Leading Through Change, Inc.
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
M+C organization	Medicare+Choice Organization
MCCOY	Managed Care Option Information System
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug Modernization Act of 2003
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MnDHO	Minnesota Disability Health Options
MOR	Model Output Report
MSA	Medical Savings Account
MSG	Message
MSHO	Minnesota Senior Health Options
NCH	National Claims History
NCHS	National Center for Health Statistics
NCPDP	National Council on Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDM	Network Data Mover
NES	Not elsewhere classified
NMUD	National Medicare Utilization Database
NOS	Not otherwise specified
NPI	National Provider Identifier
NSF	National Standard Format
OIG	Office of Inspector General
OREC	Original Reason for Entitlement Code
Palmetto GBA	Palmetto Government Benefits Administrators
PACE	Program of All-Inclusive Care for the Elderly
PCN	Patient Control Number
PHS	PACE Health Survey
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
RAPS	Risk Adjustment Processing System
RAPS Database	Risk Adjustment Processing System Database
RAS	Risk Adjustment System
RHC	Rural Health Clinic

ACRONYM	TERM
RPT	Report
RRB	Railroad Retirement Board
RT	Record Type
RxHCC	Prescription Drug Hierarchical Condition Category
SAS	Statistical Analysis Software
SCO	MassHealth Senior Care Option
SH#	Submitter CMS Contract Number
S/HMO	Social Health Maintenance Organizations
SNF	Skilled Nursing Facility
SSD	Selected Significant Disease Model
SSN	Social Security Number
SUB ID	Submitter ID
SVC	Second Validation Contractor
TOB	Type of Bill
UB-04	Uniform Billing Form 04
VA	Veterans Administration
WPP	Wisconsin Partnership Program

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CMS WEB RESOURCES

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CMS Main Page
http://www.cms.hhs.gov

Advance Notice of Methodological Changes for Calendar Year (CY) 2004 (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf

Announcement of Calendar Year (CY) 2004 Medicare+Choice Payment Rates (May 12, 2003)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004.pdf

Cover Letter Regarding Revised Medicare Advantage Rates for Calendar Year (CY) 2004 (January 16, 2004)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004b.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf

Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates (April 4, 2005)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2006.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2007 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf

Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates (April 3, 2006)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2008 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2008.pdf

Announcement of Calendar Year (CY) 2008 Medicare Advantage Payment Rates (April 2, 2007)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf

Medicare Managed Care Manual
http://www.cms.hhs.gov/manuals
(select Internet-Only Manuals, then select 100-16 Medicare Managed Care Manual)

Rate Book Information
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

Healthplans Page
http://www.cms.hhs.gov/HealthPlansGenInfo/

Risk Adjustment Page
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_Adjustment.asp

Health Insurance Portability and Accountability Act (HIPAA) Page
http://www.cms.hhs.gov/HIPAAGenInfo/

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates/

Official Coding Guidelines on Centers for Disease Control & Prevention Website
http://www.cdc.gov/nchs/data/icd9/icdguide.pdf

Risk Adjustment Model Output Report Letter
http://csscoperations.com/new/references/cmsinstructions.html

Medicare Advantage (MA) Prescription Drug Plans Plan Communications User's Guide
http://www.cms.hhs.gov/MMAhelp/02_Plan_Communications_Users_Guide.asp#TopOfPage

Individuals with Access to CMS Systems (IACS) User Guide and Website
http://www.cms.hhs.gov/MMAHelp/07_IACS.asp#TopOfPage

Reference to Types of Facilities and Taxonomy Codes
http://www.wpc-edi.com/codes/taxonomy

CMS REFERENCE DOCUMENTS

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Health Plan Management System (HPMS)

HPMS is a CMS information system created specifically for the Medicare Advantage program that provides MA organization level information.

Accessing HPMS

- Access to HPMS is accomplished via the Medicare Data Communications Network (MDCN).
- A User ID is required for HPMS access. If you do not currently have access, complete the "Access to CMS Computer Systems" form available at www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf or at the end of this Resource Guide.

If MA organizations experience difficulty logging into HPMS, please contact Don Freeburger (don.freeburger@cms.hhs.gov) 410-786-4586 or Neetu Jhagwani (neetu.jhagwani@cms.hhs.gov) 410-786-2548.

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Risk Adjustment Implementation

(Attachment B – Risk Adjustment Implementation excerpt from 2008 Final Call Letter - April 19, 2007
www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf)

1. Requirements for Submitting Risk Adjustment Data to CMS

a. File Size, Format and Filtering of Risk Adjustment Processing System (RAPS) Data

Front End Edit to Limit File Size

MA organizations have submitted files of varying sizes—some in excess of 2 million records—to our Front End Risk Adjustment System (FERAS) at the Customer Service and Support Center (CSSC). Large files require considerable data processing time and resources. In order to more efficiently process submissions to the FERAS and the CMS Data Processing Center, we are instituting the following maximum file size limits effective immediately:

Table 1. FERAS Submissions

Method of Submission	Front End Limit Per Submitter Per Day
Connect:Direct (formerly NDM)	1,000,000 CCC Records
File Transfer Protocol (FTP)	1,000,000* CCC Records
Gentran	1,000,000 CCC Records
Secure Website	1,000,000 CCC Records

*NOTE: In the past a file size of 146K was recommended. As some FTP sites can send files considerably larger than the 146K based on their systems, CMS limits the file size for FTP to 1M.

This limit applies regardless of the number of files submitted (i.e., a submitter could submit one file with 999,999 CCC records or multiple files as long as their total does not exceed 1M CCC records). In the event that a submitter has a file larger than the 1M CCC record limit that it would like to submit, the submitter must notify the CSSC one week in advance; this will enable us to schedule the file in the production run.

For additional information regarding FERAS submissions, please see Table 4a – Connectivity Options in the 2006 Risk Adjustment Data Basic Training For Medicare Advantage Organizations, Participant Guide available on our contractor's web site at http://www.csscoperations.com/new/usergroup/july2006_regtrn/raps-participant-guide_081606.pdf.

Risk Adjustment Processing System (RAPS) Format

Effective October 1, 2007—the beginning of fiscal year (FY) 2008—we will accept only risk adjustment submissions that are in RAPS format. We will continue to accept data in RAPS format as batch data files (i.e., via Connect:Direct, FTP, and Gentran) and direct data entry (DDE) (i.e., via secure website) files. This data submission requirement will enable us to 1) more efficiently process the data at CSSC and within the CMS Data Processing Center and 2) ensure appropriate payment under the risk adjustment payment models. In addition, effective immediately we will not authorize an electronic data interchange (EDI) agreement for a plan that requests to submit risk adjustment data using a non-RAPS format.

Therefore, effective October 1, 2007, the following options for submitting risk adjustment data will be discontinued:
• American National Standards Institute (ANSI)
• National Standard Format (NSF)
• Universal Bill – 04 (UB-04).

Filtering for Acceptable Provider Types and Physician Data Sources
For purposes of risk adjustment, MA organizations must collect data from the following provider types:
• Hospital inpatient facilities
• Hospital outpatient facilities
• Physician.

MA organizations are responsible for ensuring that the data they collect and submit to CMS for payment comes from acceptable sources. The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all ICD-9-CM diagnoses that are in the risk adjustment model and rendered as a result of a visit to a physician must be collected by the MA organization. This includes data collected from non-network as well as network providers.

Therefore, CMS requires MA organizations to filter and submit risk adjustment data in accordance with the appropriate provider types as approved by CMS. In addition, only those physician specialties and other clinical specialists identified in Table 3 – Acceptable Physician Data Sources of the Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions (dated April 4, 2006) are acceptable for risk adjustment. To obtain a copy of this document, please visit the CMS web site at http://www.cms.hhs.gov/healthplansgeninfo/downloads/Rev%20MA-APD%20call%20letter%20final.pdf.

b. Risk Adjustment Data Submission Schedule

Table 2. Risk Adjustment Implementation Calendar (below) provides the updated submission schedule for all diagnosis data submitted for all risk adjustment models. This includes data for both the Part C CMS-HCC and ESRD models and the Part D Drug risk adjuster model. Specific changes in implementation include the updated risk adjustment data collection and submission dates.

Table 2. Risk Adjustment Implementation Calendar

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
2007	July 1, 2005 through June 30, 2006	September 1, 2006	January 1, 2007	N/A*
2007	January 1, 2006 through December 31, 2006	March 2, 2007	July 1, 2007	January 31, 2008
2008	July 1, 2006 through June 30, 2007	September 7, 2007	January 1, 2008	N/A*
2008	January 1, 2007 through December 31, 2007	March 7, 2008	July 1, 2008	January 31, 2009
2009	July 1, 2007 through June 30, 2008	September 5, 2008**	January 1, 2009	N/A*
2009	January 1, 2008 through December 31, 2008	March 6, 2009**	July 1, 2009	January 31, 2010

* All risk adjustment data for a given payment year (CY) must be submitted by January 31st of the subsequent year.
** For 2006 forward, March and September dates reflect the first Friday of the respective month.

Changes in payment methodology for 2008, including Part C and Part D payment and risk adjustment, are described in the February 16, 2007, Advance Notice of Methodological Changes for Calendar Year (CY) 2008 Medicare Advantage Payment Rates and the April 2, 2007, Announcement of Calendar Year

(CY) 2008 Medicare Advantage Payment Rates (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

c. Updated Policies and Procedures

In order to clarify requirements for the submission of risk adjustment data by Medicare Advantage (MA) organizations, we have updated and distributed [via the Health Plan Management System (HPMS)] the following policies and procedures for—

- New MA organizations (effective on or after October 1, 2006)
  - Electronic data interchange (EDI) agreements—must complete and submit an EDI agreement to our Customer Service and Support Center (CSSC) within one month of your HPMS effective date;
  - Submission of risk adjustment test data—must submit test data within three months of your HPMS effective date; and
  - Submission of risk adjustment production files—must submit production files within four months of your HPMS effective date and continue to submit at least one time per quarter thereafter.
- Current MA organizations (effective date before October 1, 2006)
  - Electronic data interchange (EDI) agreements—must have completed and submitted an EDI agreement to our Customer Service and Support Center (CSSC) within four months of your HPMS effective date. (If your contract has a current EDI agreement, then this requirement has been met for that contract.);
  - Submission of risk adjustment production files—must submit at least once every calendar quarter; and
  - Reduction of duplicate risk adjustment submissions—must adhere to no more than five percent (5%) per file. We define a duplicate submission as a diagnosis cluster with the same attributes as that already stored in the RAPS database; duplicate submissions result in 502 errors.

In the event your MA organization acquires a new or different contract number, a new EDI agreement must be submitted to the CSSC within one month of your HPMS effective date. Since your MA organization has submitted data in the past on behalf of other contract number(s), the requirement to submit risk adjustment test data does not apply.

We will generate and distribute written CMS noncompliance letters to MA organizations that fail to fulfill these requirements; the letters will be distributed via HPMS. In addition, we will furnish copies of the letters to CMS plan managers and regional office and compliance division staff. An MA organization's failure to comply with the requirements for risk adjustment data submissions may result in suspension of its data submission privileges and, thus, impact risk adjusted payments.

To ensure appropriate payment under the risk adjustment payment models, your MA organization must submit complete and accurate risk adjustment production data at least each calendar quarter.

d. Integrity of RAPS Submissions

Although a plan may designate another entity to submit claims on its behalf to CMS, the plan remains responsible for data submission, accuracy and content.

If your MA organization needs assistance or is experiencing data submission issues, please contact our Customer Service and Support Center (CSSC) at 1-877-534-2772 or www.csscoperations.com.

2. Part A Risk Adjustment Factor Options

a. Determinations of Risk Status

As stated in the April 3, 2006 Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/), plans subject to risk adjusted payments have an option for how to treat beneficiaries with 12 months of Part A data but less than 12 months of Part B enrollment in a data collection year.

Table 3. Which Risk Adjustment Factors to Apply to Payment**

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	Time Period Beneficiary Has Been Entitled to Benefits under Part A Medicare**	
	0 - 11 months	≥ 12 months
0 – 11 months	New enrollee factors	Plan's option: New enrollee or full risk adjustment factors
≥ 12 months	Full risk adjustment factors	Full risk adjustment factors

*Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled benefits under Part A and enrolled in Part B.
**During data collection period (previous calendar year).

Table 3. Which Risk Adjustment Factors to Apply to Payment (above) illustrates that beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less than 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees, as they are now. Currently beneficiaries with 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS has created an option for how the risk adjustment payments for this category of enrollees are determined.

Effective for 2006 payments and beyond, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision will be applied to all "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.
b. Option to Elect Full Risk Option for "Part A-only" Enrollees

Effective as of 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. If an organization elects to have CMS determine payment factors (i.e., new enrollee factors or full risk adjustment factors) for all "Part-A only" enrollees, then—

1) The decision will be applied to all "Part-A" only enrollees in the plan; and
2) The option elected will remain turned "on" until CMS is otherwise notified prior to August 31st of any successive year.

Plans interested in electing this option must contact: Henry Thomas, CMS, at henry.thomas@cms.hhs.gov by August 31, 2007.

3. Risk Adjustment IT Technical Assistance Outreach

The purpose of the outreach sessions is to provide participants who are new to risk adjustment the support necessary to understand risk adjustment. This information will enable new participants to collect and submit risk adjustment data in accordance with CMS requirements. CMS offers Monthly Risk Adjustment Trainings at its Baltimore headquarters. We held our regional outreach sessions in June and August 2007.

Risk adjustment trainings were announced via the Risk Adjustment User Group and listed on our risk adjustment training contractor's web site. Additional information and registeration for the Risk Adjustment Outreach sessions and the Risk Adjustment User Group, were provided at our risk adjustment training contractor's web site at http://www.medicaretraining.net.

4. Risk Adjustment Data Validation

42 CFR §422.310(e) requires MA organizations and their providers and practitioners to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. CMS will increase emphasis on MA organization compliance with the medical record submission guidelines.
The Centers for Medicare & Medicaid Services (CMS) conducts medical record reviews to validate the accuracy and integrity of the risk adjustment data submitted by the Medicare Advantage (MA) for payments. CMS selects MA organizations to participate in the medical record review based on a number of criteria. For example, some organizations are randomly selected while others are targeted; thus, every MA organization has a chance of being selected for validation.
Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the MA organization are supported by medical record documentation for an enrollee. The primary goals of risk adjustment data validation are to:
100
- Identify
    - Confirmed risk adjustment discrepancies
    - MA organizations in need of technical assistance to improve risk adjustment data quality
- Measure
    - Accuracy of risk adjustment data
    - Impact of discrepancies on payment
- Improve/Inform
    - Quality of risk adjustment data
    - The CMS-Hierarchical Condition Category (CMS-HCC) model.

a. Missing Medical Records

If your MA organization is selected for inclusion in the data validation, your MA organization would be required to submit all necessary medical record documentation as requested within the allotted timeframe. Medical records not submitted to CMS within the required timeframe will be identified as "missing medical records." A missing medical record is a risk adjustment discrepancy. Risk adjustment data characterized as "discrepant" are used to evaluate the accuracy of payments to your MA

Organization. The results of the risk adjustment data validation will be used to develop an estimated payment error rate for your MA organization.

b. Guiding Principle & Guidelines

Since implementation of the CMS-HCC model in 2004, we have included hospital inpatient, hospital outpatient, and physician medical records in our risk adjustment data validation. Additionally, we modified our Guiding Principle to account for acceptable provider types and physician data sources for medical record documentation. Our Guiding Principle now states:

> The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, or physician) and an acceptable physician data source as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting.

MA organizations are allowed flexibility to select and submit supporting medical record documentation when responding to a medical record request. Since plans are not required to submit multiple occurrences of a unique diagnosis for a given enrollee, a medical record from any risk adjustment data source would be acceptable. This means that the medical record submitted for validation could be based on an encounter other than the one for which the data were submitted.

According to the risk adjustment data validation guidelines:
- Enrollee risk adjustment records are selected for validation based on risk adjustment diagnoses submitted to the Risk Adjustment Processing System (RAPS).
- Since CMS does not collect provider identifiers for risk adjustment, MA organizations must be able to track and locate supporting medical record documentation for its providers.
- MA organizations must select the "one best medical record" to support each HCC identified for validation. This means the MA organizations decide whether to submit a hospital inpatient, hospital outpatient, or physician medical record when more than one type of record is available.
- The medical record documentation must support an assigned HCC.
- Once a MA organization selects its "one best medical record," a date of service must be identified to facilitate the medical record review process. CMS coders who review medical records will not search beyond the date of service identified in the medical record by the MA organization for review.
- Payment adjustments are based on confirmed risk adjustment discrepancies.
- An appeals process is in place to address a MA organization's disagreement with a payment adjustment based on a confirmed risk adjustment discrepancy.

c. Acceptable Risk Adjustment Data Sources

CMS has provided a list of ambulatory services that are "non-covered services" and, therefore, are unacceptable for risk adjustment. (To obtain a copy of Table 3C – Hospital Outpatient, please visit the 2006 Risk Adjustment Data Basic Training For Medicare Advantage Organizations, Participant Guide available on our contractor's web site at
http://www.csscoperations.com/new/usergroup/july2006_regtrn/raps-participant-guide_081606.pdf

However, we continue to receive inquiries about the use of two specific "non-covered services"—laboratory and diagnostic radiology—and their potential use in risk adjustment payment and data validation. Therefore, we would like to clarify the importance of associating risk adjustment data submission with valid clinical documentation for physician specialties.

MA organizations must not submit documentation from laboratory and diagnostic radiology services as a standalone medical record for data validation. This type of medical documentation is insufficient for coding purposes. The following ICD-9-CM guideline updated November 2006 (available on the CDC web site at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide06.pdf) clarifies the appropriate use of documentation from "non-covered source" providers for determining clinical significance:

> Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

The previous version from October 2002 included the above statement along with further clarification and examples:

> The coder should not arbitrarily add an additional diagnosis to the final diagnostic statement on the basis of an abnormal laboratory finding alone. To make a diagnosis on the basis of a single lab value or abnormal diagnostic finding is risky and carries the possibility of error.
>
> It is important to remember that a value reported either lower or higher than the normal range does not necessarily indicate a disorder. Many factors influence the value of a lab sample. These include the method used to obtain the sample (for example, a constricting tourniquet left in place for over a minute prior to collecting the sample will cause an elevated hematocrit and potassium level), the collection device, the method used to transport the sample to the lab, the calibration of the machine that reads the values, and the condition of the patient. An example is a patient who because of dehydration may show an elevated hemoglobin due to increased viscosity of the blood.

As stated above, it is inappropriate for MA organizations to submit a risk adjustment diagnosis and medical documentation on the sole basis of a "non-covered service." Thus, we will identify documentation from "non-covered services" as "invalid" and, therefore, deem such documentation as a risk adjustment discrepancy.

Note that we will accept documentation from "non-covered services" provided the documentation is reviewed by the physician and the outcome of the physician's review (i.e., diagnosis) is appropriately documented by the physician in the medical record. However, we will not accept for data validation documentation whereby a MA organization submits a diagnosis based on a laboratory service within the data collection period and physician medical record documentation that is outside of the data collection period.

For additional information on data validation, please visit our contractor's web site at http://www.csscoperations.com/new/usergroup/2006rapstrn/2006-participant-guide.pdf.

d. Signatures and Credentials

For purposes of risk adjustment data submission and validation, the MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. (Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.) This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. In these instances, the coders are able to determine that the beneficiary was evaluated by a physician or an acceptable physician data source. (For additional information on acceptable physician data sources, see the above section titled Filtering for Acceptable Provider Types and Physician Data Sources.)

We have identified medical records where it is unclear if the beneficiary is actually evaluated by a physician, physician extender, or other. In several cases, we have found encounters that are documented on physician's stationery but appear to be signed by a non-physician provider. For example, a medical record appears on group stationery for a given date of service. The medical record is signed but the provider's name and credentials are not furnished on the stationery. Thus, the coders are unable to determine whether the beneficiary was evaluated by a physician, medical student, nurse practitioner, registered nurse, or other provider. This type of medical record documentation is incomplete and unacceptable for risk adjustment and, therefore, will be counted as a risk adjustment discrepancy.

CSSC WEB RESOURCES

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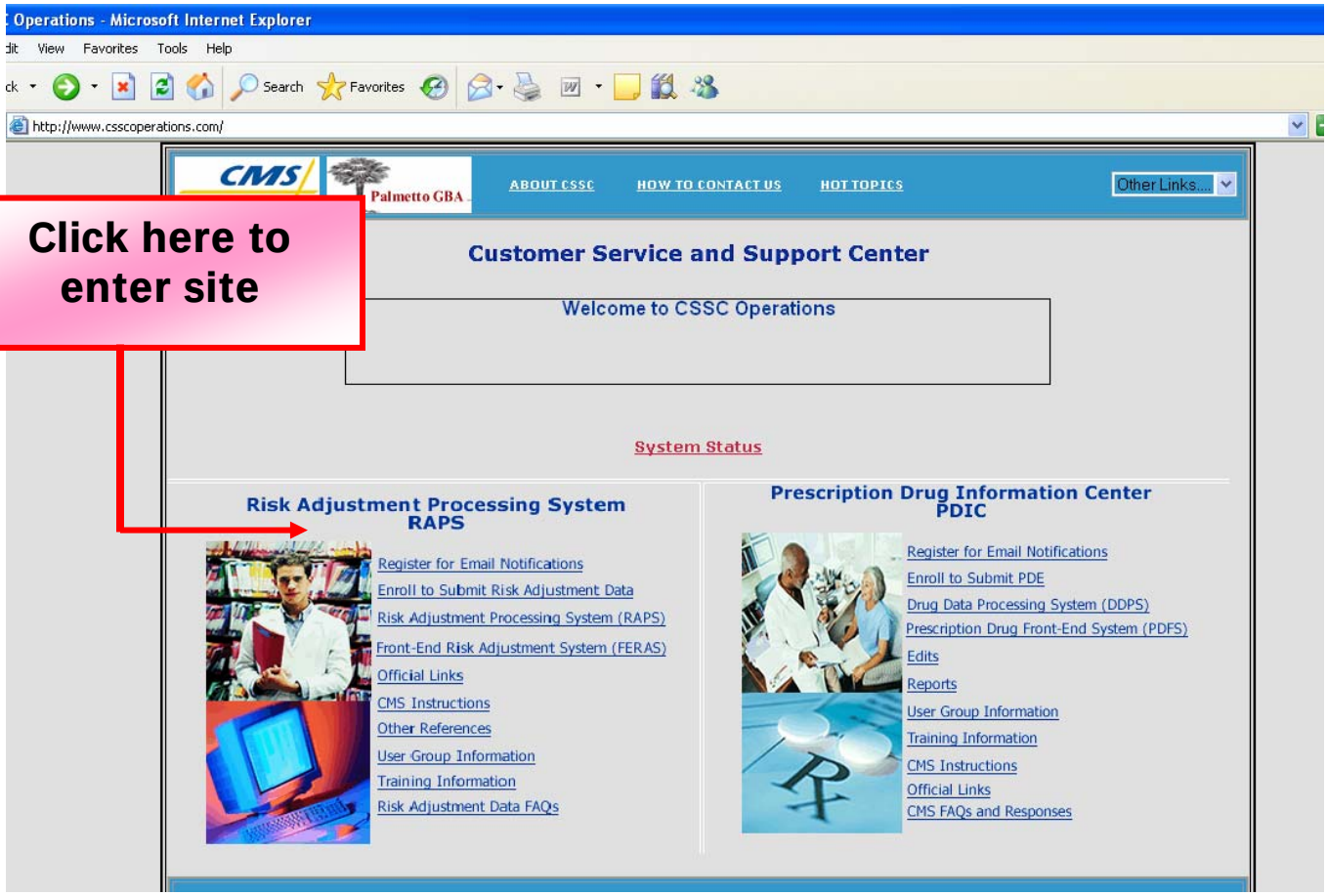
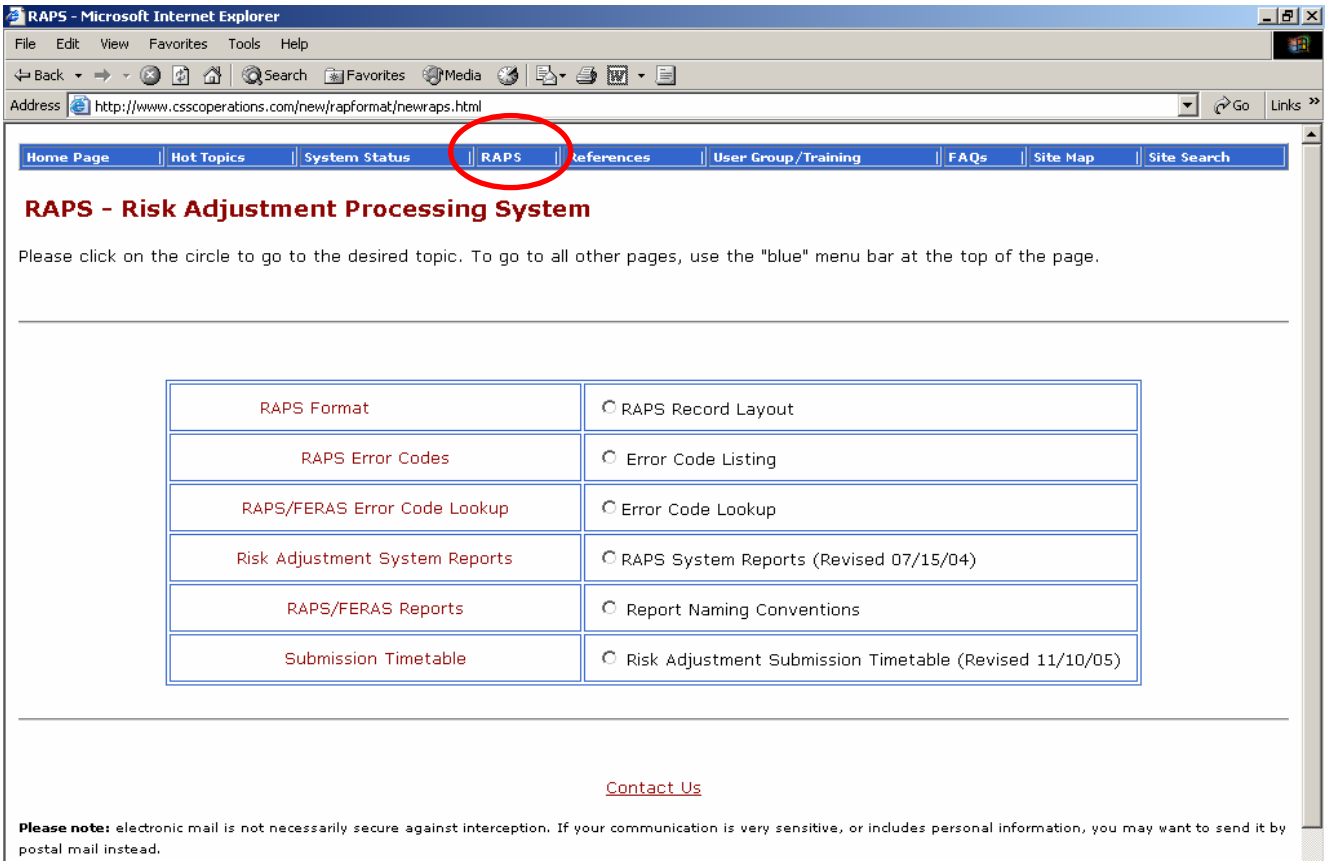
WWW.CSSCOPERATIONS.COM

http://www.csscoperations.com



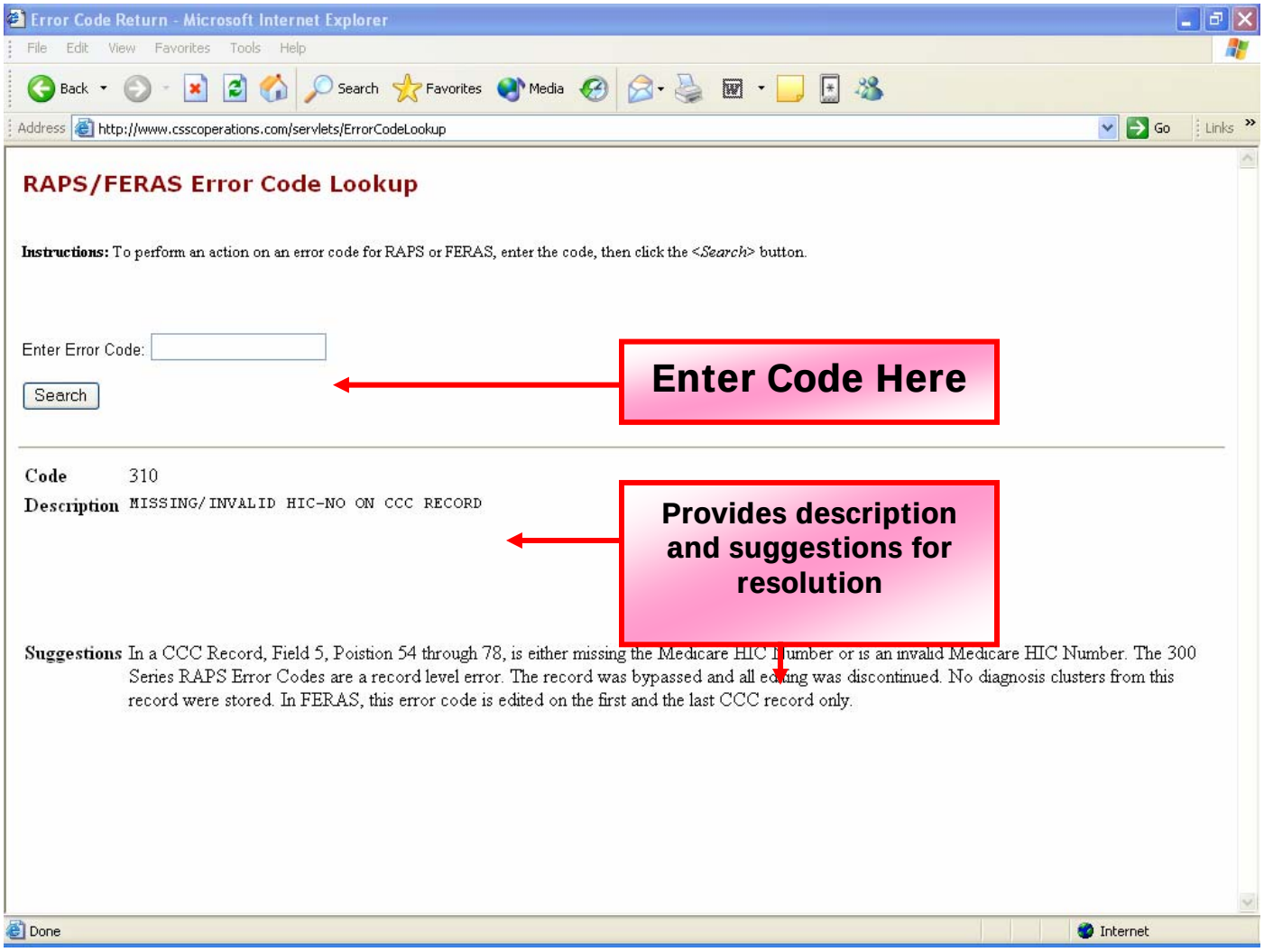
RAPS Resources

http://csscoperations.com/new/rapformat/newraps.html



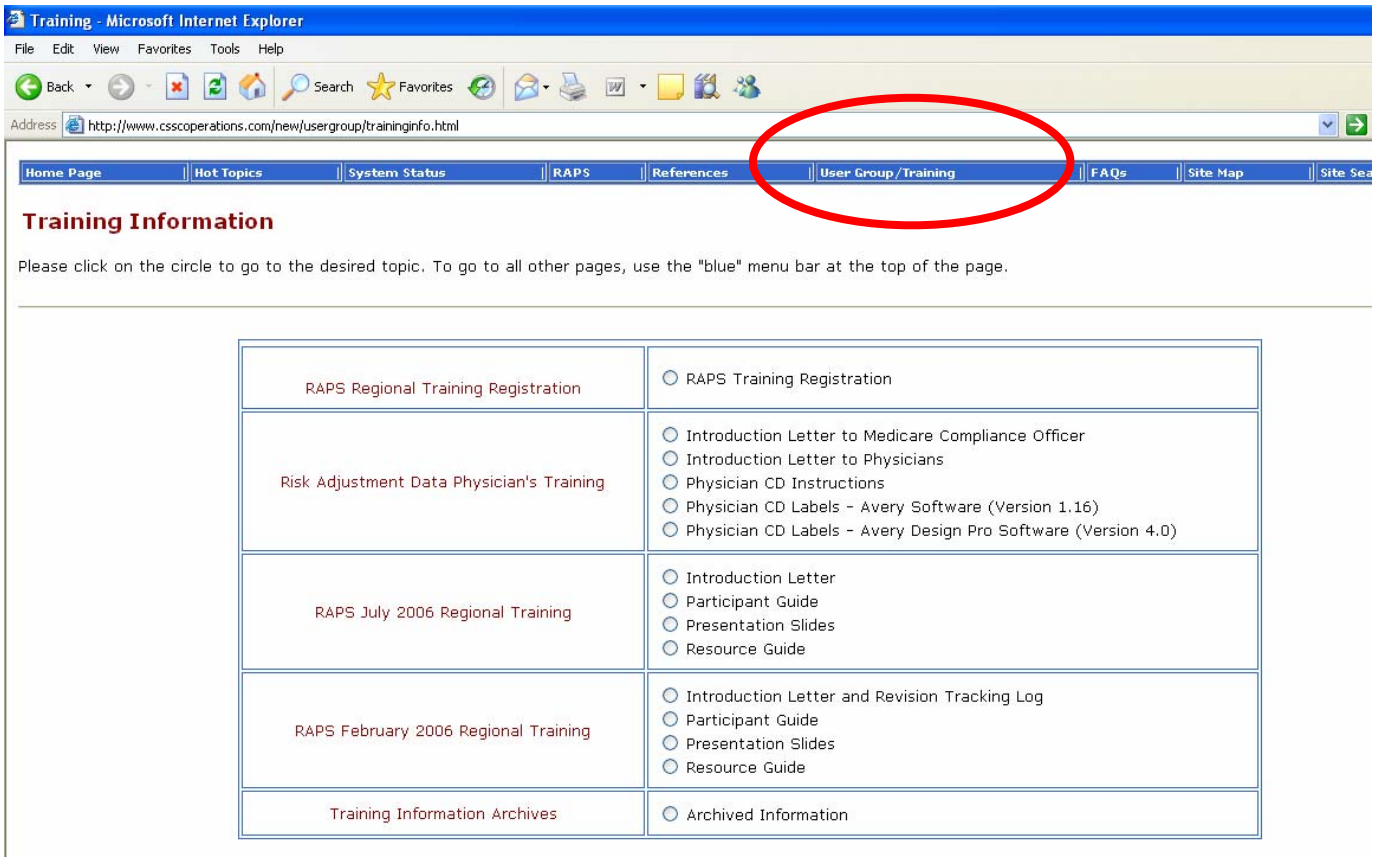
RAPS/FERAS Error Code Lookup

http://www.mcoservice.com/new/errorcodelookup_052505.htm



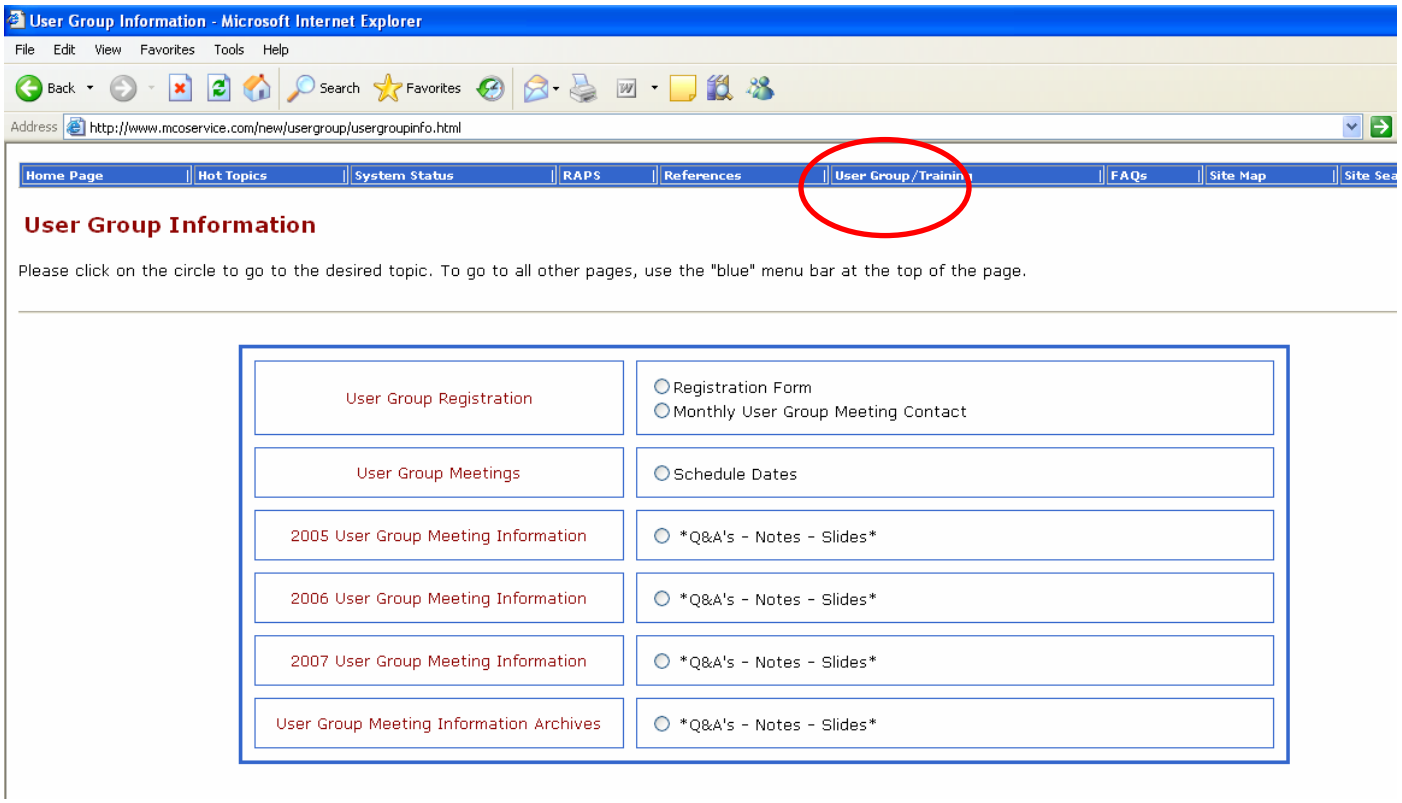
Training Guides and Updates

http://csscoperations.com/new/usergroup/traininginfo.html



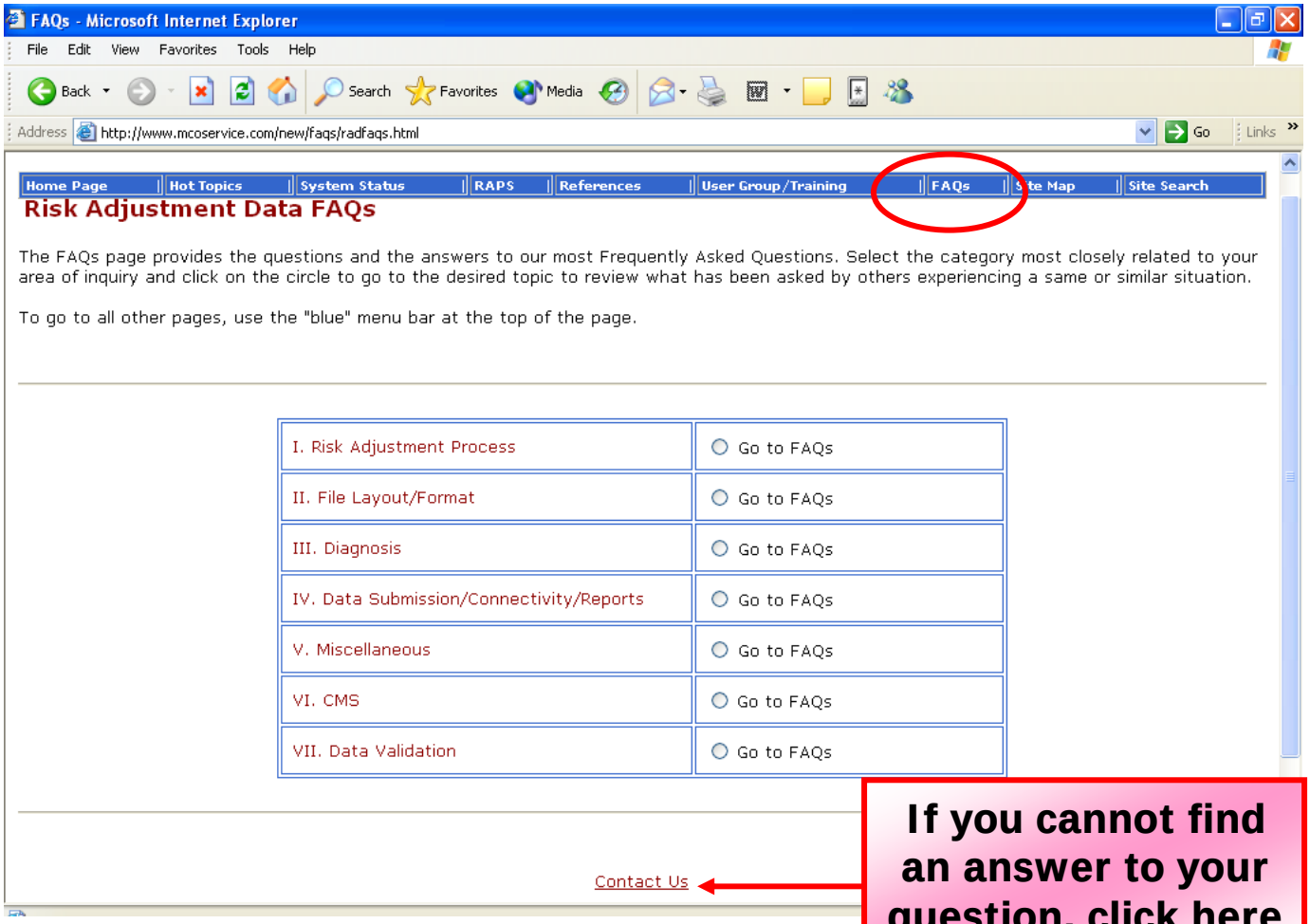
User Group Information

http://www.csscoperations.com/new/usergroup/usergroupinfo.html



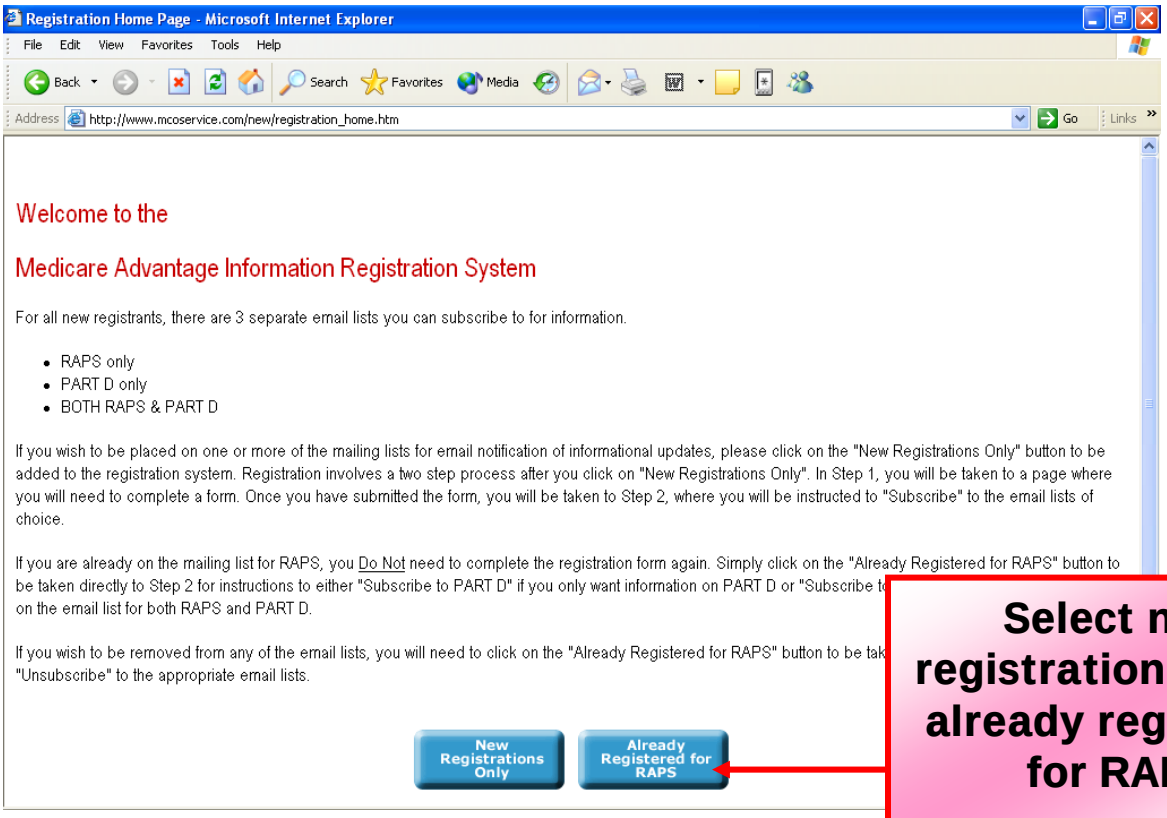
Frequently Asked Questions (FAQs)

http://www.csscoperations.com/new/faqs/radfaqs.html



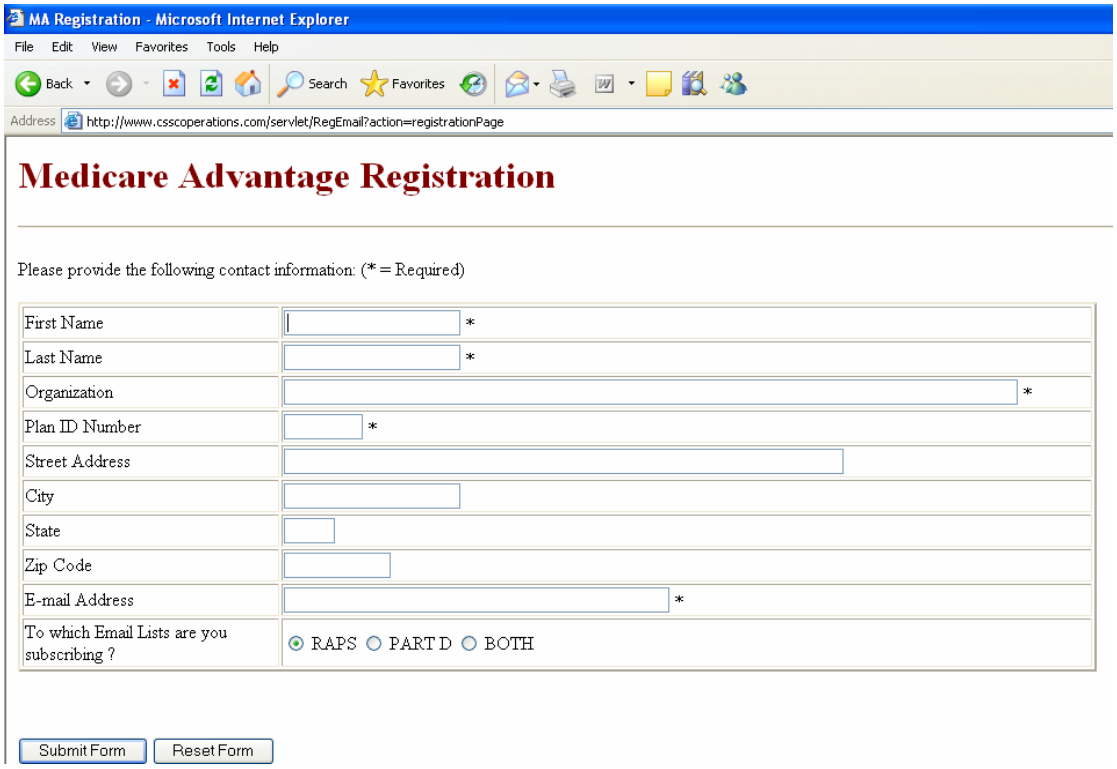
Register for Email Service

http://www.mcoservice.com/new/registration_home.htm



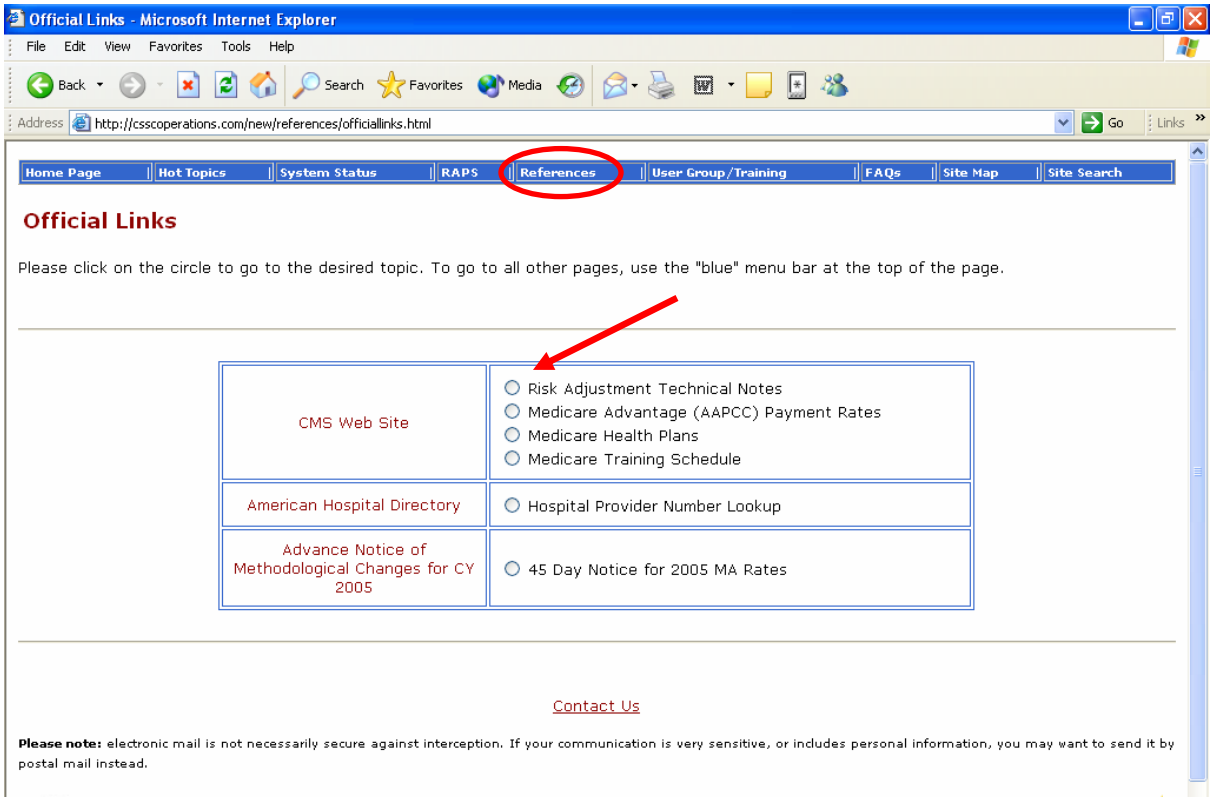
Medicare Advantage Registration

http://www.csscoperations.com/servlet/RegEmail?action=registrationPage



Link to CMS Website

http://csscoperations.com/new/references/officiallinks.html



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CSSC REFERENCE DOCUMENTS

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TO: Managed Care Organizations Submitting Risk Adjustment Data

RE: EDI Enrollment and Submitter Application for Risk Adjustment Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Managed Care Organizations submitting Risk Adjustment Data. The CSSC and the Front-End Risk Adjustment System (FERAS) look forward to working with you in all aspects of the submission of risk adjustment data.

The following information must be completed and sent to the CSSC for enrollment for the submission of data for Risk Adjustment:

- EDI Agreement for Risk Adjustment Data collection
- Submitter Application
- Risk Adjustment NDM Specifications (For NDM users only)

Please note the following for submitting Risk Adjustment Data:

- A CMS Risk Adjustment Data EDI Agreement must be completed by each submitter and on file with CSSC, prior to submitting Risk Adjustment Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** If the submitter will be an entity other than an MA organization, the Submitter must complete the Submitter ID Application form and the MA organization must complete the EDI Agreement. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. Regardless who submits the data, CMS holds the MA organization accountable for the content of the submission.

- A Submitter ID (SHnnnn) will be assigned to you by the CSSC and will remain effective for ongoing submission of risk adjustment data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application return it to CSSC Operations with the completed EDI Agreement.

- You will be submitting all Risk Adjustment Data to the FERAS. Effective October 1, 2007, MA organizations must submit data electronically using RAPS format or DDE screens for all provider types. Prior to this date data may be submitted in one of the following formats, RAPS format, UB92, NSF and/or ANSI. All data submitted to the front-end will be sent to the Risk Adjustment Processing System (RAPS) in the risk adjustment data layout.

- If you are submitting the UB04, NSF or ANSI file format, it will be necessary to identify to the front-end the data is being submitted for translation to the RAPS format using the appropriate receiver ID as designated below:

    - UB 04 - Institutional Data - 80884 (RT01-6)
    - NSF - Professional Data - 80883 (AA0-17.0)
    - ANSI 4010 Institutional (80884) and Professional (80883) - ISA08, GS03, NM109 1000B

- Datasets are required to be set up for Connect-Direct users. The Risk Adjustment Connect-Direct Specifications should be completed and returned to the CSSC with the Submitter Application and the EDI Agreement.

- Technical Specifications are available based on the communication medium that is currently in use. Connect-Direct instructions and the FERAS User Guide are available on the mcoservice.com web site. Testing instructions for each medium are included within the document.

- On-Line transaction data entry is available through the secure MDCN FERAS web site. This option allows the user to key risk adjustment data directly into the front-end, creating the file for direct data submission.

- Reports are returned on all data submitted. The following report files are available for data submitted:

Response report generated by FERAS - per file submission
FERAS Response Report — RSP#####.RSP.FERAS_RESP
RSP#####.ZIP.FERAS_RESP (zip format)

RAPS – CMS generated reports per file submission
RAPS Return File — RPT#####.RPT.RAPS_RETURN_FLAT
RPT#####.ZIP.RAPS_RETURN_FLAT (zip format)
RAPS Error Report — RPT#####.RPT.RAPS_ERROR_RPT
RPT#####.ZIP.RAPS_ERROR_RPT (zip format)
RAPS Duplicate Diagnosis Cluster Report
RPT#####.RPT.RAPS_DUPDX_RPT
RPT#####.ZIP.RAPS_DUPDX_RPT (zip format)
RAPS Transaction Summary Report
RPT#####.RPT.RAPS_SUMMARY
RPT#####.ZIP.RAPS_SUMMARY_RPT (zip format)

RAPS - CMS generated reports monthly
RAPS Monthly Plan Activity Report
RPT#####.RPT.RAPS_MONTHLY
RPT#####.ZIP.RAPS_MONTHLY (zip format)
RAPS Cumulative Plan Activity Report
RPT#####.RPT.RAPS_CUMULATIVE
RPT#####.ZIP.RAPS_CUMULATIVE (zip format)

All reference material is available on the **www.csscoperations.com** web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the information provided.

CSSC Operations
PO Box 100275, AG 570
Columbia, SC 29202-3275
1-877-534-CSSC
www.csscoperations.com
FAX: 1-803-935-0171

Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees**:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct risk adjustment data discrepancies.

12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To**:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name: _____

_____

Contract Number:_____

Signature:_____

Name: _____

Title: _____

Address:_____

_____

City/State/ZIP: _____

Phone: _____

Email: _____

Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

MA EDI Enrollment
CSSC Operations AG-570
P.O. Box 100275
Columbia, SC 29202-3275
Phone (877) 534-2772
www.csscoperations.com

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CSSC Risk Adjustment Data Submitter Application

New Submitter ID:	☐ Yes ☐ No
If no, please provide your existing submitter number:	
If yes, please indicate who will submit your data:	☐ Self ☐ Third Party Submitter
If Third Party Submitter is selected, please provide the Third Party's name:	
Plan Name:	
Address:	
Fax Number :	
Operations Contact Person:	
E-Mail address:	
Phone Number:	
Technical Contact Person:	
E-Mail address:	
Phone Number:	

Please list any additional Plan numbers your organization will submit data for:

Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:
Plan Number:	Plan Number:

**If more space is needed to list additional Plan numbers, please make a copy of this page, list the Plan numbers, and attach with the application.

What Connection Type is established via the Medicare Data Communications Network (MDCN)?

Lease Line	☐
NDM/Direct Connect	☐
Dial up / Modem	☐
GENTRAN	☐

Please return the completed submitter application, EDI Agreement and NDM dataset specifications, if applicable, to CSSC Operations at the address below.

Palmetto GBA
CSSC Operations
Post Office Box 100275, AG-570 • Columbia, South Carolina • 29202-3275
www.csscoperations.com

Risk Adjustment NDM Specifications
(SY-QSF-7.5.1-RAPS NDM Application)

The NDM Node connection is defined as follows**:**

NET ID:	**SCA**
NODE ID:	**A70NDM.MC**
APPLID:	A70NDMMC
AGNS ID:	PGBA

PLEASE ENTER YOUR NDM INFORMATION (Required):

NET ID:	_____
NODE ID:	_____
APPLID:	_____
AGNS ID:	_____

Your NDM User ID and password (if datasets are racf protected)

User ID:	_____
Password:	_____

RAPS Transaction Submission

DSN:	**MAB.PROD.NDM.RAPS.PROD.submitter id(+1)**
DISP:	(NEW,CATLG,DELETE)
UNIT:	SYSDG
SPACE:	(CYL,(75,10),RLSE)
DCB:	(RECFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.RAPS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, AAA 6, must also indicate “TEST” or “PROD”, depending on the type of file being submitted.

REVISION #: 2
REVISION DATE: 08/12/04
(SY-QSF-7.5.1-RAPS NDM APPLICATION FORM)

Report Retrieval (enter names)

We will return reports to you in the following DSN's. These datasets need to be GDGs to allow multiple files to be sent without manual intervention or overwriting of existing files.

Front End (FERAS) Response Report

Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=80,RECFM=FB,BLKSIZE=27920)

RAPS Return File

Frequency: Daily
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

RAPS Error Report

Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Summary Report

Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Duplicate Diagnosis Cluster Report (502 Error Report)

Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Summary Report

Frequency: Monthly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Cumulative Report

Frequency: Monthly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Monthly Error Frequency Report

Frequency: Monthly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

RAPS Quarterly Error Frequency Report

Frequency: Quarterly
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=133,RECFM=FB,BLKSIZE=27930)

NOTE: If you submit the UB04, NSF or ANSI file format, you may submit to the DSNs below. However, with these file formats it is necessary to identify to the front-end the data is being submitted for translation to the RAPS format and data for risk adjustment processing by using the appropriate receiver ID as designated below:

Institutional Data, UB 04

Professional Data, NSF– 80883 (AA0-17.0)

Institutional (80884) and Professional (80883)ANSI 4010 –ISA08, GS03, NM109 1000B

NSF Format Submission
DSN: **MAB.PROD.NDM.EDS.CLM.NSF.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=320,BLKSIZE=27840)
Note: For testing, use **MAB.PROD.NDM.EDS.TCLM.NSF. submitter id(+1)**

UB92 Format Submission
DSN: **MAB.PROD.NDM.EDS.CLM.UBF.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=192,BLKSIZE=27840)
Note: For testing, use DSN= **MAB.PROD.NDM.EDS.TCLM.UBF. submitter id(+1)**

837 Format Submission
DSN: **MAB.PROD.NDM.EDS.CLMA.UBF.submitter (+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=80,BLKSIZE=27920)
Note: For testing, use **MAB.PROD.NDM.EDS.TCLMA.UBF.submitter (+1)**

DSN: **MAB.PROD.NDM.EDS.CLMA.NSF.submitter (+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=80,BLKSIZE=27920)

Note: For testing, use **MAB.PROD.NDM.EDS.TCLMA.NSF.submitter (+1)**

Please note that the test/prod indicator in the file must match the DSN.

Date: May 2006

To: Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PD) Contracts

Regarding: Submitting and / or Retrieving, Risk Adjustment (RA) and / or Prescription Drug Event (PDE) Data Directly to CMS Enterprise File Transfer (GENTRAN)

Plans / Contracts submitting directly to the GENTRAN application need to submit an EDI agreement and Submitter application to the Customer Service and Support Center (CSSC), 877-534-2772, www.csscoperations.com.

- **EDI Agreement:** A CMS EDI Agreement must be completed for the specific data type, RA / PDE, by each contract and on file with CSSC, prior to submitting Test or Production Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations.

- **Submitter ID Assignment:** A Submitter ID will be assigned to you by the CSSC and will remain effective for ongoing submission of RA and/or PDE data. This is the unique ID assigned to the contract that will allow data submission and report retrieval. Complete the Submitter Application and return it to CSSC Operations with the completed EDI Agreement.

The GENTRAN mailbox(s) for any PDE or RA data must be established and access granted by contacting the Customer Support for Medicare Modernization (CSMM) technical help desk at 800-927-8069 or through the website at www.mmahelp.cms.hhs.gov or e-mail at mmahelp@cms.hhs.gov.

- Contracts using GENTRAN may not have more than 100,000 enrollees.

- The files submitted may not be over 1.5 g in size for any one submission.

- A mailbox must be established for each Plan / Contract number and type of data, i.e. RA and PDE that will be submitted through GENTRAN. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Third Party Submitters submitting RA and / or PDE data through GENTRAN would have to have mailboxes created for each of the contracts for which they are submitting. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Contracts / Plans using Third Party Submitters should request through the CSMM, that a GENTRAN mailbox be established for the Plan to receive reports / files.

Contracts / Plans considering using the GENTRAN application at CMS will work closely with the CSSC and the CSMM to complete the appropriate paperwork and establish the necessary connectivity.

GENTRAN File and Report Naming Conventions

RAPS Production

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.P

GENTRAN Report Name

RSP.FERAS_RESP_ssssss
RPT.RAPS_RETURN_FLAT_ssssss
RPT.RAPS_ERRORRPT_ssssss
RPT.RAPS_SUMMARY_ssssss
RPT.RAPS_DUPDX_RPT_ssssss
RPT.RAPS_MONTHLY_ssssss
RPT.RAPS_CUMULATIVE_ssssss
RAPS_ERRORFREQ_MNTH_ssssss
RAPS_ERRORFREQ_QTR_ssssss

RAPS Test

Plan to CMS GENTRAN Name

guid.racf.RAPS.freq.ccccc.FUTURE.T

GENTRAN Report Name

TEST.RSP.FERAS_RESP_ssssss
TEST.RPT.RAPS_RETURN_FLAT_ssssss
TEST.RPT.RAPS_ERRORRPT_ssssss
TEST.RPT.RAPS_SUMMARY_ssssss
TEST.RPT.RAPS_DUPDX_RPT_ssssss
TEST.RPT.RAPS_MONTHLY_ssssss
TEST.RPT.RAPS_CUMULATIVE_ssssss
TEST.RAPS_ERRORFREQ_MNTH_ssssss
TEST.RAPS_ERRORFREQ_QTR_ssssss

CODING RESOURCES

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E CODES

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
E95	POISON	55
E950	SUIC/SELF-POIS W SOL/LIQ	55
E9500	POISON-ANALGESICS	55
E9501	POISON-BARBITURATES	55
E9502	POISON-SEDAT/HYPNOTIC	55
E9503	POISON-PSYCHOTROPIC AGT	55
E9504	POISON-DRUG/MEDICIN NEC	55
E9505	POISON-DRUG/MEDICIN NOS	55
E9506	POISON-AGRICULT AGENT	55
E9507	POISON-CORROSIV/CAUSTIC	55
E9508	POISON-ARSENIC	55
E9509	POISON-SOLID/LIQUID NEC	55
E951	POISON-UTILITY GAS	55
E9510	POISON-PIPED GAS	55
E9511	POISON-GAS IN CONTAINER	55
E9518	POISON-UTILITY GAS NEC	55
E952	POISON-GAS/VAPOR NEC	55
E9520	POISON-EXHAUST GAS	55
E9521	POISON-CO NEC	55
E9528	POISON-GAS/VAPOR NEC	55
E9529	POISON-GAS/VAPOR NOS	55
E953	INJURY-STRANGUL/SUFFOC	55
E9530	INJURY-HANGING	55
E9531	INJURY-SUFF W PLAS BAG	55
E9538	INJURY-STRANG/SUFF NEC	55
E9539	INJURY-STRANG/SUFF NOS	55
E954	INJURY-SUBMERSION	55
E955	INJURY-FIREARM/EXPLOSIV	55
E9550	INJURY-HANDGUN	55
E9551	INJURY-SHOTGUN	55
E9552	INJURY-HUNTING RIFLE	55
E9553	INJURY-MILITARY FIREARM	55
E9554	INJURY-FIREARM NEC	55
E9555	INJURY-EXPLOSIVES	55
E9556	SELF INFLICT ACC-AIR GUN	55
E9557	SELF INJ-PAINTBALL GUN	55
E9559	INJURY-FIREARM/EXPL NOS	55
E956	INJURY-CUT INSTRUMENT	55

E CODES (CONTINUED)

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
E957	INJU-JUMP FROM HI PLACE	55
E9570	INJURY-JUMP FM RESIDENCE	55
E9571	INJURY-JUMP FM STRUC NEC	55
E9572	INJURY-JUMP FM NATUR SIT	55
E9579	INJURY-JUMP NEC	55
E958	INJURY/SELF-INJ NEC/NOS	55
E9580	INJURY-MOVING OBJECT	55
E9581	INJURY-BURN, FIRE	55
E9582	INJURY-SCALD	55
E9583	INJURY-EXTREME COLD	55
E9584	INJURY-ELECTROCUTION	55
E9585	INJURY-MOTOR VEH CRASH	55
E9586	INJURY-AIRCRAFT CRASH	55
E9587	INJURY-CAUSTIC SUBSTANCE	55
E9588	INJURY-NEC	55
E9589	INJURY-NOS	55
E959	LATE EFF OF SELF-INJURY	55

V CODES

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
V08	ASYMP HIV INFECTN STATUS	1
V421	HEART TRANSPLANT STATUS	174
V426	LUNG TRANSPLANT STATUS	174
V427	LIVER TRANSPLANT STATUS	174
V4281	TRNSPL STATUS-BNE MARROW	174
V4282	TRSPL STS-PERIP STM CELL	174
V4283	TRNSPL STATUS-PANCREAS	174
V4284	TRNSPL STATUS-INTESTINES	174
V432	HEART REPLACEMENT NEC	174
V4321	HEART ASSIST DEV REPLACE	174
V4322	ARTFICIAL HEART REPLACE	174
V44	ARTIFICIAL OPNING STATUS	176
V440	TRACHEOSTOMY STATUS	77
V441	GASTROSTOMY STATUS	176
V442	ILEOSTOMY STATUS	176
V443	COLOSTOMY STATUS	176
V444	ENTEROSTOMY STATUS NEC	176
V445	CYSTOSTOMY STATUS	176
V4450	CYSTOSTOMY STATUS NOS	176
V4451	CUTANEOUS-VESICOS STATUS	176
V4452	APPENDICO-VESICOS STATUS	176
V4459	CYSTOSTOMY STATUS NEC	176
V446	URINOSTOMY STATUS NEC	176
V448	ARTIF OPEN STATUS NEC	176
V449	ARTIF OPEN STATUS NOS	176
V451	RENAL DIALYSIS STATUS	130
V461	DEPENDENCE ON RESPIRATOR	77
V497	STATUS AMPUT	177
V4970	STATUS AMPUT LWR LMB NOS	177
V4971	STATUS AMPUT GREAT TOE	177
V4972	STATUS AMPUT OTHR TOE(S)	177
V4973	STATUS AMPUT FOOT	177
V4974	STATUS AMPUT ANKLE	177
V4975	STATUS AMPUT BELOW KNEE	177
V4976	STATUS AMPUT ABOVE KNEE	177
V4977	STATUS AMPUT HIP	177
V521	FITTING ARTIFICIAL LEG	177

V CODES (CONTINUED)

ICD-9-CM CODE	SHORT DESCRIPTION OF ICD-9 CODE	DISEASE GROUP
V55	ATTEN TO ARTIFICIAL OPEN	176
V550	ATTEN TO TRACHEOSTOMY	77
V551	ATTEN TO GASTROSTOMY	176
V552	ATTEN TO ILEOSTOMY	176
V553	ATTEN TO COLOSTOMY	176
V554	ATTEN TO ENTEROSTOMY NEC	176
V555	ATTEN TO CYSTOSTOMY	176
V556	ATTEN TO URINOSTOMY NEC	176
V558	ATTN TO ARTIF OPEN NEC	176
V559	ATTN TO ARTIF OPEN NOS	176
V56	DIALYSIS ENCOUNTER	130
V560	RENAL DIALYSIS ENCOUNTER	130
V561	FT/ADJ XTRCORP DIAL CATH	130
V562	FIT/ADJ PERIT DIAL CATH	130
V563	DIALYSIS	130
V5631	HEMODIALYSIS TESTING	130
V5632	PERITONEAL DIALYSIS TEST	130
V568	DIALYSIS ENCOUNTER, NEC	130

NEOPLASM GUIDELINES

A. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.
B. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.
C. Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:
    1. When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.
    2. When the admission/encounter is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia; the anemia is sequenced first followed by the appropriate code(s) for the malignancy.
    3. When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
    4. When the admission/encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.
D. When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.
E. Admissions/Encounters involving chemotherapy and radiation therapy.
    1. When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by chemotherapy or radiation treatment, the neoplasm code should be assigned as principal or first-listed diagnosis. When an episode of inpatient care involves surgical removal of a primary site or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.
    2. If a patient admission/encounter is solely for the administration of chemotherapy or radiation therapy code V58.0, Encounter for radiation therapy, or V58.1, Encounter for chemotherapy, should be the first-listed or principal diagnosis. If a patient receives both chemotherapy and radiation therapy both codes should be listed, in either order of sequence.
    3. When a patient is admitted for the purpose of radiotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.1, Encounter for chemotherapy.
F. When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.
G. Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

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APPLICATION FOR ACCESS

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APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

(Read and complete both sides of this form in ink)

1. **Type of Request** (Check only one) ☐ NEW ☐ CHANGE ☐ RECERTIFY ☐ DELETE

Last Name | First Name | MI

Current UserID

CAPITAL LETTERS
(Ø 1 2 3 4 5 6 7 8 9)

2. **User Information**

☐ CMS Employee
☐ Social Security Admin.
☐ FMC
☐ Contractor (non-Medicare)
☐ State Agency
☐ Office of the Inspector General
☐ Fraud Investigation
☐ End-Stage Renal Disease Network
☐ Federal (other than CMS)
☐ Mgd Care Org/Group Health Plan
☐ Vendor
☐ Railroad Retirement Board
☐ Medicare Contr/Intermediary/Carrier
☐ Peer Review Organization
☐ Researcher
☐ Other *(specify):* _____

a. SSN (*see Privacy Act Advisory Statement on back*)

e. Email Address *(non-CMS only)*

b. Mailing Address/Mail Stop

f. CMS Organization or Company Name

c. Central Office Desk Location

g. Company Telephone Number
( )

d. Daytime Telephone Number
( )

h. Contract Number(s) (*non-CMS only)*

3. **Type of Access Required (P**= Production, **D**=Development, **V**=Validation, **R**=Remote/Dialup Access**)**

a. **Application(s):**

	P	D	V	R		P	D	V	R
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )

b. **Subsystems:**

	P	D	V	R		P	D	V	R
CICS	( )	( )	( )	( )	OMVS	( )	( )	( )	( )
DB2	( )	( )	( )	( )	TSO	( )	( )	( )	( )
IDMS	( )	( )	( )	( )	WYLBUR	( )	( )	( )	( )
M204	( )	( )	( )	( )	OTHER _____	( )	( )	( )	( )
NDM	( )	( )	( )	( )	_____	( )	( )	( )	( )

d. **CMS Standard Desktop Software/LAN:**

	Email	No Email	Remote
Central Office	☐	☐	☐
DC1	☐	☐	☐
FMC	☐	☐	☐
ATL1	☐	☐	☐
BOS1	☐	☐	☐
CHI1	☐	☐	☐
DAL1	☐	☐	☐
DEN1	☐	☐	☐
KCM1	☐	☐	☐
NYC1	☐	☐	☐
PHI1	☐	☐	☐
SEA1	☐	☐	☐
SF01	☐	☐	☐
Other _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

c. **Expected Frequency of Use:** (*non-CMS only)* ☐ Daily ☐ Monthly ☐ Quarterly ☐ Annually

4. **Reason for Request**

5. **Authorization:** We acknowledge that our Organization is responsible for all resources to be used by the person identified above and that requested accesses are required to perform their duties. We understand that any change in employment status or access needs are to be reported immediately via submittal of this form.

Requesting Official

Print Name

Signature Date

Telephone Number CMS Userid

Contract Number Contract Exp. Date or 'Not-to-Exceed' Date

Approving Official
(*for non-CMS user only*)

Print Name

Signature Date

Title Organization

Telephone Number CMS Userid

CMS RACF Group Administrator

Print Name

Signature Date

Telephone Number

Desk Location Organization or Region

(July 2001)

PRIVACY ACT ADVISORY STATEMENT
Privacy Act of 1974, P. L. 93-579

The information on side 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's (formerly HCFA's) computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on this form will be maintained in the Individuals Authorized Access to the Centers for Medicare & Medicaid (CMS) Data Center Systems of Records and may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED. REG. 41329 (08-11-94) and as CMS may establish in the future by publication in the *Federal Register*.

Collection of the Social Security Number (SSN) is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in delaying the processing of this request.

SECURITY REQUIREMENTS FOR USERS OF CMS's COMPUTER SYSTEMS

CMS (formerly HCFA) uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of Federal programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in Federal computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. CMS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. CMS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to CMS Computer Systems containing sensitive information must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the con sequences of unauthorized or illegal transactions.
- Do not browse or use CMS data files for unauthorized or illegal purposes.
- Do not use CMS data files for private gain or to misrepresent yourself or CMS.
- Do not make any disclosure of CMS data that is not specifically authorized.
- Do not duplicate CMS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter CMS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of CMS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from Federal Service, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

_____ _____

Signature of User Date

Instructions for Completing the Application for Access to CMS Computer Systems

This form is to be completed and submitted whenever the following situations occur:
– A user **requires access** to a CMS computer system to perform their job duties. (Submit NEW Request)
– A user **changes names**, has a **change in access needs, job duties,** or **moves to another component.** (Submit CHANGE Request)
– A user receives notice that they must **recertify** their access needs. (Submit RECERTIFY Request)
– A user **retires, resigns,** is **removed from a contract with CMS,** or for any reason **no longer requires access**. (Submit DELETE Request)

Section 1: Type of Request COMPLETE FOR ALL REQUESTS. Check one box indicating type of request, enter name and current CMS UserID in blocks indicated, if using one. A separate form must be submitted for each action desired.

Section 2: User Information COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS. Check employee type, and complete blocks a. through h.

CMS Employees – Blocks e., g. and h. may be left blank. If not stationed at CMS Central Office, provide a complete mailing address in block b. and leave block c. blank.

Non-CMS Employees – Block c. may be left blank if not stationed at CMS Central Office. For block h., if your contract number is unknown, obtain it from your Project Officer or your CMS contact person.

Section 3: Type of Access Required COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS.

For NEW Requests – Check each type of access required. List the names of all CMS applications you require access to (i.e., OSCAR, CROWD, CAFM, CLIA) in block a., Application(s). For each application, check the appropriate columns to indicate the environment(s) access is needed in, and if remote access is required. DO NOT USE THIS BLOCK TO ENTER SOFTWARE THAT IS PART OF THE STANDARD CMS WORKSTATION CONFIGURATION; SEE BLOCK D. Use block b., Subsystems, to request access not specific to particular applications. This block is used to note accesses such as native TSO commands, usually required by system developers. If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. Non-CMS employees should complete block c., Expected Frequency of Use. If access to a CMS desktop or LAN is required, check your location in block d., CMS Standard Desktop Software/LAN. Checking this box will ensure you have access to all software available on the standard CMS workstation (i.e., Word, Excel, GroupWise, etc.).

For CHANGE Requests – If access needs have changed, enter an 'A' to add, or a 'D' to delete, for each type of access requiring a change. (Most changes in job duties or organizational placement require a change in access needs.) If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. For name changes only, leave this block blank and go to Section 4.

For RECERTIFY Requests – Check each type of access required to perform your job duties. If additional accesses are required, submit a separate change request. **(Those accesses currently held but not checked will be lost.)** If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, be sure to specify here and in Section 4, Reason for Request.

Section 4: Reason for Request COMPLETE AS REQUIRED.

For NEW Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For CHANGE Requests – Note the nature of the action requiring a change. For name changes, include previous and new names. For organizational changes, include old and new organization names. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For RECERTIFY Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For DELETE Requests – Note the nature of the action requiring the removal of accesses.

Read, sign and date the back of the form. Then obtain signatures for Section 5.

Section 5: Authorization COMPLETE FOR ALL REQUESTS. All requested information must be supplied or noted 'N/A'.

CMS Employees – **Requesting Official:** The immediate supervisor must sign and complete the Requesting Official block. The **RACF Group Administrator** must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Non-CMS Employees – **Requesting Official:** The Project Officer, if designated, must sign and complete the Requesting Official block. For Medicare Contractors/Intermediaries/Carriers, a designated company contact must sign and complete the Requesting Official block. For others, the CMS Liaison/Contact or ADP Coordinator must sign and complete the Requesting Official block. (IT IS IMPORTANT THAT CONTRACT NUMBER AND EXPIRATION DATE ARE INCLUDED WHERE APPLICABLE. IF ACCESS IS REQUIRED FOR MULTIPLE CONTRACTS, THE NUMBER AND EXPIRATION DATE FOR THE CONTRACT WITH THE LONGEST PERIOD OF PERFORMANCE SHOULD BE USED. IF NO CONTRACTS APPLY, AN APPROPRIATE 'NOT-TO-EXCEED' DATE SHOULD BE NOTED, OR 'N/A' IF INDEFINITE ACCESS IS REQUIRED.) **Approving Official:** The immediate supervisor of the Requesting Official must sign and complete the Approving Official block. For Medicare Contractors/Intermediaries/Carriers, the Consortium Contractor Management Staff member assigned as Contractor Manager for the company must sign and complete the Approving Official block. The **RACF Group Administrator** should note the preferred group for UserID assignment in Section 1. They must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Required Signatures for Applications for Access to CMS Computer Systems

Type of CMS User	Requesting Official	Approving Official	RACF Administrator
CMS Employee	Immediate Supervisor	N/A	HQ or Regional GA
State User	RO Coordinator (OSCAR, MDS, OASIS or ASPEN Coordinator) or Project Officer	Division Director*	Regional GA
Medicare Contractor/ Intermediary/Carrier	Company Contact	Consortium Contractor Management Staff Member	Regional GA
Managed Care Organization/ Group Health Plan	Project Officer	Division Director*	HQ GA
Researcher	Project Officer	Division Director*	HQ or Regional GA
Office of Inspector General	OIG Supervisor	OIG Regional GA	HQ GA
Other Federal Agency (Inter/Intra Agency)	System of Records Owner or CMS Liaison or Project Officer or Contact Person	Division Director*	HQ or Regional GA
Contractor (non-Medicare)	Project Officer	Division Director*	HQ or Regional GA
Vendor	Project Officer	Division Director*	HQ or Regional GA
Peer Review Organization Member	Project Officer	Division Director*	HQ or Regional GA
ESRD Network Member	Project Officer	Division Director*	HQ GA

*When Division Director signature would be redundant or not applicable, first-line supervisor of Requesting Official may sign as Approving Official.

(July 2001)