DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**CENTER FOR MEDICARE**

**DATE:** July 21, 2015

**TO:** All Medicare Advantage Organizations (MAOs), PACE Organizations, Medicare-Medicaid Plans, Section 1833 Cost Contractors and Section 1876 Cost Contractors, and certain Demonstrations

**FROM:** Cheri Rice, Director
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**SUBJECT:** Draft Encounter Data Diagnosis Filtering Logic

As finalized in the 2015 and 2016 Rate Announcements, CMS will incorporate diagnoses from encounter data into risk score calculations in payment year (PY) 2015 and 2016. For PY 2015, diagnoses (2014 dates of service) submitted on encounter data records will be an additional source of diagnoses to calculate risk scores. For PY 2016 (2015 dates of service), risk scores used for payment will be a blend of two risk scores: 10% of the risk score calculated using diagnoses from encounter data records and FFS claims will be added to 90% of the risk score calculated using diagnoses submitted to RAPS and FFS claims.

Historically, Medicare Advantage Organizations (MAOs) have done their own filtering and submitted to CMS a minimum data set of diagnoses into the Risk Adjustment Processing System (RAPS) that meet our risk adjustment criteria. Therefore, CMS has not needed to filter diagnoses submitted by MAOs in order to calculate risk scores. Since MAOs are now submitting the full breadth of information regarding services furnished to a beneficiary, including all diagnoses, CMS must now extract (i.e., filter) diagnoses submitted to the Encounter Data System (EDS) that are eligible for risk adjustment.

The purpose of this memo is to solicit feedback on the proposed encounter data filtering logic, which is outlined below. If you wish to submit comments on this filtering logic, please submit them to RiskAdjustment@cms.hhs.gov, with the subject heading "Encounter Data filtering," by August 21, 2015.

## Introduction

CMS will apply the current risk adjustment rules when filtering encounter data and identify which diagnoses to use in the risk score calculation. For a diagnosis to be acceptable for risk adjustment, it must be documented in a medical record from an acceptable provider type (hospital inpatient, hospital outpatient, or professional). CMS has established rules regarding

which inpatient and outpatient facilities, and which professional encounters, are acceptable for risk adjustment. For example, diagnosis codes from encounters solely related to diagnostic radiology and laboratory procedures are not acceptable, in addition to those from procedures/services that would not indicate a face-to-face visit.

Currently, to apply risk adjustment rules to professional encounters, CMS utilizes a list of acceptable physician specialty type codes (the list can be found at CSSCOperations.com, under "Risk Adjustment Processing System," and then under "References"). This list of physician specialties and qualified health professionals is derived on the basis that a face-to-face service has been rendered with the patient to determine the diagnoses. For example, the Acceptable Physician Specialty Types for 2015 Payment Year (2014 Dates of Service) include 72 physician specialty codes.

Specialty codes are identified when a physician or other professional enrolls as a Medicare provider. The database where this information is stored – the Provider Enrollment, Chain and Ownership System (PECOS) – is not publicly available. In order to provide a level of transparency in how we filter diagnoses from encounter data, CMS proposes to identify acceptable diagnoses from professional encounters using a filtering method based on Healthcare Common Procedure Coding System codes. HCPCS Level I are the Current Procedural Terminology (CPT) codes published by the American Medical Association; Level II codes are additional alpha-numeric codes maintained by CMS and other entities. (We will refer to Level I and Level II HCPCS codes as "CPT/HCPCS codes" in this memo.) Diagnoses from institutional outpatient encounters will be filtered based on a combination of Type of Bill and HCPCS codes, and institutional inpatient encounters will be filtered using Type of Bill Codes. The link to the risk adjustment acceptable 2014 Medicare CPT/HCPCS codes is at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending.

## I. CPT code-based Filtering of Professional Encounter Records

CMS will select encounters with service "through dates" in the data collection year, e.g., in 2014 for payment year 2015. Using the most recent version of an accepted professional encounter (whether an original or a replacement), CMS will evaluate lines on an encounter data record to determine if the CPT/HCPCS codes are acceptable, based on the acceptable Medicare Code list. If there is at least one acceptable line on the record, CMS will use all the header diagnoses. If there are no acceptable service lines on the record, then CMS will not use any of the diagnoses for risk adjustment.

## II. Filtering Institutional Inpatient Encounter Records

CMS will select encounters with service "through dates" in the data collection year, e.g., in 2014 for payment year 2015. Using the most recent version of an accepted encounter (whether an original or a replacement), CMS will use the Type of Bill Code to determine if an encounter is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment.

The acceptable institutional inpatient facility Type of Bill codes are listed in Table 1. We will take all header diagnoses from records where the Type of Bill Code equals one of these acceptable codes. There is no CPT/HCPCS procedure screen for institutional inpatient bill type code.

**Table 1: Institutional Inpatient Acceptable Type of Bill Code**

| Medicare Bill Type Code | Label (first 2 digits) |
|---|---|
| 11X | Hospital Inpatient |
| 41X | Religious Nonmedical (Inpatient) |

## III. Filtering Institutional Outpatient Encounter Records

CMS will select encounters with service "through" dates in the data collection year, e.g., in 2014 for payment year 2015. Using the most recent version of an accepted encounter (whether an original or a replacement), CMS will use the Type of Bill Codes to determine if an encounter is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment. We will then evaluate lines (revenue centers) on an encounter data record to determine if the CPT/HCPCS codes are acceptable, based on the acceptable Medicare Code list.

The acceptable institutional outpatient facility Type of Bill codes are listed in Table 2. We will take all header diagnoses from records where (1) the Type of Bill Code equals one of these acceptable codes, and (2) there is at least one acceptable CPT/HCPCS code on a service line.

**Table 2: Institutional Outpatient Acceptable Type of Bill Codes**

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

## IV. Incorporation of Chart Review

In addition to submitting encounters, plan sponsors are also allowed to submit encounter data records that reflect chart reviews. These records allow a plan sponsor to (1) submit additional diagnoses that were not submitted on the original encounter, but that were later found to be associated with an encounter through chart review, and (2) delete diagnoses via linked chart review that had been submitted on an original encounter, but were later found to be unsupported by the medical record. While additional or deleted diagnoses may also be submitted using the process of voiding and replacing an encounter data record, if additional diagnoses or deleted diagnoses are submitted via chart review records we will follow the process below.

We will select chart review records with "through" dates in the data collection year, e.g., in 2014 for payment year 2015. If the chart review record is adding diagnoses –diagnoses that were not on an original encounter – we will filter the record as we do non-chart review encounter records (see Sections II – IV above). If the linked chart review record is deleting diagnoses – that is, is deleting diagnoses from a previously-submitted encounter or chart review record – we will not consider the deleted diagnoses as eligible for risk adjustment.

## V. Submission Deadline

Diagnoses submitted on encounters will only be used in calculating risk scores if the encounter data records are submitted by the final risk adjustment data submission deadline for the payment year. Per the May 13, 2015 HPMS memo, the risk adjustment deadline for Payment Year 2015 is February 1, 2016. We remind plan sponsors that they must delete unsupported diagnoses from encounter data, as well as from RAPS.