



Risk Adjustment Data Validation (RADV) and Prescription Drug Event Data Validation

Program Overview

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Section I

Risk Adjustment Data Validation

Why RADV?



- Legislative/regulatory mandates to
 - Risk adjust Part C payments
 - Validate payments (diagnoses)
 - Report payment error
 - National (IPIA)
 - Contract level (payment adjustments)

Purpose of Risk Adjustment



- Pay appropriately based on individual demographic and health status
- Protect beneficiary access to care, reduce adverse selection

How Does Risk Adjustment Work?



- ICD-9 Diagnoses →
- Hierarchical Condition Categories (HCCs) →
- Risk Score = Unit that directly affects payment

Part C payments = Plan-specific county rate * Beneficiary Risk Score –
MA Monthly Beneficiary Premium (if any) + Applicable Rebate

RADV - What Is New?



- Contract-level payment error estimates and payment adjustments
- Attestations
 - CMS-generated attestation may be submitted up front with medical records to correct signature and provider credential errors
 - Attestations will not be accepted after the medical record submission deadline
- Administrative processes
 - Revised 'Documentation Dispute' process
 - New 'Appeals' process

CY 2007 RADV Audit



- CY 2007 RADV audit includes:
 - Pilot plans
 - Targeted plans
 - Selection criteria based on plan's relative coding intensity score in the 2004 to 2007 Coding Intensity study
 - National sample

Risk Adjustment Data Validation Audit Process: Overview



Sampling
(1)

Medical Record
Request
(2)

Medical Record
Receipt
(3)

Medical Record
Review
(4)

Report of Findings
(5)

Documentation
Dispute
(6)

Appeals
(7)

Risk Adjustment Data Validation Sampling



Targeted Contract Selection Approach

- Organizations included in the 2004-2007 MA Coding Intensity study
- Contracts with >1,000 enrollees were ranked based on their 3-year average change in disease component of the risk score growth (high, medium, low)
- 33 contracts randomly selected
 - Two-thirds of the targeted contracts were selected from the group with the highest change in disease growth (25 contracts)
 - The remainder was selected from the medium and low groups (8 contracts)

What Is A Medical Record for RADV?



- A medical record represents one face-to-face encounter on one date of service (for outpatient and physician records) or a date range (for inpatient records)

Medical Record Requirements



- Medical records have to meet the following requirements to avoid a discrepant finding:
 - Acceptable risk adjustment provider type and physician specialty
 - Date of service within the data collection period
 - January 1, 2006 through December 31, 2006 (for the CY 2007 Targeted sample)
 - Valid signature and credentials
 - If missing, use CMS-generated attestation
 - Correct beneficiary

Submit “The One Best Medical Record”



- May have one or multiple medical records to support a specific CMS-HCC
- Select and submit “the one best record medical record” to support the CMS-HCC
- Only submit one medical record per CMS-HCC, even if a beneficiary has multiple diagnoses (ICD-9-CM) associated with that one CMS-HCC
- CMS will only review one medical record to validate the CMS-HCC indicated on a coversheet

CMS-Generated Attestations



- What is the purpose of the CMS-generated attestation?
 - Attestations are a new component of RADV which may be used to address problematic or missing signatures and/or credentials on physician and outpatient medical records
 - CMS has carefully drafted and tested the use of these attestations
 - Attestations are simple to complete and submit – but must meet CMS requirements
 - Attestations are voluntary

Attestation Requirements



- If “the one best medical record” has a missing or illegible physician/practitioner signature and/or credentials, the MA organization may wish to consider using the CMS-generated attestation
- The attestation must be submitted with the related coversheet and medical record, including replacement records

Medical Record Review



- The RADV coders will review the date (physician/outpatient records) or range of dates (inpatient records) specified on the coversheet
- The coders will abstract all valid ICD-9-CM codes in the documentation within the specified dates
- For example, if the medical record indicates pneumonia and congestive heart failure, they will abstract both diagnoses and both will be used to validate the risk score for the beneficiary

Coding Protocol



- All coding discrepancies are confirmed at four levels using two independent contractors who are blind to each other's findings.
 - Initial Validation Contractor
 - Primary coder
 - Senior coder
 - Second Validation Contractor
 - Primary coder
 - Senior coder

Proposed Documentation Dispute Process



- The purpose of documentation dispute is to allow plans the opportunity to resolve errors that arose from the operational processing of medical records submitted by the deadline
- “Operational processing errors” refers to errors arising from the collection and processing of medical records for RADV audit. For example,
 - Two pages of a medical record are inadvertently separated into “two medical records”, or
 - Technical failures cause faxed pages to be missed/obliterated
- MA organizations may only dispute issues that pertain to medical records that were submitted by the deadline in response to the medical record request

Documentation Dispute Continued



MA organizations may not use the Documentation Dispute process to:

- Address medical record coding discrepancies relating to the interpretation of coding guidelines
- Submit new medical records in place of previously-submitted medical records
- Introduce new/additional CMS-HCCs for payment that were not earlier identified by CMS for audit
- Submit medical records for CMS-HCCs that were in error because the MA organization failed to meet the medical record submission deadline established by CMS (i.e., missing medical records)
- Submit attestations for signature and/or credential errors.

Proposed Voluntary Payment Error Calculation Appeals Eligibility Criteria



- MA organizations must adhere to established RADV audit requirements.
- Appeals process applies only to errors identified in the RADV payment error calculation
- Medical record review-related errors are not eligible for appeal
- Physician / practitioner signature / credential-related review-related errors are not eligible for appeal
- CMS' payment error calculation methodology is not eligible for appeal

Proposed Voluntary Payment Error Calculation Appeals Eligibility Criteria



Three Stage Process

- Reconsideration
- Hearing
- Discretionary Administrator Review

CY 2007 CMS Prescription Drug Event Data Validation MA-PD and PDP

Section II

Calendar Year 2007 Medicare Part D Prescription Drug Event Data Validation



- Being conducted by CMS to meet the Improper Payments Information Act of 2002 (IPIA) payment error reporting requirements
- IPIA requires that government agencies:
 - Identify programs at risk for improper payments,
 - Estimate the annual amount of improper payments for the programs; and
 - Report the annual estimates to Congress.
- CMS is developing component payment error estimates in order to build a Part D composite payment error estimate

PDE Data Validation



- The purpose of the PDE Data Validation process is to capture data inconsistencies between:
 - The prescription drug claim as adjudicated by the Part D Plan and its downstream entities; and
 - The PDE record, which must be submitted to CMS by the Part D Plan.

PDE Based Payment Error Estimate



- The accuracy of sampled PDE records will be evaluated using supporting documentation
- Payment error estimates will be extrapolated from sample validation findings onto the eligible population of PDE records
- Estimate changes to 2007 Part D CMS payments to reflect the adjustments in beneficiaries' benefit phases resulting from invalid and/or inaccurate PDE records

CY 2007 PDE Data Validation Sample



- Any accepted PDE for a covered Part D drug was included in the sample
- 2,000 PDE records have been sampled
- 245 plans were sampled to provide these PDE records
- Based on plan size, 1-179 PDE records have been sampled for review
- Stratified sample based on five PDE characteristics: PBM, drug costs, Low Income Cost Sharing status, Long Term Institutional status and catastrophic status

PDE Data Validation Requirements



- Contracts must submit 7 pieces of supporting documentation for each sampled PDE:
 - Prescription record hard copy image
 - Prescription record screenshot
 - Signature log/proof of delivery
 - Explanation of benefits
 - Claims detail screenshot
 - PDE detail screenshot
 - Pharmacy payment detail screenshot
- Certain data elements must be present for supporting documentation to be valid

Timeline



- Contracts were notified November 11, 2009
- Contracts received their sample data November 24, 2009
- Submission deadline for PDE documentation is 11:59 PM ET, January 25, 2010

Questions

