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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

HHS-Operated Data Collection Policy FAQs

Supplemental Diagnosis Code Sources for HHS-operated Risk Adjustment Data Submission

Q: Will HHS accept supplemental diagnosis codes for consideration in calculating enrollee risk scores when HHS operates risk adjustment on behalf of a State? What sources are permitted for supplemental diagnosis codes; and, what are the data collection procedures for diagnosis codes from a supplemental source?

A: In the HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, HHS indicated that standards related to use of chart review for data collection would be provided in future guidance. This FAQ is the initial guidance that HHS is providing on the subject of chart review as a source of supplemental diagnosis codes for acceptable claims and encounter data as defined under 45 CFR § 153.710. Additional, detailed operational guidance related to collection of supplemental diagnosis codes will be provided in future guidance and in advance of the final data submission deadline of April 30, 2015.

Guidance on Supplemental Diagnosis Codes for HHS-Operated Risk Adjustment:

1. HHS will accept supplemental diagnosis codes from the following sources:
    a. Fee-For-Service Claims Environment:
        i. Chart (medical record) review by the issuer subsequent to medical billing when an issuer has submitted risk adjustment data related to an allowed claim for hospital inpatient, hospital outpatient and professional medical services. In this case, the issuer has paid a claim that is the result of services provided to an enrollee and is supported by medical record documentation. In such cases, the chart review must evaluate all diagnoses on the original claim, and the issuer must delete any diagnoses not supported by the chart. We note that any chart review would be governed by applicable privacy and security laws and standards. Any diagnoses added through such a process would be linked to an individual's de-identified record on the issuer's edge server; HHS will not access individual records except in cases of audit.

        ii. Diagnosis codes that are received via electronic data interchange (EDI) and exceed the number of diagnosis codes that are accepted by the issuer's claims system. HHS understands that in some instances the number of an enrollee's diagnosis codes exceeds the number of diagnosis codes that the issuer's translator and claims system can accept.

Issuers are allowed to pick up diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end.

b. Encounters in a Capitated Environment:
   i. Chart (medical record) review by the issuer subsequent to medical billing when an issuer has submitted risk adjustment data related to an allowed claim for hospital inpatient, hospital outpatient and professional medical services. In this case, the issuer has paid a claim that is the result of services provided to an enrollee and is supported by medical record documentation. In such cases, the chart review must evaluate all diagnoses on the original claim, and the issuer must delete any diagnoses not supported by the chart. We note that any chart review would be governed by applicable privacy and security laws and standards. Any diagnoses added through such a process would be linked to an individual's de-identified record on the issuer's edge server; HHS will not access individual records except in cases of audit.

   ii. Routine medical record (chart) review. Supplemental diagnosis codes must be related to services that are defined as an encounter for hospital inpatient, hospital outpatient and professional medical services.

   iii. Diagnosis codes from allowed encounters.

   iv. Diagnosis codes that are received via electronic data interchange (EDI) and exceed the number of diagnosis codes that are accepted by the issuer's encounter system. HHS understands that in some instances the number of an enrollee's diagnosis codes exceeds the number of diagnosis codes that the issuer's translator and claims system can accept. Issuers are allowed to pick up diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end process.

2. Issuer shall submit supplemental diagnosis codes to the distributed data environment (Edge Server) during the appropriate data collection period in a format designated by HHS (45 CFR § 153.700). **NOTE:** Because HHS is allowing supplemental diagnosis codes, an additional file format will be established to support this submission. HHS intends to provide information in future guidance for this additional format. The file format for collection of supplemental diagnosis codes shall require the identification of the source of the diagnosis codes. Specifically, a qualifier for source type will be a required data element.

3. Deletions of incorrect diagnoses shall also be submitted. If an allowable source of supplemental diagnosis codes (see item 1 above) identifies incorrect diagnosis codes, then an issuer shall submit a deletion in the additional file format (described in item 2).

4. Denied claims are not a source of supplemental diagnoses.

Use of Enrollee Health Assessments as Source for Diagnosis Data Submission

Q: Does HHS plan to utilize health assessments as a source of risk adjustment diagnosis codes?

A: For the first year of operations, HHS will allow health assessment diagnoses to be submitted for the HHS-operated risk adjustment program provided that the diagnoses submitted based on these assessments comply with clinical coding guidelines. We would like to discuss this issue with the issuer community and determine the best approach to use in future years. We note that any diagnoses added through such a process would be linked to an individual's de-identified record on the issuer's edge server; HHS will not access individual records except in cases of audit.
