CMS Risk Adjustment Data Validation Audit Protocol

The Centers for Medicare & Medicaid Services (CMS) perform risk adjustment data validation audits annually on members' medical records.

Definition of Risk Adjustment Data Validation:

- The process of verifying diagnosis codes submitted for payment are supported by medical record documentation.

Two Types of CMS RADV Audits:

1. National RADV Audit (stratified random sample of beneficiaries up to 5 per contracted MA/Health Plan).
2. Contract Level RADV Audit (sample of beneficiaries up to 201 per contracted MA/Health Plan).

The Purpose:

- To ensure risk adjusted payment integrity and accuracy
- CMS has announced its intention to increase auditing activity consistent with an emphasis on reducing payment errors.

To promote compliance with CMS data validation, CalOptima highlights some key documentation guidelines as follows:

- ✓ **Medical record documentation must be legible.**
- ✓ **For risk adjustment data validation purposes, CMS will only consider medical record documentation from a face-to-face encounter (between a patient and physician/provider) and the condition or findings from a face-to-face encounter must be discussed and notated in the patient medical record.** [**Important Notes:** Unacceptable types of medical record documentation to validate ICD9-CM/ICD10-CM code per CMS include: Initials and a date on a lab report as adequate documentation, superbills or encounter forms and problem lists].
- ✓ **Physician's signature and credentials must be included for each patient encounter. The following is acceptable: Jane Anne Doe, MD or JAD, MD.** [**Important Note:** credentials must be either next to the provider's signature or pre-printed with the provider's name on the practice's stationery].
- ✓ **Electronic Signature — requires authentication by the responsible provider** (for example, but not limited to, "Approved by," "Signed by," or "Electronically signed by." It must also be password protected and used exclusively by the individual provider).
- ✓ **Signature Stamp — Stamped signatures are no longer acceptable for provider documentation effective January 1, 2009.**
- ✓ **Typed Signature — is unacceptable unless it is authenticated by the physician/provider.**
- ✓ **Patient's name must appear on every page of the medical record and all entries/encounters must be dated**.
- ✓ **Records must be coded in accordance with the ICD-9 or *ICD10-CM Guidelines for Coding and Reporting***. Medical record documentation must support the code selected and substantiate that the proper coding guidelines were followed. Documentation must support the condition that was addressed

such as status of condition, lab values, physical exam, symptoms or education. Ordering labs and medications does not validate the diagnosis.

- ✓ **Code all documented conditions that coexist at the time of the visit, and require or affect patient care treatment or management.** Do not code conditions that were previously treated and no longer exist. However, history codes may be used if the historical condition or family history has an impact on current care or influences treatment. Do not document a diagnosis as "history of" for a condition that is acute or chronic still requiring management or treatment.
- ✓ **Chronic conditions treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).** Address chronic conditions at least every 6 months. Code all documented conditions that coexist at the time of the visit and require or affect patient treatment or management. Even if the note states, "doing well with diabetic diet or continues to do home blood sugar monitoring," CMS considers this notation as meeting their criteria.
- ✓ **Sign the medical record and make all notations timely.** [Note: CMS expects records to be documented at the time of the visit.] Addendums are acceptable in certain circumstances, such as the following example: Patient has visit for a liver biopsy. The pathology report is received several days after the office visit and confirms malignant neoplasm of liver. The physician reviews the findings, initials the report, interprets, and documents in the record the results and notification to the patient. Since the liver biopsy was done during the office visit, the new code assignment for primary liver cancer (155.0 in ICD-9, and C22.8 in ICD-10) should be submitted with that date of service.
- ✓ **Unacceptable types of diagnoses:** "Probable," "suspected," "questionable," "rule out" or "working" diagnoses cannot be reported to CMS as valid diagnoses by a physician or in the outpatient hospital setting.
- ✓ **Document specificity of condition.** Specify conditions as acute, chronic, major, recurrent, remission, type or nature of clinical condition.
- ✓ **Linking diagnosis with manifestations.** When conditions are related, use the qualified linking terms (**due to, secondary to, associated with, diabetic or hypertensive**) to demonstrate the cause-and-effect relationship between the two conditions. For example, if the physician states diabetes ***with*** peripheral vascular disease (PVD), then the two diseases are considered ***unrelated***. The coder must report 250.00 (ICD-9 Type II Diabetes without complication) and 443.9 (ICD-9 Peripheral vascular disease, unspecified). For CMS to consider the manifestation of PVD to be causally related to the diabetes, the physician must specify the PVD is a complication of the diabetes and document it such "**PVD due to diabetes**". The coder will assign and report 250.70 and 443.81 (ICD-9) or E11.51 (ICD-10). CMS will count this as a higher valued HCC for diabetes. When linking conditions, include documentation to support both conditions. Use additional diagnosis codes to identify manifestation. If both conditions are not validated, it cannot be coded as linked.
- ✓ **Use V codes (ICD-9) or Z codes (ICD-10) when appropriate.** These codes document factors influencing health status conditions. For example, in notes indicate amputation status, transplant status, dialysis, HIV status, and artificial opening such as colostomy and ileostomy.

Important Note:

The information described here complies with accepted coding practices and guidelines as defined in the ICD-9 and ICD-10 coding books. It is the responsibility of the health care provider to produce accurate and complete documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to adequately substantiate the use of the most appropriate ICD-9 or ICD-10 CM code(s) according to the Official Guidelines for Coding and Reporting.