Contract-Level 15 Risk Adjustment Data Validation

Medical Record Reviewer Guidance

In effect as of 01/10/2020*

Version 2.0

* This guidance will be used for audits commencing after 01/10/2020

01/10//2020

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Revision History

Version	Date	Page Number	Sections Revised	Sample
2.0	10/30/20	6	Introduction: Paragraph 2, last 2 sentences modified.	CON15
2.0	10/30/20	15	*Signatures:* Last sentence modified	CON15
2.0	10/30/20	18	Electronic Signatures: Reviewer Guidance – The date signed **must** be within 180 days. Electronic point of service…CMS-attestation with the medical record.	CON15
2.0	10/30/20	18	Electronic Signatures: RADV Auditor Action: Revised	CON15
2.0	10/30/20	20	Point of Service EMR: RADV Auditor Action: Additional guidance added	CON15
2.0	10/30/20	26	Dates of Service: 4th bullet removed	CON15
2.0	10/30/20	30	Table 5: Provider Type/Record Issues : Face to Face Visit – RADV Auditor Action – Additional Guidance added	CON15
2.0	10/30/20	55	Uncertain Diagnoses – AHA Coding Clinic for ICD-9-CM 3rd Qtr., 2014 – added	CON15

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Introduction

The Contract-Level Risk Adjustment Data Validation (RADV) Medical Record Reviewer Guidance has been created to provide information on the RADV medical record process. These guidelines are used by coders to evaluate the medical records submitted by plans to validate audited diagnoses. Centers for Medicare & Medicaid Services (CMS) is legislatively mandated to risk adjust Medicare Part C payments and report a Medicare Part C payment error rate. By regulation, CMS conducts annual RADV audits to ensure risk-adjusted payment integrity and accuracy. CMS' Contract-Level RADV audit initiative is the agency's primary strategy to address the payment error rate for the Medicare Advantage (MA) program. The RADV audit is conducted pursuant to regulations under 42 CFR § 422.310 – Risk adjustment data, section 422.310(e): "MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data."

CMS selects a subset of Part C contracts for each annual RADV audit cycle. Enrollees are sampled from each selected MA contract to estimate payment error related to risk adjustment. Once the enrollees have been selected, the MA Organization is required to submit medical records to support all CMS-Hierarchical Condition Categories (HCCs) in the sampled beneficiaries' risk scores for the payment year. For risk adjustment purposes, CMS refers to the MA model of disease groups as HCCs. The CMS-HCC assigned to a disease is determined by the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes submitted during the data collection period. Only selected diagnosis codes are included in the CMS-HCC model. The term "hierarchical" in HCC refers to the ranking of these disease groups, or "hierarchies," based on the relative factor (weight) assigned to the HCC. Hierarchies allow CMS to pay for only the most severe manifestation of a disease when diagnoses for less severe manifestations of a disease are also present in a beneficiary during the data collection year. A chart showing the HCCs involved in hierarchies for the 2015 calendar year, along with an example of how payments were made with a disease hierarchy, can be found in Table 1 and Table 4 of the 2014 Rate Announcement. The tables from 2014 remain in effect for 2015.

MA Organizations may appeal eligible medical record review determinations and RADV payment error calculations for their selected contracts via an administrative appeals process. CMS regulations require MA Organizations to adhere to established RADV audit procedures and RADV appeals requirements. Failure to follow CMS rules regarding the RADV medical record review audit procedures and RADV appeals requirements may render the MA Organization's request for appeal invalid.

To validate the audited CMS-HCCs for sampled enrollees, the MA Organization must request medical records from hospitals (for Hospital Inpatient and Hospital Outpatient records) and physicians/practitioners (for Physician records) that provided services to the selected enrollees; this document will refer to those hospitals, physicians, and practitioners collectively as "providers."

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Purpose

This guidance focuses on areas impacting those RADV submissions with apparent documentation issues that could impact the validity of the medical record when submitting it to confirm an audited CMS-HCC. The lack of these validity elements will result in an error under the RADV medical record review process leading to a discrepancy for the audited CMS-HCC findings.

Each medical record correctly submitted with a matching sampled enrollee CMS coversheet is evaluated independent of all other submissions and is reviewed for both validity and diagnosis coding. The entire medical record is reviewed before making a final decision on validity and coding. Only RADV coding results from valid medical record submissions are used to substantiate payment. Invalid or a lack of a medical record submitted will potentially impact the payment error calculation. It is critical to understand all guidance pertaining to these documentation issues will be considered on a case-by-case basis. The guidance and examples are not exhaustive in content. Topics, guidance, and actions have been included based on experience of prior RADV samples, but medical records can be unique in format, legibility, content, organization, etc.

The reviewers must first apply their expertise in documentation and official coding guidelines to each scenario. This guidance is organized in tables addressing the validity of medical record submission and attestations regarding enrollee name, signature, credentials, date of service, provider type, and other documentation issues. This guidance does not give advice for specific diagnosis coding; it does not contradict the *ICD-9-CM Official Guidelines for Coding and Reporting.* CMS reiterates the purpose of those official guidelines.

> "These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task." *ICD-9-CM Official Guidelines for Coding and Reporting, page 1.*

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Important Resource: *ICD-9-CM Official Guidelines for Coding and Reporting* are found at https://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf document includes ICD-9-CM Conventions (definitions of abbreviations, punctuations, symbols and terms), guidelines for each code range (primarily by body system) chapter, Reporting of Additional Diagnoses, and Diagnostic Coding and Reporting Guidelines for Outpatient Services.

At a minimum, medical records must meet the following requirements to avoid a discrepant finding:

- Correct beneficiary as provided on the CMS RADV coversheet
- Acceptable risk adjustment provider type, source, and physician specialty providing the face to face encounter
- Dates of service within the data collection period under review
- Valid signatures and credentials
  - For outpatient or physician encounters, a CMS-Generated RADV Attestation form may be submitted to authenticate (with signature and credential) the entries. The RADV Attestation form is provided with the MA Organization enrollee sample file. The attestation form is not for validating dates or diagnoses.
- Coded according to the official conventions and instructions provided within ICD-9-CM, the ICD-9-CM Official Guidelines for Coding and Reporting, and guidance provided in the "AHA Coding Clinic for ICD-9-CM" published quarterly by the American Hospital Association. Refer only to issue dates effective at the time of encounter.

MA Organization Pre-Review of Submissions

Once medical records are received from the providers, the MA Organization should review the records internally to determine if the records meets Risk Adjustment (RA) policies and if the documentation supports one or more of the audited CMS-HCCs. The MA Organization does not have the option to change or amend any medical record documentation at the time of the RADV audit. Requesting that the provider change or amend a medical record at the time of the audit does not meet requirements for timely medical record completion made at or near to the provider encounter and may have legal implications. CMS understands the constraint when provider medical records are incomplete or documented inadequately. Therefore, the RADV process, which is described in detail in submission instructions sampled MA Organizations receive, allows for multiple medical record submissions from multiple approved providers from any encounter date in the data collection period, even if a diagnosis from that encounter was not previously submitted to Medicare.

The MA Organization must select at least one medical record to support each audited CMS-HCC being validated. For the purposes of RADV audits, a medical record is required to be documentation of a single face to face encounter for physician/practitioner office and hospital outpatient visits or a single admission for hospital

Inpatient stays. The medical records must be selected from an inpatient (IP) hospital, outpatient (OP) hospital, or physician specialty that is acceptable for risk adjustment (see Appendix B: *CMS-HCCs and Physician Specialties*). The CMS Centralized Data Abstraction Tool (CDAT) generates a Medical Record Coversheet for each of the sampled enrollees. The coversheet includes pre-populated contract information and enrollee identification plus sections to designate the CMS-HCC(s) and date of service for the attached medical record. If the MA Organization finds more than one medical record (from multiple provider types and/or dates of service) to support a given audited CMS-HCC, a separate Medical Record Coversheet in CDAT must be completed for each medical record (i.e., a single date of service [Physician or Hospital Outpatient] or a single admission [Hospital Inpatient]).

When MA Organizations receive records from providers, they should:

- Verify both the CMS RADV Medical Record Coversheet enrollee name and date of birth for every record received;
- Confirm all pages of every record are for the correct enrollee (if any page contains protected health information (PHI)/personally identifiable information (PII) of another person, remove that portion before attaching the medical record for submission into CDAT);
- Confirm the date of service is clearly documented and within the data collection year;
- Confirm the provider type, specialty, and face to face requirement is clearly documented; and
- If no attestation was received and the provider name and credential are not clear on the medical record, re-request the provider legibly indicate their name and credential and include another CMS RADV attestation form in the follow-up request.

Submission Review upon Receipt for RADV

Once the coversheets and medical records are submitted through CDAT, there is a process to perform an initial check on the submissions. This process is referred to as the intake process. The RADV intake process will initially check that

- The medical record submission is not completely blank;
- The name on the Medical Record Coversheet matches the name on the medical record:
  - If the name on each page of the medical record does not match the coversheet, this could mean a possible PHI/PII data breach. Further submission review is suspended if escalated for potential PHI/PII breach;
- Each submission contains one **Medical Record Coversheet**:
  - Medical Record Coversheet is correctly labeled “CY 201X (review year) Contract-Level RADV” on all pages
  - All data fields in Section I contain data
  - All data fields in Section II contain enrollee data that matches the name on the medical record submitted. The birth date may be used as a

secondary identifier for common shortened names if it is present on the medical record. Note if the correction area has been populated to explain any name variance.

- Section III, IV, and V are populated as directed with one radio button selection and at least one CMS-HCC indicated. If any unusual format or population issues are noted, the RADV intake reviewer may escalate the case for confirmation to a Senior Evaluator (SE) who will submit a support ticket if indicated. For CON15 reviews:
- The Discharge Date Year of Review field for a Hospital Inpatient record is populated with "2014"
- The Year of Review field for a Physician/Specialist/Hospital Outpatient/Observation record is populated with "2014"
- All fields in the *Medical Record Submission Information* section (File Name, Submitted By, and Submission Date) contain data
- On page 2, the Coversheet displays the ICD-9-CM codes that correspond to the audited CMS-HCCs selected within Section IV of the Coversheet

- The CMS Attestation, if indicated, as attached is present and valid:
  - Attestation is in the CMS Attestation format.
  - The CMS-Generated Attestation must be completed, signed, and dated by the physician/practitioner who provided those services. No other forms of an attestation will be accepted. The completed fields must include the printed physician/practitioner's name, the date of service of the medical record to which they are attesting, the physicians/practitioner's specialty or credential, and must be signed and dated by the physician/practitioner that encountered the face to face visit.
  - Date ranges or multiple dates of service cannot be entered on a Medical Record Coversheet from an outpatient record. A CMS-Generated Attestation may be completed by the attending physician/practitioner for a single date of service. If the date of service on the submitted CMS-Generated Attestation does not match the medical record submitted by the MA Organization with the Medical Record Coversheet, it will be deemed invalid and will result in an error under the CMS RADV medical record review process if the medical record lacks the necessary physician/practitioner signature and/or credentials.
  - If the attestation is invalid, the reviewer will flag for Invalid Attestation and select the appropriate invalid reason. Multiple reasons can be selected.

    Invalid Attestation Reasons in CDAT include:

1. *Attestation Altered*
2. *Attestation Incomplete*
3. *Date of Service Mismatch*
4. *Incorrect Enrollee* – Enrollee name does not match both coversheet and medical record

5. *Inpatient Record*
6. *Non-CMS Generated Attestation*
7. *Other* – Include specific comment
8. *Unacceptable Credentials*
9. *Unacceptable Signature* – this includes attestation signed by someone other than the physician/practitioner with or without explanation (retired, expired, Power of Attorney, etc.)

The following table presents examples of various attestation issues and how they are evaluated. Date examples are for audits that will be conducted on payment year 2015 (CON15), dates of service in 2014.

Table 1: Attestation Issues

What the Reviewer Might Encounter	Examples/Comments	Acceptable for CON15 (Y/N)
A. Physician/practitioner signed for another or signature stamp used	1. I, John Smith signed by Jane Doe, MD. 2. "I am completing this form because John Doe is not available." 3. Name does not match the record without any explanation. Compare handwriting to the extent possible, denying only blatant differences when no printed name is available in the medical record. 4. If first name matches but last name does not, escalate to Quality Assurance (QA) Panel for guidance. 5. John Smith, Power of attorney for Jane Doe, MD. Include a comment "attesting name does not match physician/ practitioner name."	N
B. Marked through physician/practitioner name attesting to his/her own record.	John Doe is marked through. James Dean is entered, and the attestation is signed James Dean, MD. The medical record is assumed to be that of James Dean, not that James Dean is signing for John Doe.	Y

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What the Reviewer Might Encounter	Examples/Comments	Acceptable for CON15 (Y/N)
C. Marked through date of service	Jan. 01/31/2014 (21 is written above or below the incorrect day 31).	Y
D. Blank form	Name, Date of Service, or signature line is blank. For blank credential line, see letter L. below.	N
E. Date of service handwriting error	(Date of Service is written over.)	Y
F. Date of service outside the data collection period	12/30/2013 or 01/25/2015.	N
G. Partially illegible date of service	01/H/2014 It could be "4" or "11." (Choose the one that matches the medical record.)	Y
H. Date range	Jan. 1–Dec. 31, 3/4/14–5/6/14 (a date range).	Y/N Pass only if Medicare Record (MR) matches the first or last date.
I. Invalid risk adjustment physician/practitioner credentials	Medical Assistant, Licensed Practical Nurse (LPN), Dietician.	N
J. Multiple individual dates of service	1. May 1, May 10, May 15, 2014 2. May 1–3, May 6, May 12, 2014	Y/N (Only accept the date that matches MR date of service.)
K. Wording of attestation crossed out or added to	Attestation becomes invalid	N
L. Credential area is blank, illegible, or not a common credential	MSN (Master of Science in Nursing), "Provider."	Escalate to a more senior coder for review.

The following table presents scenarios the submission reviewers may encounter and what actions are indicated. See Appendix A for the complete list of invalid (INV) flags with definitions.

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Table 2: Submission Intake Issues

What the Reviewer Might Encounter	Actions
One Medical Record Coversheet 'erroneously' submitted with incorrect medical record. The whole medical record or document within the medical record clearly is not for the same enrollee designated on the coversheet. A. Entire medical record does not match. B. A portion or one document within correct submission is for a different person. C. The name matches but the date of birth is significantly different (not a likely data entry error and no correction indicated on coversheet).	• The coversheet correction area is reviewed to see if the difference has been identified by the MA Organization. • PHI/PII breach protocol is followed. If the PHI/PII breach is confirmed, the submission will be removed during the next CDAT maintenance window. If no breach, a comment is entered regarding the acceptable name difference.
Enrollee name does not match medical record. The name (and DOB when available) on the coversheet does not match the medical record or portions of the medical record. ***Examples:*** Lack of a name on a full report such as inpatient progress notes, multi-part emergency department (ED) record forms, single or multi-page transcribed reports. A multi-part continuous form with the enrollee identification on at least one page.	• Check the coversheet correction area. If correction area is filled in, note the change in the variation of name comment. • If the name is completely different, escalate to initiate PHI/PII protocol. • If the name is the same but birthdate is completely different (not just a typo), escalate to initiate PHI/PII protocol. • If the name appears to be a nickname or other variation, escalate and enter comment regarding acceptance decision in the comment area so all levels will be able to view the decision. • Generally, any report within a multiple page record without a name will not be reviewed, but these are handled on a case-by-case basis. • If the documentation flows to each page and the reviewer can reasonably determine it is the same patient, it can be reviewed.

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What the Reviewer Might Encounter	Actions
Multiple medical records submitted in a single medical record file (with one Medical Record Coversheet).	• If all medical records are not dated in the data collection year, the record is flagged invalid for date of service outside data collection period (INV14=NO). • Whenever a submission contains multiple records with dates of service in the data collection period, the submission is reviewed to determine 1) which date of service to review and 2) which pages to review. ◦ The coversheet date and validity (selecting a date of service that documents signature, credential, etc.) of each of the medical records will be considered in the decision. • The reviewer will note the date of service selected for review in the date validity comment area (INV4=YES). • During coding, if the HCC can only be validated from another valid encounter with a date not indicated on the Cover Sheet or in the INV4 comment, the submission will be reset to intake and the new date will be reviewed.

Medical Record Review

Medical record pre-review should be performed on all records received by the MA Organization from their providers. A cursory review of the first page by someone not experienced in medical record documentation and coding is not sufficient. CMS RADV reviewers are certified coders, experienced in risk adjustment data validation that are familiar with a variety of medical record layouts, electronic medical record entries, and handwritten medical record documentation.

The following table presents issues that may impact the MA Organization's decision to submit the medical record, potential follow-up with the provider to obtain an attestation or additional documentation, and guidance on the action auditors may use to evaluate and resolve the issue. The listed examples and guidance are not exhaustive, and all are continuously evaluated for consistency in interpretation and application.

Signature and Credential Issues

Instructions Received by the MA Organization

Excerpt from CY 2015 Contract-Level RADV CMS Submission Instructions (Chapter 3, Section 2).

Physician Specialties and Credentials
• Medical records submitted for RADV must be from an acceptable physician specialty type (*see* Appendix 3: *Reference Materials: CMS-HCCs and Physician Specialties*) and must be authenticated by the provider. MA Organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via signature and physician specialty credentials. This means the credentials for the provider must appear somewhere on the medical record (e.g., next to the physician/practitioner's signature or pre-printed with the physician/practitioner's name on the practice's stationery). If the credentials of the physician/practitioner are not listed on the stationery, then the credentials must be part of the signature for that physician/practitioner.

Signatures

- Acceptable physician/practitioner authentication comes in the form of handwritten signatures and electronic signatures. Stamped signatures are not acceptable. Signature logs generated at the time of the RADV request may not be attached to correct records that have a missing or illegible signature or credentials. In these cases, please use the CMS-Generated Attestation for the Physician/Practitioner office or Hospital Outpatient visit. Signature logs that are part of inpatient record documentation procedures are recorded at the time of the encounter and are, therefore, acceptable as signature/credential verification. Transcribed reports – Electronic signatures are an acceptable form of medical record authentication so long as the system requires the provider to authenticate the signature at the end of each note. Examples of acceptable electronic signatures include: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," and "Validated by." In all cases, the signature must contain the physician's or practitioner's name and credentials along with the date signed, which must be within 180 calendar days of the encounter. Physician group partners may not sign for each other unless both saw the patient during the encounter.
- Electronic Medical Records (EMRs) – Electronic point of service type medical record entries are typically considered authenticated at login since the physician/practitioner is directly entering the content into a template and populating from other sections of the EMR. Often only the provider name will be documented at the beginning or end of the note, without the "electronically signed by" dated notation. Since EMR formats differ, the presence and significance to RADV of a signature authentication statement and a date in a signature line depends on the structure of the EMR.
- Handwritten provider signatures on paper medical records need not have an accompanying signature date. CMS attempts to associate each signature with a date of service on the record. Accordingly, please be sure each signature is clearly associated with a date of service for the note in question.

Instructions Received by the MA Organization

- All medical record entries must be complete and must be authenticated by the physician or practitioner who was responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be clearly identified and must authenticate his or her entry. Regardless of the provider type, a consultation report with the typed name of the dictating physician/practitioner should be signed by that physician/practitioner. For purposes of this RADV, "promptly" is defined as within 180 calendar days of the encounter. Electronic signatures or EMR authentication dated greater than 180 calendar days must include a valid CMS-Generated Attestation for the review to continue.
- In addition:
  - *For physician/practitioner office and hospital outpatient visits*: Hospitals often release copies of dictated reports prior to obtaining a consultant's signature. These reports then are filed in another physician/practitioner's record in an "acceptable" form. Diagnoses from these reports will be coded and abstracted from a physician/practitioner record when either of the following conditions applies: 1) the physician/practitioner has referenced the report diagnosis as part of his/her documentation in the office record; or 2) the consultation to which the physician/practitioner is referring is signed and valid as a stand-alone encounter in the data collection period. If the corresponding medical record has a missing or illegible physician/practitioner signature and/or credential or is signed only by the receiving provider, your MA Organization may wish to consider re-requesting the record from the original provider with the CMS-Generated Attestation provided in the CDAT Enrollee Data Package.

  - *For Hospital Inpatient discharges*: For hospital records or records from any risk adjustment- covered inpatient facility, a typed signature alone is not acceptable. All records must be signed and authenticated by the responsible physician/practitioner. Within a lengthy inpatient record, a few unsigned notes or reports will not render the entire inpatient record unsigned. The inpatient medical record must contain sufficient signed documentation to validate any of the audited CMS-HCC(s). The RADV coder will review only the signed documentation when coding the principal and secondary diagnoses for the enrollee's discharge; unsigned documentation will not be used for coding. MA Organizations must determine on a case-by-case basis if a record suffices to substantiate the CMS-HCC being validated.

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Table 3: Signature and Credential Issues

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
No Signature (or Initials)	The MA Organization submits an inpatient, physician office, or a hospital outpatient visit medical record. Inpatient – entire document unsigned: No physician/practitioner authentication is on <u>any</u> of the submitted documents for which relevant conditions are identified. Inpatient – parts unsigned: Unsigned documents within acceptable Inpatient record.	Inpatient: Submit conditions from only signed documents. Note that documents may continue to another page or several pages where a valid signature is located. Outpatient: Request a CMS attestation. Multiple handwritten encounters in the same handwriting, on the same page will be reviewed and, therefore, should be submitted if one of the encounters is signed even if the date is different from the coversheet date.	INV2 – Invalid or lack of signature Notes on the same page (or sections, such as continuous progress notes) that are signed in the same handwriting will be evaluated on a case-by-case basis to determine if provider authentication occurred.
No Signature (or Initials)	Outpatient/physician: The selected visit note is not signed or initialed by a valid physician/practitioner.	**Transcribed Reports** – Dictated reports either standard or through **voice recognition** software, must be signed by the physician/practitioner (either handwritten or with acceptable electronic signature). The physician/practitioner's typed name with transcriptionist's identification only is not acceptable.	INV2 – Invalid or lack of signature

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Electronic Signatures	Medical record has an electronic signature with the physician/ practitioner's discipline indicated within the record. [See list of Acceptable Physician Specialty Types (Attachments B1 and B2)]. Acceptable Electronic Signatures: Accepted by – Acknowledged by – Approved by– Authenticated by – Charted by – Closed by – Completed by – Confirmed by – Created by – Digitally signed by – Electronically authored by – Electronically signed by – Entered by – Entered data sealed by – Finalized by – Generated by – Read by – Released by – Reviewed by – Sealed by – – signature on file {date/time signed} – Signed by – Validated by – Verified by – Written by – Performed by (when meaning the exam and related documentation are being performed by the same physician/practitioner). Note that this example would apply also to notes specified as dictated using Voice Recognition software with associated "signature" by an acceptable physician/practitioner. If there is any question if the voice recognition document does not appear properly edited and reviewed by the dictator, escalate for another opinion.	There is no standard format for electronic signatures. This guidance is intended for **dictated** reports that require a separate review and dated signature/authentication. The date signed must be within 180 days. Electronic point of service type medical record entries are typically considered authenticated at login since the physician/practitioner is directly entering the content into a template and populating from other sections of the EMR. Often only the provider name will be documented at the beginning or end of the note, without the "electronically signed by" dated notation. Since EMR formats differ, the presence and significance to RADV of a signature authentication statement and a date in a signature line depends on the structure of the EMR. If the EMR does not contain an obvious login name with date stamp, and only notes the provider name in the header, consider re-requesting a CMS-attestation with the medical record.	An approved format of a provider's electronic signature, dated within 180 days of the encounter is acceptable.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Unacceptable Electronic Signatures	Electronic signatures are an acceptable form of authentication, but there are exceptions. Unacceptable Electronic Signatures: • Administratively signed by • Dictated, but not signed • Electronic signature on file [with no other indication of a date/time] • Electronically signed to expedite delivery • Proxy signature-Signed via approval letter or statement, such as: ◦ I authorize my name to be electronically affixed by using my unique dictation computer key ◦ Signature on File or Manually Signed by (The meaning of this is unknown. In some transcription/EMR systems, this might be acceptable but is seems to mean the physician/practitioner will hand sign the document after review.)	EMR formats are not standardized, and the industry is changing rapidly. Both the acceptable and unacceptable lists are not exhaustive. Request a CMS attestation for unacceptable electronic signatures.	If the RADV reviewer notes the HCC is only documented on an unsigned page of the EMR, the case will be evaluated on a case-by-case basis. Reviewer will refer new electronic signature formats to supervisor for evaluation on a case-by-case basis to determine if provider authentication occurred.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Point of Service EMR	Many physician/practitioners are now using "bedside" EMRs whereby upon physician/practitioner login, the entry date, time, and writer are electronically stamped at the beginning of the note. A final authentication at the end of the encounter is not always programmed into the specific EMR software.	Electronic point of service type medical record entries are typically considered authenticated at login since the physician/practitioner is directly entering the content into a template and populating from other sections of the EMR. Often only the name will be documented at the beginning or end of the note without the "electronically signed by" dated notation. Since EMR formats differ, the presence and significance to RADV of a signature authentication statement and a date in a signature line depends on the structure of the EMR.	In some cases, the record submitted is a point of service (POS) type EMR but also has an electronic signature notation by either the physician/practitioner or some other person responding to the audit request. The late dated or secondary signature does not make the original POS entry invalid as long the provider's dated login notation or dated signature within 180 days of the encounter is also documented
Incomplete Electronic Signature	Transcribed reports followed by the phrase "electronically signed by" or "signed before import" where there is no physician/practitioner name are not valid. The phrase "electronically signed, but not authenticated," "signed but not read/reviewed," or "electronically signed but not verified" indicates the physician/practitioner has not reviewed and signed off on the electronic version of the document.	Request a CMS attestation.	RADV reviewer will code the unsigned physician/practitioner record portions covered by the valid CMS-Generated Attestation.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
	Likewise, "auto-authorization" EMR signature programs that add a signature after a specified number of days are not acceptable.		
Other Signature Verification Documents	No signature and/or credentials with, signature log, business card, blank prescription pad sheet, or other document not considered part of the patient medical record. Unrequested documentation submitted as a means to verify the physician/practitioner's signature and credential will not be accepted for review. These methods of verification were likely introduced into the medical record solely for the purposes of validation and not at the time of the encounter. Signature logs that are part of inpatient record documentation procedures are recorded at the time of the encounter and are, therefore, acceptable as signature/credential verification.	Request a CMS attestation.	Cases with any unusual signature logs will be researched on a case-by-case basis if there is no valid CMS-Generated Attestation. Code only the unsigned record portions that are covered by the valid CMS-Generated Attestation.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Consultation Reports	Inpatient: Consultation report submitted without signature, as part of an authenticated inpatient provider type medical record (consultation report is not submitted as stand-alone documentation). The full inpatient record may be valid for signature, but individual reports within the inpatient record need to be evaluated on a case-by-case basis for valid authentication prior to coding. Outpatient: The document submitted is a typed (usually dictated) consultation report only. The report may be on the consultant's or hospital's letterhead. The report has the consultants name typed at the conclusion. The submitted report does not have a valid electronic or handwritten signature.	The consultation report within the inpatient medical record is a typed (usually dictated) report detailing evaluation of a condition and included at the request of the attending physician. There is typically an associated progress note signed by the consultant on the date of the patient evaluation. The attending physician **generally** will refer to the consultant's diagnosis in subsequent progress notes and his/her final summary. There may be instances where disagreement or further work up eliminates the consultant's diagnosis from consideration. As in all medical record documents, the consultation report is expected to be authenticated by the consultant; however, the absence of a consultant's signature does not preclude the attending physician from including the consultant's findings in his/her final diagnosis. Unless the attending physician explicitly disagrees with the consultant's findings, the documented condition should be submitted for RADV.	If the final assessment by the specialist consultant includes an unconfirmed diagnosis statement (rule-out, suspected, likely, etc.) impacting the audited CMS-HCC, and the diagnosis or any related diagnosis is not eliminated elsewhere in the record yet not mentioned in the final discharge diagnoses, a decision will be made on a case-by-case basis, in accordance with ICD-9-CM Official Guidelines for Coding and Reporting.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Office Note Referencing Unsigned Dictated Report	Coder Guidance: Hospitals/Specialists often release copies of dictated reports prior to obtaining the dictator's signature. These reports then are filed in another physician's record in an "acceptable" form. A signed physician's note, including a statement such as "see discharge summary from <date> hospitalization" or "see specialist consultation report <date>," would be sufficient to link the current visit/progress note to the dictated summary without having to re-write all of the findings.	The circumstances of the current encounter would determine which diagnoses from the hospitalization or other visit are still applicable (i.e., acute, chronic, or status post).	The entire record is reviewed to determine the context of any conditions listed as status post to determine the correct coding.
Signature Stamp	Acceptable physician authentication comes in the form of handwritten signatures and electronic signatures. Stamped signatures as the only authentication on a document, are not acceptable. Effective April 28, 2008, signature stamps will no longer be permitted. Source: Medicare Program Integrity Manual, Publication 100-8, chapter 3, section 3.4.2.1, CR 5971, Transmittal 248.	Request a CMS attestation.	RADV reviewer will code the unsigned, stamped record portions only if covered by the valid CMS-Generated Attestation. If the signature looks like a stamp but could also be a digital signature, a decision will be made on a case-by-case basis to determine if provider authentication occurred.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Signature Location	Beginning of note: It is unusual for a physician/practitioner to sign a medical record entry at the beginning of a transcribed or handwritten note. Traditionally the signature follows the medical record entry, but there could be circumstances where the signature is in an unusual place and the evaluator can relate it to the encounter.	Confirm the signature relates to the encounter that documents the condition and not a prior encounter. Request a CMS attestation if not clear.	RADV reviewers will only code the unsigned record portions that are covered by the valid CMS-Generated Attestation. In the unusual instance of an electronic signature statement inserted into a handwritten document, it shall be regarded as equivalent to a "signature on file" statement, which is not acceptable. These will be evaluated on a case-by- case basis to determine if provider authentication occurred.
Physician Initials	The MA Organization submits a dated handwritten or typed (non-electronic) physician office or a hospital outpatient medical record for the enrollee, and the selected medical note is initialed by hand. The physician/practitioner's name and credentials appear in the heading. It is obvious the initials are **not** those of the treating physician.	Do not confuse a provider's initials with other office staff initialing orders completed or receipt of a record copy. Illegible initials are difficult to attribute to a provider. Request a CMS attestation.	It is common for non-clinical (clerical) employees to initial records upon receipt or that the record has been coded. In addition, there may be clinical staff members not from an acceptable physician specialty that have initialed the record. In this scenario, the medical record would be deemed invalid. Code only the unsigned record portions that are covered by the valid CMS-Generated Attestation.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Example	Reviewer Guidance	RADV Auditor Action
Illegible Signature without Legible Credential	The MA Organization submits a medical record with illegible physician/practitioner credentials and no CMS attestation. The type of physician/practitioner specialty is not apparent (i.e., no form heading, office letterhead, or title included in the signature line). It is questionable whether the face to face encounter was conducted by a valid risk adjustment physician data source. Although a signature may appear illegible, (squiggles, etc.), if it is located in an appropriate section of the medical record, it will be evaluated on a case-by-case basis since each form and authentication areas are designed differently.	The term "provider" on a signature line or form heading is not sufficient to infer one of the acceptable physician specialties. MA Organizations should re-request the medical record legibly identify the provider. Include another CMS attestation with instructions.	INV7 – Lack of credential Code all reportable diagnoses from illegibly signed physician/practitioner documents covered by a CMS attestation.
Other Credentials	Often the credential acronym is difficult to match with one on the acceptable Physician Specialty list and requires additional research.	LPC – licensed professional counselor. Do not assume this is a psychologist or a LCSW. Not valid for review. PhD – acceptable when the note is a mental health encounter. In counseling notes, the PhD is likely a Psychologist. Resident, Post Graduate Medical Students (PGY-1, PGY-2), Hospitalists – Assume each of these titles implies a Medical Doctor (MD) or Doctor of Osteopathy (DO). Valid for review.	Unusual credentials will be researched, and a decision made on a case-by-case basis. MSN, RN – Unless there are further credentials after research indicating Nurse Practitioner or other Clinical Nurse Specialist, this is invalid.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Instructions Received by the MA Organization

Excerpt from CY 2015 Contract-Level RADV CMS Submission Instructions (Chapter 3, Section 2)

All medical records that are submitted must display a clear date of service and be signed by a physician/practitioner with a risk adjustment-eligible physician specialty.

Dates of Service

• Medical records submitted for this RADV must have a clear date of service within the data collection period. Once again, a medical record submitted for CON15 RADV need not match the date of service previously submitted to RAPS for the audited CMS-HCC.

• If a medical record is missing a date of service then that medical record will be deemed invalid, resulting in an error under the CON15 RADV medical record review process. Examples of invalid dates include fax date, dictation date, review date, missing year of service, and date partially cut off.

• If the date of service (Physician/Specialist/Hospital Outpatient/Observation record) or Admission Date to Discharge Date (Hospital Inpatient record) on the submitted medical record does not match the designation made by your MA Organization on the Medical Record Coversheet, the medical record may be deemed invalid and result in an error determination under the CON15 RADV medical record review process.

• If there is a chart note with multiple dates of service on the same page, your MA Organization must complete a separate Medical Record Coversheet in CDAT for each medical record (i.e., each single date of service) you want to submit in support of the audited CMS-HCC(s). If only one medical record (i.e., one date of service) is being submitted, you should still submit the whole page; coders will review the one date of service indicated on the Medical Record Coversheet.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Table 4: Date Issues

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Undated Visit **Signature Date** **Lack of Discharge Date**	**Outpatient/physician:** The MA Organization submits a physician office or a hospital outpatient medical record, and the selected medical record is not dated. The only date on the medical record is a signature date. There is no separate indication of the encounter date. Inpatient records must have both **admission** and **discharge date.**	Do not submit medical records that do not support a date of service within the data collection period. Depending on the document format, if the only date on the record is a signature date, it is not assumed to be the date of service. The inpatient dates of service must be documented at least one place in the record (face sheet, summary, discharge orders etc.).	INV4 – Invalid for date of service Evaluated on a case-by-case basis if admission date is in December and content may indicate a discharge not in 2014 for CON15. An exception may be applicable on a case-by-case basis when a discharge or transfer summary contains the admission date but lacks the discharge date.
Dictation Date	The medical record submitted is a transcribed consultation report or discharge summary. The report does not indicate the date of consultation, admission date, or discharge visit. The report has **only** the **dictation date**, and the dictation date is within the data collection period. Dictated consultation/medical record with dictation date and other supporting documentation:	It is not acceptable to submit conditions from documents with date of dictation only. Submit the document(s) for the DOS indicated including results data for pre/post visit testing ordered/ performed on that date.	INV4 – Invalid for date of service. When there are other documents to possibly support the date of service, these will be evaluated on a case-by-case basis. This advice is intended for orders/testing and follow-up closely linked, not months apart or occurring in a different data collection year.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	• The medical record submitted is a transcribed consultation report. The report does not indicate the date of service. The report has the dictation date, and the dictation date is within the data collection period; AND • The MA Organization has submitted a diagnostic service report that is dated for a service that is referenced in the typed undated report and matches the Coversheet date of service (DOS). BOTH CONDITIONS MUST BE MET.		
Dates of Service outside Data Collection Period	**Inpatient:** The inpatient documentation submitted contains an admission date (within the data collection period) and a discharge date (outside the data collection period). ***Example:*** The History and Physical dated in the data collection year 2014, submitted as a physician record, though IP discharge date is in 2015. For inpatient records, the **discharge date** must be within the audit's data collection period. The admission (from) date may be in a prior year.	Do not submit records with a discharge date outside the data collection period as an inpatient provider type. Locate any physician portions documenting the CMS-HCC within the data collection period and submit separate coversheets for each.	INV14 – Invalid for date not within data collection period In the case of an admission date in the prior year, but discharge in the current data year, the entire inpatient record is reviewed as one encounter.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	Outpatient & Physician: For physician and hospital outpatient records, the date of service must be within the audit's data collection period. ***Example:*** A discharge summary dated 1/3/2015, which is outside the data collection year 2014, submitted as a physician record is invalid.		
Date Located on Encounter Label	An addressograph type stamp or other electronic demographic identification typically notes the patient's name, birth date, patient number, physician, and admission date. In ambulatory surgery, the date may be a registration date prior to the surgery date.	The label date may be interpreted as the date of service for ED records or other hospital outpatient single date records. For ambulatory surgery, use the surgery date. Include any pre-operative reports.	The reviewer will confirm the date on the label is consistent with the content entries. Ambulatory surgery pre-op history and physical and testing may note a prior date but are included in the review of the surgery record.
Referral Responses	The document describes an outpatient consultation in response to a referral from another provider. The medical record may be in a letter format to the requesting provider or handwritten on a referral form.	Enter the date of service of the encounter on the Coversheet. This date should be documented at the beginning of the referral response and may be different than the date of the letter or date of request for referral.	The content of the document will be reviewed to determine if it is a referral response vs. a non-medical record letter that is not valid for RADV.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Instructions Received by the MA Organization – Provider Type/Record Issues

Excerpt CY 2015 Contract-Level RADV CMS Submission Instructions (Chapter 3, Section 2)

Inpatient Requirements

Hospital Inpatient medical records must display an admission date and discharge date and include a signed Discharge Summary (or a Discharge Note for admissions less than 48 hours).

Physician Specialties and Credentials

• Medical records submitted for RADV must be from an acceptable physician specialty type (*see* Appendix 3: *Reference Materials: CMS-HCCs and Physician Specialties*) and must be authenticated by the provider. MA Organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via signature and physician specialty credentials. This means the credentials for the provider must appear somewhere on the medical record (e.g., next to the physician/practitioner's signature or pre-printed with the physician/practitioner's name on the practice's stationery). If the credentials of the physician/practitioner are not listed on the stationery, then the credentials must be part of the signature for that physician/practitioner.

Table 5: Provider Type/Record Issues

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Face to Face Visit	The submitted record documents a face to face encounter with the enrollee from an acceptable RADV provider type and data source. The three acceptable RA provider types are: Hospital Inpatient, Hospital Outpatient, and Physician.	Unacceptable physician/practitioner specialty findings or impressions, such as diagnostic radiologist, dietitians, or lab results, must be acknowledged or referenced in the valid provider's note to be submitted for the condition. See abnormal findings section.	INV 5 – Invalid source, provider type Inpatient record submissions without a discharge summary or discharge note (for under 48-hour admissions) will be evaluated on a case-by-case basis for provider type validity.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	Note that specific facility sources are not included as acceptable inpatient and outpatient facilities; however, acceptable physician provider type documentation may occur in most any facility, including the patient home. The RADV process does not include determining the type of claim supporting the original RA data submission. Outpatient and Physician provider types are combined on the coversheet, so unless the documentation is clearly made by an employee from a non-acceptable source, the coder assumes a physician provider type based on the acceptable specialty list.		

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Stand-alone Discharge Summary	A stand-alone discharge summary is considered an acceptable physician provider type face to face visit for the date of discharge or the date of service documented (if done earlier) as indicated on the summary and Medical Record Coversheet. **Inpatient Note:** An appropriately detailed discharge summary that documents at least one reportable condition and includes the admission and discharge date with a Medical Record Coversheet indicating inpatient provider type is acceptable for review as an inpatient record. An exception for the lack of or noting a different discharge date may be granted by the QA Panel/CMS if the content indicates the actual date was likely within the data collection year.	Report the conditions documented in the stand- alone discharge summary (submitted as IP or OP) keeping in mind any procedures done during the admission (i.e., amputations, ostomies, acute dialysis) are not reported as a "status" V code. Review the content carefully to determine if conditions listed as "status post" (i.e., MI, CVA) were acutely active during the current admission or an earlier one.	Submission of an inpatient record lacking a discharge summary that does not appear to contain sufficient documentation for coding will be handled on a case-by- case basis.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Non-face to face Visit	Although RA submission requires a face to face visit (with the exception of pathology), RADV outpatient/physician medical records may include **interpretations** of diagnostic tests or related interventional, minimally invasive procedures that do not involve a face to face visit with the interpreting physician specialist. Even if the services are not acceptable to submit diagnoses for risk adjustment (e.g., non-hospital-based outpatient services), RADV allows the interpreted reports to support CMS-HCCs in the data year when interpreted by valid RA provider specialties. As in all coding, the Official Guidelines for Coding and Reporting must be applied. For inpatient provider type, do not report abnormal findings of diagnostic results unless the physician/practitioner indicates the clinical significance.	Do not submit records that do not support a face to face visit.	INV 5 – Invalid source, non-face to face.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Diagnostic Testing (with or without interventional procedures) with acceptable provider interpretation	**Acceptable Examples include:** • **Cardiology and Vascular Surgeons** ◦ Echocardiogram (including Doppler, Duplex, Color flow of the heart vessels) ◦ EKG (electrocardiogram) – Stress test, Cardiac catheterization ◦ Myocardial perfusion and other nuclear medicine imaging of the heart ◦ Pacemaker analysis (non-telephonic) ◦ Vascular Doppler Study interpretation- not performed by Diagnostic Radiologists ◦ Percutaneous transluminal coronary angiography (PTCA) • **Interventional Radiology** ◦ Catheter angiography – Coronary Computed tomography angiography (CTA) ◦ Endoscopic retrograde cholangio-pancreatography (ERCP) ◦ Embolization procedures ◦ Extracorporeal shock wave lithotripsy (ESWL)	Reviewers should only submit diagnoses documented in the physician interpretation, not the technical report. Do not submit records of diagnostic radiologist only. **Standalone/outpatient/physician encounters:** If an exact diagnosis is not reported, and the record is identified as **outpatient**, apply outpatient coding guidelines to code the condition to the level of certainty documented. Often the reason for the test is listed as symptom or abnormal findings on another test. If the reason for the test is to rule out a diagnosis, do not report the diagnosis if the exam is normal or does not indicate the rule out diagnosis. The reviewer must use judgment based on the type of procedure/test or other documentation available when determining if a chief complaint or reason for a test is a current diagnosis or was a condition to be ruled out. ***Example:*** MRA, reason for test: non-	Researched on a case-by-case basis to determine if study is performed by a Diagnostic Radiologist or a valid physician specialist, such as Vascular Surgeon or Cardiologist. Stand- alone/outpatient EKG interpretations are considered for reporting on a case- by-case basis. The cardiologist signature must be present and the results supported in the clinical notes. Findings are often "suggestive of" and not confirmed diagnoses. This is especially true for "Old MI (myocardial Infarction)" findings since false positive findings are not uncommon.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	◦ Magnetic resonance arteriogram (MRA) ◦ Fluoroscopic Guidance ◦ Genitourinary vascular flow imaging (nuclear medicine) ◦ Radiofrequency ablation ◦ Radiation Therapy – Ultrasound Guidance Catheter angiography – Coronary Computed tomography angiography (CTA) ◦ Endoscopic retrograde cholangio- pancreatography (ERCP) ◦ Embolization procedures ◦ Extracorporeal shock wave lithotripsy (ESWL) ◦ Magnetic resonance arteriogram (MRA) ◦ Fluoroscopic Guidance ◦ Genitourinary vascular flow imaging (nuclear medicine) ◦ Radiofrequency ablation ◦ Radiation Therapy – Ultrasound • **Neurology** ◦ Electroencephalography (EEG) ◦ Electromyography (EMG) ◦ Nerve Conduction Studies	healing ulcer. MRA studies rule out vascular or heart disease, not ulcers. The ulcer would be reported as a current condition along with any abnormal findings of the study. **Interpreted diagnostic testing within inpatient records**: See guidance for **Other Physician Documentation**. Generally, interpretations from acceptable provider specialties are acceptable as long as there is no contradiction with the attending physician diagnosis. Diagnoses documented in EKGs, MRA, Doppler studies, and other testing must be addressed by the attending physician or consulting provider to submit for condition validation.	

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	◦ Nuclear Medicine Brain imaging ◦ Sleep Studies (Polysomnography) • **Pulmonology** ◦ Pulmonary Function Tests (PFT) ◦ Pulmonary perfusion and ventilation imaging		
Technical Component Only	Diagnostic testing and infusion type encounters are generally performed by technical staff not included on the list of acceptable physician specialties. If there is no accompanying interpretation or consultation by a physician specialist, other than diagnostic radiology, the provider type is invalid for RADV. ***Examples:*** pacemaker analysis, INR (International normalized ratio) blood coagulation (clotting) checks.	Do not submit studies only documented by non- physician technicians or nurses.	INV5 – Invalid source

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Clinical Laboratory Test Results (e.g., "blood test" results, urinalysis results, etc.) submitted as stand-alone medical record	Clinical lab test results, when submitted alone, are not acceptable for RADV purposes. If the only medical record documentation submitted is a clinical lab report, the medical record is considered "Invalid." Examples of the types of documentation that are unacceptable, when submitted alone, include the following: • CBC blood count report; Chemistry profile report • Hepatitis antigen/antibody tests • Pleural fluid analysis report • Rheumatoid factor • Urinalysis report, Urine culture report • Urine pregnancy test • Wound culture report **NOTE:** The above list is not all inclusive.	Do not submit lab results to validate conditions. Request the office visit where the results were ordered, or the results were reviewed with the patient.	INV5 – Invalid source
Pathology Reports-with pathologist interpretation (including surgical pathology, cytopathology, etc.) with an interpretation by a pathologist	The **interpretation of the findings by a pathologist** as an acceptable physician specialty is acceptable. This is an exception to the face to face requirement. Examples of pathology reports include the following: • Pathology report from a tissue biopsy (e.g., lung biopsy, bone biopsy, etc.) • Cell block report	Enter date of collection as the date of service. The interpretation and findings may be submitted to validate conditions.	Locate "collection date" or "results date" to match with DOS being reviewed. Either is acceptable.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	• Cytopathology report of fluids/brushings • PAP (Papanicolaou) smear report • Chromosome analysis		
Pathology Reports-laboratory test only (including surgical pathology, cytopathology, etc.) without an interpretation by a pathologist	Pathology reports, when submitted as a laboratory test alone, are **not acceptable** for risk adjustment purposes.	Do not submit lab results to validate conditions. Request the office visit where the results were ordered, or where the results were reviewed with the patient.	INV5 – Invalid source

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Telephone or Telemedicine/Video Contact	The MA Organization submits a medical record, and the selected visit note is documentation of a telephone/video contact with the enrollee or is documentation of lab values received over the telephone. Medicare policies for telemedicine apply. The medical record of the origin site must include documentation by a valid risk adjustment provider specialty. The remote consultation report should be mentioned and included in that origin site encounter record. Video chat type encounters that are not face to face with a valid risk adjustment provider are not valid. Telephone encounters are not valid.	Do not submit documentation of telephone contacts to validate conditions. Telemedicine documentation is allowable in only limited situations.	INV5 – Invalid source

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Emergency Department (ED)	The MA Organization submits a medical record for an ED visit. ED records often consist of multiple check-off sheets from various members of the treatment team with signatures not always on the same page as the documentation. The ED record date of service is considered part of the inpatient date range when followed by a direct admission.	Review all pages of the ED record whether dated or not. MA Organizations should report only conditions either documented by or clearly reviewed and signed off by an acceptable RA physician/practitioner specialty. Conditions ruled out during the ED testing or conflicting with the Emergency Room (ER) physician/practitioner's (i.e., MD, Physician Assistant [PA], Nurse Practitioner [NP]) final note should not be submitted. Only submit diagnoses from the ER records not overturned by IP documentation.	If from date is next day after ED date, date may pass validity.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Observation Visits	Observation "admissions" are typically under 24 hours. Longer observations are possible, and in those cases, the MA Organization is instructed to enter the first date of observation status as the DOS on the coversheet and reflected in CDAT. Any of the observation dates selected at intake for review within the data collection period are acceptable. Observation encounters submitted as IP provider type on the face sheet.	Confirm the observation status was clearly documented and not later changed to inpatient. Check the face sheet patient status, orders, ED disposition, and final progress notes for documentation or mention of Observation Status, 24-hour hold, or similar terminology. Submit the observation encounter as an outpatient for any conditions documented within the entire observation stay.	INV15 – Invalid provider type if observation is submitted as an inpatient If status is inconsistently documented in the record resulting in a discrepancy in provider type, the decision will be handled on a case-by-case basis. The RADV reviewer will code from the entire observation range of dates.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Problem Lists (within a medical record)	See related topic of **Chronic and Other Additional Diagnoses**. Lists of diagnoses (conditions, problems) may be numbered, bulleted, or separated by commas. A list may be documented in the patient history, assessment, discharge summary, or other areas of a medical record. When conditions commonly associated are listed under the same number or bullet, the conditions can assume to be linked. These diabetes examples are effective for ICD-9-CM and will be updated for ICD-10-CM. ***Example 1:*** 1. Hypertension 2. DM, neuropathy (link diabetes and neuropathy) ***Example 2:*** 1. Hypertension 2. DM 3. Neuropathy (do not link diabetes and neuropathy)	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment. Do not submit conditions from lists labeled as PERTINENT NEGATIVES.	Problem lists are evaluated on a case-by-case basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS. Lists of conditions written by the patient are not acceptable. Lists of code numbers without narratives are not acceptable.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	Example 3: 1. Diabetes with hypertension (Although these conditions could occur together and be related, unless the documentation clearly shows a cause and effect relationship, do not link diabetes and other condition if not typically a known manifestation of diabetes.)		Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.
Skilled Nursing Facility (SNF)	The MA Organization submits a SNF record as an inpatient provider type. SNF record with no physician specialty encounter documentation. ***Example***: Nursing Home case management conference summaries. The submission is a **physician/practitioner visit** that indicates the enrollee is a resident of the SNF. Although CMS does not accept risk adjustment data from nursing home facilities (as an inpatient provider type), some beneficiaries who reside in a nursing home will have a nursing home medical record (single acceptable physician specialty encounter) as the only source to support their diagnostic data. The physician/practitioner's encounter must have been face to face with the beneficiary.	Do not submit SNF records as an inpatient provider type. Do not submit portions or SNF records unless the encounter is documented by a valid RA specialty. Locate physician note for DOS. Often MD visit documentation is part of the orders template. Review progress notes for Physical Therapists or other types of acceptable outpatient therapists that may support the condition and could be submitted separately as an OP encounter.	INV5 – Invalid for inpatient provider type RA source Notes are reviewed for documentation of a separate valid provider, not an employee of the SNF.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Health Risk Assessments (HRAs)	HRA forms must be completed by a valid risk adjustment provider specialty. Those completed by the patient are not acceptable. The documentation must support that the provider was present with the patient. Conditions listed are evaluated for chronicity and support in the full medical record, such as history, medications, and final assessment. Results of HRA screening portions are not considered confirmed diagnoses unless supported by the final assessment documentation.	Do not submit HRA forms that do not document a face to face encounter. The provider documentation of dated patient vitals is one element that supports a face to face encounter.	HRA forms that do not appear to be a face to face encounter will be evaluated on a case-by-case basis. Since the HRA is primarily a question and answer form that can be created online or over the phone, the physician signature is not always sufficient to validate the provider was present.
Referral Authorization Forms	The MA Organization submits a signed and dated referral authorization form (not documenting a face to face encounter).	Do not submit conditions documented only on referral authorization forms. Request instead the office visit/consult in which the patient was evaluated.	INV5 – Invalid source

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Order Forms Documenting an Encounter	The MA Organization submits a signed and dated order form with evidence of a face to face encounter. Order forms often have as much clinical information as a progress note or are used as a combined progress note and order. ***Examples:*** 1. Inpatient order sheet stating date of service, diagnosis, and treatment submitted with other confirmed inpatient documentation. 2. Inpatient order sheet submitted as a stand-alone physician provider type for one date of service. 3. Outpatient or physician order form (often on a prescription pad form) stating date of encounter, diagnosis, and treatment ordered.	Submit conditions only to the level confirmed in the documentation. The reason for the test may be to rule out a condition not yet diagnosed. Do not use prescription drug information on the order form to report conditions. The condition must be documented.	These will be evaluated on a case- by-case basis. Not all order forms are valid for review.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Prescription Forms	For drugs that do not contain a diagnosis or other evidence of a face to face visit: The MA Organization submits a signed and dated prescription form ordering a diabetic medication or other condition-specific medication. Prescription forms for drugs that do contain a diagnosis or other evidence of a face to face visit: Outpatient or physician order form (often on a prescription pad form) stating date of encounter, diagnosis, and treatment ordered.	CMS does not accept prescriptions as a form of validation. Prescription forms documenting only a drug order are not acceptable as a stand-alone document, even if the drug named is used only for one condition. Review carefully that a separate face to face encounter is clearly identified.	INV5 – Invalid source Evaluated on a case- by-case basis.
Certified Clinical Nurse Specialist	The MA Organization submits medical record documentation signed and dated by a Certified Clinical Nurse Specialist (CNS), Advanced Practice Registered Nurse (APRN), APR-CNS, or Psych CNS. For RADV, the approved specialties of Certified Clinical Nurse Specialist, Nurse Practitioner, Certified Nurse Midwife, and Certified Registered Nurse Anesthetist all fall in the sometimes-used blanket designation of Advanced Practice Registered Nurse (APRN, APN, or APR-CNS), so these credential terms are also acceptable.	It is acceptable to submit documentation from nurse practitioners.	MSN-RN without further specialty noted will be researched on a case- by-case basis.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Therapists Physical Therapy (PT) Occupational Therapy Speech and Language Pathology Clinical Licensed Social Worker (stand-alone evaluation and treatment) **Other Specialties or Credentials**	**Outpatient Provider Type:** These therapists are included in the acceptable physician specialties for RA. Therapy evaluations typically include the patient's past and current conditions, including chronic conditions not related to the therapy. **Inpatient Provider Type:** Ancillary services are typically provided by employees of the facility and their findings are under the responsibility of the attending physician. Therefore, these services are not considered separate professional specialists as is the case in outpatient encounters. Clinical Research Professionals – CPI. This is a designation by a physician/practitioner responsible for clinical trials. The professional would have another acceptable physician/ practitioner specialty of MD, PA, or other. Note that Radiologists or other medical professionals may be performing in the capacity of a general practitioner for purposes of face to face HRAs. This is acceptable as long as the physician/practitioner's credentials are MD, DO, PA, or NP.	Submit all reportable diagnoses from all RADV approved specialty therapy outpatient/physician submissions. For inpatient coding, reportable diagnoses must be documented by the attending or consulting doctor specialists. Conditions documented only in inpatient ancillary service notes should not be submitted for validation. Make sure the documentation supports an acceptable specialty or credential.	When submitted as a stand-alone outpatient/physician document, the reviewer may consider the medical record submission as valid for review. Diagnoses documented on the authenticated therapy document are valid for coding according to outpatient coding rules. If the coder comes across other credentials or unusual circumstances of specialists performing home visits or HRAs, the case may be evaluated on a case- by-case basis.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	"Adult Medicine" notes or clinics are generally staffed by general practice or internal medicine physician/practitioners (MD, DO, PA, NP) and notes from these acceptable physician/practitioners may be reviewed. Note that the RADV team does not update the specialty list. We can only provide examples of credentials on the list until the next CMS RA policy release.		

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Other Unacceptable Source Documents	Other types of unacceptable medical record documentation include: • **List of ICD-9-CM codes** • Ambulance • **Claim forms**-may possibly be used to verify dates, credential, or legibility issues but not for coding purposes • Claims data pre-populated conditions (case-by- case basis due to EMR differences) • Durable medical equipment • **Hospice care** in a hospice designated unit or facility • Hospital inpatient swing bed components also called Transitional Care Units • **Home Health** Facility agency staff documentation or certifications (CMS 485 forms) that do not document a face to face visit with the physician/practitioner. DO NOT CONFUSE physician provider type HOME VISITS, HRA done in the home by a health plan or their contracted service, OR HOUSE CALLS with HOME HEALTH AGENCY encounter sources • Intermediate care facilities • List or check list of patient conditions	Lists of ICD-9-CM codes **with narratives** are acceptable when included as part of a documented face to face office visit/exam. These need to be reviewed on a case-by-case basis and questioned when accompanied by notation of "pre-populated from claims data" or similar terminology. ICD-9-CM codes without narrative are not acceptable to report in place of a diagnosis to support a CMS-HCC. It is the codes that are being validated by medical record written documentation. AHA *Coding Clinic* 1Q 2012 p. 6* states "**Question:** Since our facility has converted to an electronic health record, providers have the capability to list the ICD-9-CM diagnosis code instead of a descriptive diagnostic statement. Is there an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-9-CM code number? **Answer:** Yes, there are regulatory and accreditation directives that require providers to supply documentation to support code assignment. Providers need the ability to specifically document the patient's diagnosis, condition, and/or problem. **Therefore, it is not appropriate for providers to list the**	INV5 – Invalid source

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
	without evidence of a face to face visit (see also problem list section) • Orthotics • Print outs of claim screens • Prosthetics • Respite care facilities • Super bills • Supplies • Repetitive encounter flow sheets without physician note for the date of treatment (e.g., dialysis, infusion/injections, chemotherapy, radiation, Coumadin/INR/Protime).	**code number or select a code number from a list of codes in place of a written diagnostic statement**. ICD-9-CM is a statistical classification, per se; it is not a diagnosis. Some ICD-9-CM codes include multiple different clinical diagnoses, and it can be of clinical importance to convey these diagnoses specifically in the record. Also, some diagnoses require more than one ICD-9- CM code to fully convey**. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes."** © Copyright 1984-2017, American Hospital Association ("AHA"), Chicago, Illinois*	

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Other Documentation Issues

This section includes other documentation issues involving the support of diagnoses within a valid medical record. Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the *Official Guidelines for Coding and Reporting* quoted below. Section numbers are indicated after each quote.
Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions, both chronic and acute or short-term conditions for consistency within the full provider documentation of the one encounter submitted for RADV. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.

Chronic and other additional diagnoses

ICD-9-CM Official Guidelines for Coding and Reporting – Outpatient Services

> Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions(s). (Section IV, J)
>
> Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. (Section IV, K)

ICD-9-CM Official Guidelines for Coding and Reporting – Inpatient Services

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES (Section III)

For reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The Uniform Hospital Discharge Data Set (UHDDS) item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term care, long-term care, and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038–40.

Since the application of the UHDDS, definitions have been expanded to include all non-outpatient settings (acute care, short-term care, long-term care, and psychiatric hospitals; home health agencies; rehabilitation facilities; nursing homes, etc.).

AHA *Coding Clinic for ICD-9-CM* © 3rd Qtr, 2007, p. 13–14*

Question:

We need to get clarification on the coding of chronic conditions. One of the quality improvement organizations (QIOs) will not allow the inclusion of chronic obstructive pulmonary disease (COPD) as a secondary diagnosis when it is only mentioned as a history of COPD and no active treatment is documented. Am I correct in stating the presence of a documented history of COPD in the physician's history and physical on an inpatient record is enough to code COPD as a secondary diagnosis since this is a chronic condition that always affects the patient's care and treatment to some extent?

Answer:

As stated in Coding Clinic, July–August 1985, page 10, the criteria for selection of the conditions to be reported as "other diagnoses" include the severity of the condition, use or consideration of alternative measures in the treatment of the principal diagnosis due to a coexisting condition, increased nursing care required in the care of patients due to the disabling features of the coexisting condition, use of diagnostic or therapeutic services for the particular coexisting condition, the need for close monitoring of medications, or modifications of nursing care plans. If there is

documentation in the medical record to indicate the patient has COPD, it should be coded. Even if this condition is listed only in the history section with no contradictory information, the condition should be coded. Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding.

The following guidelines are to be applied in designating "other diagnoses" for both inpatient and outpatient when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provides direction. **The listing of the diagnoses in the patient record is the responsibility of the attending provider.**

ICD9-CM Official Guidelines for Coding and Reporting

Underlying Conditions

Conditions that are an integral part of a disease process "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification." (Section I, B. 7)

Conditions that are not an integral part of a disease process "Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present." (Section I, B. 8)

Previous Conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, ICD-9-CM personal history codes (codes V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. (Section III, A) [For example, the Official Coding Guidance regarding neoplasms states:

> *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.* (Section I, C. 2d)]

Abnormal Findings

Inpatient: Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added. Please note this differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider. (Section III, B)

Outpatient: For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses. (Section IV, L)

Uncertain Diagnoses

Inpatient: If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," "still to be ruled out," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis. (Section III, C)

Outpatient: Do not code diagnoses documented as "probably," "suspected," "questionable," "rule out," "working diagnosis," or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit. (Section IV, I)

AHA *Coding Clinic for ICD-9-CM* © 1st Qtr, 1999, p. 5*

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the X-ray report states the site of fracture is the shaft of the femur. Is it appropriate to use the X- ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an X-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

AHA *Coding Clinic for ICD-9-CM* © 3rd Qtr., 2014 "It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician. Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction."

Other Physician Documentation

Medical records often contain documentation from more than one acceptable RA provider specialty. Inpatient records especially require careful review to determine if conditions documented by providers other than the attending physician are confirmed, relevant, and consistent with the final diagnoses.

AHA *Coding Clinic for ICD-9-CM*© 1st Qtr 2004, p. 18*

Question:

Please provide clarification regarding the appropriateness of code assignments based on the documentation in the medical record by a physician other than the attending physician. Previously published *Coding Clinic* advice has allowed using documentation from the anesthesia report. Our coders have interpreted the lack of contrary documentation from the attending can be perceived as concurrence with the anesthesiologist. We have recently been advised we cannot use a consultant's note without "confirmation" from the attending physician. Our coders tell us it is operationally impossible to confirm every single diagnosis or condition the consultant writes. Of course, if there is conflicting information, we will query the attending physician for clarification. Can you comment on whether our interpretation of coding instructions is correct?

Answer:

Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician. Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. A physician query is not necessary if a physician involved in the care and treatment of the patient, including consulting physicians, has documented a diagnosis, and there is no conflicting documentation from another physician. If documentation from different physicians' conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis. This information is consistent with the American Health Information Management Association's (AHIMA) documentation guidelines.

*For all AHA *Coding Clinic for ICD-9-CM* references the following statement applies:

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The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Table 6: Documentation Issues

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
No Exam, Reason for the Encounter, or Condition Documented	Coder Guidance: The medical record for the one visit or admission selected by the MA Organization does not contain any documentation of the type of exam or other reason for the visit (e.g., the record only documents the enrollee's vital signs and height and weight).	Do not submit the medical record if no conditions are documented.	Reviewer will assign applicable V code if possible or flag as "No ICD-9."
No Documented Findings, Symptoms, or Conditions	The medical record documentation includes a type of exam or screening with no positive findings, symptoms, or conditions. Examples include: • Annual check up • Adult physical exam (APE) • Blood pressure check • Cholesterol check • Prostate Specific Antigen (PSA) • Therapy session • Follow-up (F/U) exam • Pre-op exam • Well visit	Do not submit the medical record if no conditions are documented.	Reviewer will assign applicable V code if possible or flag as "No ICD-9."

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Illegible Diagnosis – Handwriting	The *only* diagnoses in the medical record submitted are illegible due to handwriting. Some illegible (or non-English or both) words that are possibly a diagnosis.	Unless there is no other record available, do not submit medical records that cannot support the CMS-HCC due to illegibility. Be careful of illegible negative finding (e.g., [No or R/O] CHF) where the preceding word is illegible.	If, after review of context, similar words, medications, etc., the coder is not able to decipher an illegible word that is documented in areas typically containing diagnoses or with other legible diagnoses, the CMS- HCC to be validated is checked to determine if that condition is legible and already validated on the record or is possibly the illegible word. If a second review still indicates the condition is illegible, it will not be coded.
Illegible Diagnosis – Document Image	The only diagnoses in the medical record submitted are illegible due to a document image that is too light, too dark, or distorted.	Do not submit the record. Request a clear copy from the provider.	Medical record cannot be coded.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Non-English Documentation	Coder Guidance: The record submitted includes diagnoses, but the words are not English.	Identify the documentation that validates the CMS- HCC. If it is legible and can be translated, then it is acceptable to submit.	Refer to Medical Record Review Contractor (MRRC) Project Manager regarding resources for medical translation of pertinent sections of the medical record.
Abbreviation with Multiple Meanings	Coder Guidance: Several common abbreviations have more than one meaning. ***Examples:*** MD – major depression, muscular dystrophy, macular degeneration CRF – chronic renal failure, chronic respiratory failure	Evaluate the abbreviation within the context of the full medical record before submitting to support the condition.	If more than one meaning applies or documentation is too limited to differentiate, and this is the only diagnosis listed within the record, evaluate on a case- by-case basis. Otherwise, use discretion to report or not based on other circumstances in the record.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Medical Record Amendments *See detailed definitions in Appendix C.* An amendment is an alteration of the health information by modification, correction, addition, or deletion.	**Acceptable Amendment:** An amendment must be based on an observation of the patient on the date of service and signed by the physician. Only the attending or treating physician can amend the medical record. The most common example is for follow-up notes based on a diagnostic test ordered and related test results received subsequent to the patient visit. Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician. For RADV "timely manner" generally means up to 90 days from the encounter but there could be exceptions such as extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, or delays due to physicians called to military service. **Unacceptable Amendment** – It is **unacceptable** for a third party that was not involved in the treatment and evaluation of the patient (e.g., coder, reviewer) to amend the medical record or query the provider for additional diagnoses or clarifications not documented in the original medical record.	It is not appropriate to add diagnoses to the medical record that have been identified by a source other than the treating physician (e.g., identifying diabetes from a disease management program). If the unacceptable amendment is the only source of the CMS-HCC, select a different record for submission.	RADV reviewer will code reportable diagnoses from acceptable amendments. Reviewers will ignore unacceptable amendments for coding.

The general guidance in this document is not exclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation substantiation of diagnoses and the coding of diagnoses apply, including, but not limited to, that the supporting medical records be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Query Forms *See detailed definitions in Appendix C.* A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.	When submitted with the associated medical record, diagnosis query forms that are completed, signed, and dated in a timely manner (i.e., within 90 days of the date of service) by the physician/practitioner and became part of the official medical record will be reviewed for validity and clinical consistency with the medical record documentation. For RADV, a coder or clinical documentation improvement specialist may query a physician/provider at the time of the encounter and the response documented and authenticated by that physician/provider is what is meant by a medical record query. The query form letter becomes part of the official medical record per that facility's documentation policies. This is a standard of practice defined by CMS recognized leaders in health information documentation, the American Health Information Management Association (AHIMA) Some MAO's have adopted similar appearing MAO coder/physician "query" labeled type letters. Examples of these have been found in prior RADV audits added as unacceptable alternative data sources to their RADV submissions to attest to prior claim HCCs or additional diagnoses after the original encounter.	Query type forms generated by the MA Organization or their coding staff contractors are not acceptable for review as part of the medical record. They are considered extraneous data from an alternative data source not allowed per Risk Adjustment policy. If the unacceptable query type form is the only source of the HCC, select a different record for submission.	Query forms will be considered on a case-by-case basis to determine whether the document is an acceptable standard physician query made by a coder or similar facility staff at or near the time of the encounter or if it is some other unacceptable late addition of conditions after the original encounter. RADV reviewer will not code from documents even if labeled (incorrectly) as "coder query" if the documentation is not generated at or near the time of the encounter by the facility or physician office.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care. Source: AHIMA Practice Brief: *Guidelines for Achieving a Compliant Query Practice.*			
Missing Pages	In some instances, it is possible to identify missing pages from a pre-numbered medical record or a partial record submission. ***Example:*** A History and Physical (H&P) with pages 1 and 3; however, page 2 is missing. ***Example:*** First line of a document submitted appears to be a continuation from a previous page.	Consider re-requesting the full medical record from the provider.	Reviewer will code from available pages if the record meets other validity criteria (signature, credential, etc.). If no condition is present to code, then it will be evaluated on a case-by-case basis.

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What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Medical Record Documentation is Distorted or Obscured	In some instances, the record documentation is obscured by sticky notes or other markings on the document.	Do not submit documents with obscured portions.	Reviewer will code from legible pages.
Medical Record Documentation is Too Dark or Too Light	Some medical record documentation is of poor image quality, and the Senior Evaluator (SE) is unable to identify key elements. This is common in photographed records.	Check that scanned images are readable. If needed, re-request the medical record.	Reviewer will code from legible pages.
Pages or Margins of the Medical Record are Cut Off	Some medical record documentation can have portions of the record text cut off during the submission.	Check that scanned images are readable. If needed, re-request the medical record.	Reviewer will code from legible pages.

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Appendix A: What Makes a Medical Record Invalid for RADV?

During Intake Evaluation, the MRRC SE answers all of the following questions relative to each medical record. Only results from valid medical records are used for the payment error calculation.

- **Question 1 (INV1) = Does the medical record correctly identify the sampled beneficiary?** Senior evaluator fails this check if the medical record name and identifying information is completely different from the name on the Medical Record Coversheet (sampled beneficiary CMS- HCC). If INV1= NO, SE will evaluate if name is a derivative as in INV3 and change to YES. The SE may escalate this record to request CDAT support to determine if enrollee is in the sample. See related INV3 and INV 20. If INV3=YES, the system WILL NOT move the record forward for coding unless the SE changes INV1 to YES also.
- **Question 2 (INV2) = Is the medical record signed?** The SE fails this check if the medical record submitted is not signed at all. The signature does not have to be complete or legible. Note: The SE does not answer this based on the presence of an attestation, only the medical record document.
- **Question 3 (INV3) = Is the name on the medical record an acceptable variance of the name of the sampled beneficiary?** SE fails this check when the name on the medical record is similar but does not match the Medical Record Coversheet. The SE may decide the name is acceptable or not and, if not acceptable, fail both INV3 and INV1. Examples of possible scenarios include reported Health Insurance Claim Number (HICN) is spouse's number, use of middle name as first name, maiden name, and father/son mix up with same name but different birth date. The SE may escalate this record for further clarification or questions. INV3 should never = NO without INV1=NO also. If name was corrected on the coversheet, SE will assign INV3=YES with a comment describing the difference.
- **Question 4 (INV4) = Is there a date on the medical record?** Does the medical record contain a valid date of service? The SE fails this check if the date is missing completely or only partially there and the year cannot be confirmed.
- **Question 5 (INV5) = Is the medical record from a valid source?** The SE fails this check for invalid sources, which are not on the acceptable sources list, such as: hospice, home health, lab only, super-bill, and non-face to face. The SE also fails this check if the physician/practitioner credential/specialty is not on the ACCEPTABLE PHYSICIAN SPECIALTY TYPES list (see attachment B1 and B2).

  NOTE: If the source is on the acceptable sources list, and the only issue is the lack of a credential/specialty, then INV5 passes, but INV7 should fail.
- **Question 7 (INV7) = Are you able to confirm an acceptable credential/specialty (e.g., MD, PA, DPM, Cardiology, Internal Medicine)?** The SE fails this check if the medical record is signed but there is no credential in the signature and no credential (MD, DO, NP) or specialty reference (Renal, Cardiology, PCP, Hospitalist, Attending, etc.) to the one specific physician/practitioner named on the document (heading, defined provider type in signature line). The INV is evaluated on a case-by-case basis in situations where the credential is implied in a pre-printed note designation (doctors/provider notes). Note the SE does not answer this based on the presence of an attestation, only the medical record document.

- **Question 14 (INV14) = Is the date on the medical record within the data collection period?** The SE fails this check if the medical record date of service is not within the date collection period. If date cannot be determined (blank or illegible), question 14 passes as unknown, but INV4 fails.
- **Question 15 (INV15) = Does the Provider Type of the medical record match the Provider Type selected on the Medical Record Coversheet?** SE fails this check if the medical record provider type doesn't match the Medical Record Coversheet provider type. For example, the provider type is marked as Inpatient but only a physician or outpatient record is attached. An exception is made for several pages of an inpatient record, which the plan has identified as a physician/outpatient record on the Coversheet. The presence of the additional documentation in the inpatient is helpful to set the context for assigning accurate codes for the one date of service selected. INV15 would not be failed in this case.
- **Question 17 (INV17) = Is acceptable Medical Record documentation included?** This is assigned when the submission includes a coversheet, but the attached document is not a medical record. When INV 17 applies, all other INV flags are automatically assigned "no." When plan checks no record attached, the record does not move to intake, so no INV is flagged.
- **Question 20 (INV20)** = **Miscellaneous INV: Is the record free from invalid issues not otherwise addressed through existing INV checks?** SE fails this check if there is a medical record issue that hasn't already been identified in any of the INV questions.

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Appendix B1:

Acceptable Physician Specialty Types Program Year (PY) 2015 (2014 Dates of Service) – Numeric

Code	Specialty	Code	Specialty	Code	Specialty	Code	Specialty
1	General Practice	19	Oral Surgery	40	Hand Surgery	79	Addiction Medicine
2	General Surgery	20	Orthopedic Surgery	41	Optometry	80	Licensed Clinical Social Worker
3	Allergy/Immunology	21	Cardiac Electrophysiology	42	Certified Nurse Midwife	81	Critical care (intensivists)
4	Otolaryngology	22	Pathology	43	Certified Registered Nurse Anesthetist	82	Hematology
5	Anesthesiology	23	Sports Medicine	44	Infectious Disease	83	Hematology/Oncology
6	Cardiology	24	Plastic and Reconstructive Surgery	46*	Endocrinology	84	Preventive Medicine
7	Dermatology	25	Physical Medicine and Rehabilitation	48*	Podiatry	85	Maxillofacial Surgery
8	Family Practice	26	Psychiatry	50*	Nurse Practitioner	86	Neuropsychiatry
9	Interventional Pain Management (IPM)	27	Geriatric Psychiatry	62*	Psychologist	89*	Certified Clinical Nurse Specialist
10	Gastroenterology	28	Colorectal Surgery	64*	Audiologist	90	Medical Oncology
11	Internal Medicine	29	Pulmonary Disease	65	Physical Therapist	91	Surgical Oncology
12	Osteopathic Manipulative Medicine	33*	Thoracic Surgery	66	Rheumatology	92	Radiation Oncology
13	Neurology	34	Urology	67	Occupational Therapist	93	Emergency Medicine
14	Neurosurgery	35	Chiropractic	68	Clinical Psychologist	94	Interventional Radiology

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Code	Specialty	Code	Specialty	Code	Specialty	Code	Specialty
15	Speech Language Pathologist	36	Nuclear Medicine	72*	Pain Management	97*	Physician Assistant
16	Obstetrics/Gynecology	37	Pediatric Medicine	76*	Peripheral Vascular Disease	98	Gynecologist/Oncologist
17	Hospice and Palliative Care	38	Geriatric Medicine	77	Vascular Surgery	99	Unknown Physician Specialty
18	Ophthalmology	39	Nephrology	78	Cardiac Surgery	C0	Sleep Medicine

* Indicates that a number has been skipped.

Appendix B2: Acceptable Physician Specialty Types PY 2015 – Alphabetic

Specialty	Specialty	Specialty	Specialty	Specialty
Addiction Medicine	Emergency Medicine	Internal Medicine	Ophthalmology	Podiatry
Allergy/Immunology	Endocrinology	Interventional Pain Management	Optometry (Optometrist)	Preventive Medicine
Anesthesiology	Family Practice	Interventional Radiology	Oral Surgery (Dentists only)	Psychiatry
Audiologist	Gastroenterology	Licensed Clinical Social Worker	Orthopedic Surgery	Psychologist
Cardiac Electrophysiology	General Practice	Maxillofacial Surgery	Osteopathic Manipulative Medicine	Pulmonary Disease
Cardiac Surgery	General Surgery	Medical Oncology	Otolaryngology	Radiation Oncology
Cardiology	Geriatric Medicine	Nephrology	Pain Management	Rheumatology
Certified Clinical Nurse Specialist	Geriatric Psychiatry	Neurology	Pathology	Sleep Medicine

Specialty	Specialty	Specialty	Specialty	Specialty
Certified Nurse Midwife	Gynecologist/Oncologist	Neuropsychiatry	Pediatric Medicine	Speech Language Pathologist
Certified Registered Nurse Anesthetist	Hand Surgery	Neurosurgery	Peripheral Vascular Disease	Sports Medicine
Chiropractic	Hematology	Nuclear Medicine	Physician Assistant	Surgical Oncology
Clinical Psychologist	Hematology/Oncology	Nurse Practitioner	Physical Medicine and Rehabilitation	Thoracic Surgery
Colorectal Surgery	Hospice and Palliative Care	Obstetrics/Gynecology	Physical Therapist	Urology
Critical Care (Intensivists)	Infectious Disease	Occupational Therapist	Plastic and Reconstructive Surgery	Vascular Surgery
Dermatology	*	*	*	Unknown Specialty

* Left blank.

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Appendix C: Glossary

AHA – American Hospital Association

Alternative data sources – Alternative data sources (ADS) include diagnostic data from sources other than hospital inpatient, hospital outpatient, and physician services. MA organizations may use ADS as a **check** to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes, such as pharmacy records and information provided to national or state cancer registries. The MA organization may not, however, use ADS as substitutes for diagnoses from a hospital/physician. As in all diagnoses submitted, there must be medical record documentation to support the diagnosis as having been documented as a result of a hospital inpatient stay, a hospital outpatient visit, or a physician visit during the data collection period.

Amendment (to medical record documentation) – Source AHIMA corrections, amendments and addendum tool kit
An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation. Entries added to a health record to provide *additional* information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.

Attestation – A CMS-generated document that allows a physician to attest to his/her signature and/or credentials for a specific date of service for outpatient/physician records only. Attestations are not accepted for inpatient records.

CDAT – Central Data Abstraction Tool

CMS – Centers for Medicare & Medicaid Services

CNS – Clinical Nurse Specialist

CON15 – Contract level RADV payment year 2015

DOB – Date of birth

DOS – Date of service

01/10/2020

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DS – Discharge Summary

ED – Emergency Department

EMR – Electronic Medical Record

H&P – History and Physical

HCC – Hierarchical Condition Category

HIPAA – Health Insurance Portability and Accountability Act

HRA – Health risk assessments (HRAs) are medical record questionnaire forms that identify patient reported past, present, potential or chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual. HRAs may be documented through a telephone interview or web-based program, during community-based prevention programs or during an encounter with a health care professional. The HRA may or may not be performed by the patient's regular provider and is often done by a physician or non-physician health professional contracted by the MAO specifically to perform this function. The intention is to have the HRA reviewed by the patient's provider in conjunction with other health records and testing to confirm, treat and correctly report the potential conditions identified.

For purposes of RADV an HRA is valid as a medical record coding source if performed during a face-to-face encounter by a valid risk adjustment provider. Diagnoses from HRAs not performed during a face to face encounter (e.g. telephone interviews or patient completed forms) must be substantiated in other valid medical record documentation during a face to face encounter with a valid risk adjustment provider in order for the conditions to be coded and the HCCs potentially validated.

ICD-9-CM, ICD-9 – International Classification of Disease, Ninth Revision, Clinical Modification

IP – Inpatient

Late Entry – Source AHIMA corrections, amendments and addendum tool kit.
An addition to the health record when a pertinent entry was missed or was not written in a timely manner. The late entry should be timely, bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. Typically, late entries apply to direct documentation only; for example, physician orders, progress notes, or nursing assessments. Dictated reports such as history and physicals, although dictated outside of organizational time frames, would not be considered a late entry. ***Note:*** *Some systems may not have late entry functionality. The late entry is then displayed as an addendum.*

MA – Medicare Advantage

N/A – Not applicable

NP, APRN, ACNP, ANP, FNP, GNP – Nurse Practitioner credentials

OP – Outpatient

PHI/PII – Personal health information/personal identifiable information

PA – Physician assistant

PA-C – Certified Physician Assistant

PA Credentials:

MPAP – Master of Physician Assistant Practice

MSPAS – MS in Physician Assistant Studies. Graduates from these master's programs are eligible to sit for the national certification examination to be licensed

Physician – The term "physician" is generally used throughout this document to refer to any of the acceptable physician data sources for risk adjustment (see Attachment B1 and B2). Understand that several of these physician specialties (i.e., nurse practitioners, physician assistants, physical therapists, licensed clinical social workers, etc.), are not physicians but are considered acceptable provider types/physician specialties for RADV.

POS – Point of service. A type of EMR where the provider logs in and enters notes directly into the patient's medical record during the encounter.

QTR – Quarter (1, 2, 3 or 4), the publication yearly quarter for AHA Coding Clinic issues.

Query, Physician Query, Coder Query – Source: AHIMA Practice Brief: *Guidelines for Achieving a Compliant Query Practice.* All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process. A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update *[an "update" can be a late entry, addendum, or approved query form per individual facility medical record documentation policy]* of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care. In court an

attorney cannot "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists cannot lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information. The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation

A query should include the clinical indicators, as discussed above, and should not indicate the impact on reimbursement. A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.

RADV – Risk Adjustment Data Validation

RAPS – Risk Adjustment Processing System

SE – Senior Evaluator. RADV medical record review contractor senior coder tasked with researching questions, confirming invalid cases from initial levels of coders, and conducting a second level of coding.

SNF – Skilled Nursing Facility