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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

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

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

This HPMS memo provides updated information about how CMS will extract risk adjustment eligible diagnoses from encounter data records for use in calculating risk scores. CMS released draft logic for encounter data filtering on July 21, 2015. We are now finalizing the filtering logic for payment year (PY) 2015 by providing an updated description of the filtering logic, a discussion of the development of the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) list that will be used for filtering encounter data, and responses to comments that we received on the draft logic. In addition, we have posted an updated Medicare Risk Adjustment CPT/HCPCS list for PY 2015 at (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

As discussed in the respective Advance Notices and Announcements, CMS will incorporate diagnoses from encounter data into the risk scores used in payment for (PY) 2015 and 2016. For PY 2015, diagnoses (2014 dates of service) submitted on encounter data records will be an additional source of diagnoses in the calculation of the risk scores. For PY 2016 (2015 dates of service), risk scores used for payment will be a blend of two risk scores: 10% of the risk score calculated using diagnoses from encounter data records and fee-for-service (FFS) claims added to 90% of the risk score calculated using diagnoses submitted to the Risk Adjustment Processing System (RAPS) and FFS claims. For both PY 2015 and PY 2016, CMS will calculate risk scores used to pay PACE organizations by using diagnoses submitted on encounter data as an additional source of diagnoses.

Historically, Medicare Advantage Organizations (MAOs) have done their own filtering and submitted to CMS risk adjustment eligible diagnoses in a minimum data set to the RAPS. Therefore, CMS has not needed to filter diagnoses submitted by MAOs in order to calculate risk

scores. Since MAOs are now submitting the full breadth of information regarding services furnished to a beneficiary, including all diagnoses, CMS must now extract (i.e., filter) diagnoses submitted to the Encounter Data System (EDS) that are eligible for risk adjustment.

The purpose of this memo is to finalize the EDS filtering logic that CMS will use for PY 2015 to identify risk adjustment eligible diagnoses submitted on encounter data records. CMS considered public comments before finalizing this filtering logic. Filtering is the use of procedure codes to determine whether a particular encounter data record should be used as an acceptable source of diagnoses to be considered for risk adjustment. Section 1 discusses how CMS will use the CPT/HCPCS codes to filter eligible diagnoses from professional encounters. Section II describes how CMS will filter eligible diagnoses from institutional inpatient encounters using Type of Bill Codes. Section III describes how CMS will filter institutional outpatient encounters based on a combination of Type of Bill and CPT/HCPCS codes. Attachment A provides information regarding the principles and criteria used to determine the codes included on the Medicare Risk Adjustment acceptable CPT/HCPCS list. Attachment B provides responses to public comments.

Introduction

CMS is not changing the existing risk adjustment rules; however, there is a change in the method for determining which diagnoses are eligible to be used in the risk score calculation. For a diagnosis to be eligible for risk adjustment, it must be documented in a medical record from an acceptable provider type (hospital inpatient, hospital outpatient, or professional) and the result of a face-to-face visit. The objective of these rules is to ensure that we only use reasonably definitive diagnoses to predict costs. CMS has further established rules regarding which inpatient and outpatient facilities, and which professional encounters, are acceptable sources for risk adjustment-eligible diagnoses.

The EDS filtering methodology outlined in this memo does not change rules regarding plan submissions to the RAPS. For example, to apply risk adjustment rules to professional encounters in RAPS, plans should continue to utilize CMS's list of acceptable physician specialty type codes.

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

Professional encounter data records are encounters, or related chart review records, where Part B items and services have been provided. These items and services are provided by physicians, non-physician practitioners (NPPs), and other Part B suppliers, and are submitted in an 837P format. CMS will use CPT/HCPCS codes when filtering these encounters and chart review records to identify risk adjustment eligible diagnoses. When filtering encounters and chart review records, CMS will not use on the specialty code(s) associated with each NPI.

CMS will select encounter data records with service "through dates" in the data collection year, e.g., 2014 dates for PY 2015. Using the most recent version of a professional encounter data record accepted by EDPS (i.e., a record that has passed system edits), CMS will evaluate the

accepted lines on the record to determine if the CPT/HCPCS codes are on the acceptable Medicare Risk Adjustment CPT/HCPCS list (also referred to as the "Medicare CPT/HCPCS list"). If there is an acceptable CPT/HCPCS code on at least one accepted line on the record, CMS will use all the header diagnoses on that record. If there are no acceptable CPT/HCPCS codes on any of the lines on the record, then CMS will not use any of the diagnoses on the record for risk adjustment. CMS will use this process both for records that report an encounter and associated chart review records.

Note: HCPCS Level I codes are the CPT codes published by the American Medical Association; HCPCS Level II codes are additional alpha-numeric codes maintained by CMS and other entities. We will refer to Level I and Level II HCPCS codes as "CPT/HCPCS codes" in this memo.

II. Filtering Institutional Inpatient Encounter Data Records

Institutional Inpatient encounter data records are encounters, or related chart review records, where Part A items and services have been provided in an inpatient setting. These items and services are provided by facilities including hospitals and are submitted on an 837I format. CMS will select encounters with service "through dates" in the data collection year, e.g., 2014 dates for PY 2015. Using the most recent version of an accepted institutional inpatient encounter or the most recent version of an accepted chart review, CMS will use the Type of Bill Code to determine if an encounter data record is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment. There is no CPT/HCPCS procedure screen for institutional inpatient bill type code.

The institutional inpatient Type of Bill Codes that we will use to determine whether diagnoses are risk adjustment eligible are listed in Table 1. We will take all header diagnoses from records when:

(1) the Type of Bill (TOB) code on the encounter data record equals one of these acceptable TOB codes,

(2) it is the most recent accepted version of an encounter or a chart review record.

(3) One exception is when the most recently accepted record for an encounter is a void of a previously submitted encounter or chart review record: In these cases, we will not consider the diagnoses from that record to be risk adjustment eligible. Such situations include when the latest version of an encounter data record is voiding a previously-submitted encounter data record, or when the latest version of an encounter has a TOB code 118, indicating that the encounter has been extracted from a claim (submitted from a provider to the plan) that voided a previously-submitted claim.

Table 1: Institutional Inpatient Acceptable Type of Bill Code

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

III. Filtering Institutional Outpatient Encounter Records

Institutional Outpatient encounter data records are encounters, or related chart review records, where Part B items and services have been provided to a beneficiary on an outpatient basis. These items and services are provided by facilities including hospitals and various clinic settings and are submitted on an 837I format. CMS will select encounters with service "through" dates in the data collection year, e.g., 2014 dates for PY 2015. Using the most recent version of an accepted institutional outpatient encounter or the most recent version of an accepted chart review, CMS will use the Type of Bill Code to determine if an encounter data record is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment. We will then evaluate lines (revenue centers) on an encounter data record to determine if the CPT/HCPCS codes are acceptable, based on the acceptable Medicare acceptable CPT/HCPCS list.

The institutional outpatient facility Type of Bill Codes that we will use to determine whether diagnoses are risk adjustment eligible are listed in Table 2. We will take all header diagnoses from records when:

(1) the Type of Bill (TOB) code on the encounter data record equals one of these acceptable TOB codes,

(2) there is at least one acceptable CPT/HCPCS code on a service line,

(3) it is the most recent version of an encounter or a chart review record.

(4) One exception is when the most recently accepted record for an encounter is a void of a previously submitted encounter or chart review record. In these cases, we will not consider the diagnoses from that record to be risk adjustment eligible. Such situations include when the latest version of an encounter data record is voiding a previously-submitted encounter data record, or when the latest version of an encounter has a TOB code 128, indicating that the encounter has been extracted from a claim (submitted from a provider to the plan) that voided a previously-submitted claims.

Table 2: Institutional Outpatient Acceptable Type of Bill Codes

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

IV. Incorporation of Chart Review

In addition to submitting records for encounters, plan sponsors are also allowed to submit encounter data records that reflect their reviews of medical records (called "chart review" records). These records allow a plan sponsor to (1) submit additional diagnoses that were not submitted when they reported the encounter, but that were later found to be associated with the encounter through a chart review, and (2) delete diagnoses via linked chart review that had been submitted on an encounter, but were later found to be unsupported by the medical record. Plan sponsors also submit chart review records using the 837 formats. While additional or deleted diagnoses may also be submitted by replacing the record where the encounter was reported, if additional diagnoses or deleted diagnoses are submitted via chart review records we will follow the process below.

We will select chart review records with "through" dates in the data collection year, e.g., 2014 dates for PY 2015. If the chart review record is adding diagnoses –diagnoses that were not reported when the encounter was first submitted – we will filter the chart review record as we do non-chart review encounter records (see Sections I – III above). If the chart review record is deleting diagnoses – that is, is deleting diagnoses from a previously-submitted encounter or chart review record – these deleted diagnoses will no longer be considered as eligible for risk adjustment. Please note that deleting a diagnosis using a chart review record only deletes the diagnosis from the specific encounter or chart review record that is referenced on the delete record; in other words, it does not delete that diagnosis from any other encounter data records. The deleted diagnosis from that specific encounter will no longer be included in a beneficiary's pool of risk adjustment eligible diagnoses.

V. Submission Deadline

Diagnoses submitted on encounter data records or chart review records will only be considered for risk adjustment eligibility if they are submitted by the final risk adjustment data submission deadline for the payment year. Per the May 13, 2015 HPMS memo, the risk adjustment deadline

for PY 2015 (2014 dates of service) is February 1, 2016. We remind plan sponsors that they must delete unsupported diagnoses from both encounter data and from RAPS.

If you have questions regarding the filtering logic, please submit them to RiskAdjustment@cms.hhs.gov.

Addendum A: Methodology for Creating the Medicare CPT/HCPCS Code List

Level I of the Healthcare Common Procedure Coding System (HCPCS) consists of CPT (Current Procedural Terminology) codes, a numeric coding system maintained by the American Medical Association (AMA). Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. The Level II HCPCS code set is established by CMS's Alpha-Numeric Editorial Panel, and primarily represents items and supplies and non-physician services not covered by the AMA's CPT codes.

CMS' risk adjustment models are prospective, using diagnoses from a data collection year to adjust payments in the subsequent payment year. Thus, when we refer to the acceptable Medicare Risk Adjustment CPT/HCPCS code list "in effect for a payment year," we are referring to the codes that will be used to filter (extract) encounter data and chart review records for the data collection year tied to that payment year. For example, the acceptable Medicare CPT/HCPCS list for PY 2016 will be used to filter 2015 encounter data and chart review records in order to extract risk adjustment eligible diagnoses.

For each payment year, CMS will first publish a preliminary list at the start of the data collection period and will then publish a final Medicare Risk Adjustment CPT/HCPCS list ("Medicare CPT/HCPCS list"), following an annual review of all new, revised, and deleted CPT/HCPCS codes, at the beginning of the payment year (to allow for the most recent quarterly updates from the previous year). For example, the preliminary list of Medicare acceptable CPT/HCPCS for PY 2017 (dates of service 2016) will be released in early 2016. We will finalize the PY 2017 (dates of service 2016) list at the beginning of 2017.

CMS applies risk adjustment rules when developing its criteria for inclusion and exclusion of CPT and HCPCS codes for the Medicare Risk Adjustment CPT/HCPCS code list, which will be used to determine whether diagnoses are risk adjustment eligible. Risk adjustment eligible diagnoses are those that meet risk adjustment criteria and will be run through the model when CMS calculates risk scores.

Inclusion Criteria:

- Procedures that indicate a face-to-face visit with a physician or other qualified health professional (QHP) from which a definitive diagnosis could be attained
- Telehealth or videoconference codes where the consulting physician/QHP may provide an acceptable diagnosis (e.g., 0189T videoconf crit care 74 minutes)
- Physician planning time codes (e.g., for operative or therapeutic radiation procedures) that would likely include diagnoses related to the planned procedure
- Chronic care management codes that would likely include diagnoses
- Diagnostic testing codes if they also include a non-diagnostic procedure/treatment
- Face-to-face procedures for device evaluations that include diagnoses from ongoing conditions that might not otherwise be recorded
- Special ophthalmological services where the ophthalmologist is both the ordering physician and the professional who can diagnose based on the findings

Exclusion Criteria:

- Procedures done by technicians or non-QHPs
- Procedure codes that correspond to diagnostic radiology/lab/pathology or testing procedures because the resulting diagnosis would appear on a separate claim by the ordering physician/QHP
- Optional procedure codes (CPT Level I Category II codes are not required)
- Procedure codes that are used for quality reporting and functional limitation reporting (not primary source for diagnoses if unaccompanied by allowable CPT code on another service line)
- Procedure codes that are additionally reported for Medicare demonstrations (not primary source for diagnoses if unaccompanied by allowable CPT code on another service line)
- Procedure codes that would not be coded by a physician/QHP without also coding an office visit (e.g., supplies) or HCPCS codes that have comparable CPT codes for services (vision/hearing screenings)
- Procedure codes not involving physician services (e.g., transportation, DME, drugs, prosthetics/orthotics)
- Dental (HCPCS "D") procedure codes. (Maxillofacial procedures will have acceptable corresponding CPT codes.)
- New technology codes (CPT Level I Category III codes) that are diagnostic/testing only
- Procedure codes not appropriate or not covered for the given population's payment model
    - The Medicare acceptable CPT/HCPCS list excludes commercial/Medicaid codes
- Procedure codes for follow-up visits where earlier face-to-face visits involving the patient and physician would already have captured the diagnoses necessitating the provided care
- Biopsy-only procedures that do not include treatment
- Incidental procedures that are supplementary to a main procedure treating the diagnosable condition
- Add-on codes (these should never appear without the "base" procedure code)

Addendum B: Responses to Comments

Comment: A number of the commenters supported the filtering approach described in the July 21st memo, including the logic to filter the institutional inpatient and outpatient encounters using Type of Bill codes and the CPT/HCPCS-based filtering method for professional encounters, citing transparency compared to the use of specialty codes.

Response: We appreciate the support for this approach and agree that there is more transparency with this approach.

Comment: Plans commented that the transition to EDS draft logic will require additional time to complete further analysis, specifically to conduct impact analysis. A few plans requested that CMS make public any deviation in the risk scores comparing EDS to RAPS.

Response: By starting with the addition of diagnoses from encounter data into the PY 2015 risk score, CMS has signaled its intent to move to the use of diagnoses from encounter data. We feel that the blend for PY 2016 (weighting the risk score from RAPS and FFS by 90% and the risk score from the EDS and FFS by 10%) is a reasonable, modest step toward ultimately relying exclusively on encounter data as the source of plan-submitted diagnosis information, particularly given that PY 2016 (2015 dates of service) will be the fourth year of the encounter data initiative. We look forward to working with plans to understand the reports and risk scores calculated for payment.

Comment: CMS should define what an original encounter is (e.g., original vs. adjustment vs. chart review).

Response: We have tried to simplify our use of terms in this memo. The reporting of an encounter (or "encounter") is the reporting of a clinical encounter in an encounter data record. A chart review record is an additional set of data regarding an already-reported clinical encounter. This additional data resulted from the plan sponsor's medical record review(s). Currently, a chart review record is linked or unlinked, (i.e., has an ICN from a previous record or not). Either type of record – an encounter or a chart review – can have an original record, and then a void and /or a replacement. Rather than referring to "originals," we are referring to the latest accepted version of either an encounter or a chart review.

Comment: Two commenters asked whether we would use a diagnosis on the header if a line was rejected.

Response: CMS reviews all the accepted (non-rejected) lines on professional and outpatient institutional records. For these types of encounter data records, if there is at least one line that has an acceptable Medicare CPT/HCPCS code, among the accepted lines on the record, CMS will consider all the header diagnoses as risk adjustment eligible. If there are no acceptable service lines on the record, then CMS will not consider any of the diagnoses on the encounter data record as risk adjustment eligible.

Comment: A number of commenters asked whether the proposed EDS filtering logic would also apply to RAPS submissions. Further, some requested explicit clarification that the EDS draft filtering logic would only apply to EDS diagnoses for data years that will be included in risk score calculations, and would not be retroactively applied to prior service year submissions.

Response: Plans should continue to follow the existing filtering rules for their RAPS submissions (e.g., use specialty code-based filtering for professional data). The filtering logic discussed in this memo (e.g., HCPCS code-based filtering logic) will only be used for identifying risk adjustment eligible diagnoses on encounter data records. The encounter data filtering logic will apply to data collection years 2014 and later.

Comment: Numerous plans requested that the MAO-004 report be returned soon after they submit a file (24-48 hours), to align with the MAO-002 Report, along with the reason code for excluded RA eligible diagnoses. In addition, plans strongly encourage that CMS provide a testing environment for the MAO-004 report in order for plans to evaluate any potential issues with the operational component of diagnoses feedback and reconciliation process. Since the MAO-004 Report only identifies risk adjustment eligible diagnoses, plans also requested that CMS provide the actual mapping of RA acceptable codes to payment HCCs on the flat file that feeds the risk score calculation for payment. Plans also requested that, before CMS officially distributes the report beginning with January 2014 dates of service, CMS should allow a 'test' run in order to provide plans' with the opportunity to compare against internal analysis.

Response: In order to report risk adjustment eligible diagnoses – those diagnoses that meet risk adjustment rules, but that have not yet been determined to map to a condition category in the model -- CMS will send the MAO-004 flat file report to Plan sponsors (MAOs, PACE Organizations, entities under contract to offer cost plans, and certain demonstration projects) monthly. CMS determined that monthly reports are the most optimal in terms of resources needed to filter the encounter data records and process the reports. The MAO-004 report will include diagnoses that are eligible for risk adjustment, not all diagnoses submitted on encounter data records. Given the filtering rules, CMS feels that there is no need to indicate why a diagnosis is not found risk adjustment eligible. We will work with plans to answer their questions about diagnoses that are reported (and are not reported) on the MAO-004 report and will prepare clarifications where there appears to be confusion. CMS does not plan to map a diagnosis to a condition category on the MAO-004 for several reasons: (1) at the time we are processing diagnoses from the initial months for a year, we may not have finalized the model for the following payment year, (2) the diagnoses may be later deleted, and (3) a later diagnoses may be higher in a hierarchy and a condition category may no longer be included in a risk score. We note that we do not provide this information for RAPS-submitted diagnoses. We encourage plans to use the publicly available software for each payment year to map diagnoses to the condition categories for a payment year.

Comment: One commenter asked that CMS provide the same extra two weeks submission time for encounter data that we have provided for RAPS data.

Response: Please note that CMS no longer sweeps two weeks after the published data submission deadline. Risk score runs will only include risk adjustment data – RAPS or encounter data -- submitted as of the final risk adjustment data submission deadline.

Comment: Several plans asked for clarification if the Professional filtering logic indicated service site neutrality. In RAPS data submission, plans filter out non-RA acceptable sources such as SNF services, but for encounter data filtering, CMS has included codes from sources that are traditionally non-RA acceptable such as nursing facility services (e.g., codes for initial care and subsequent care are included in the Medicare CPT/HCPCS list).

Response: Site neutrality still means that CMS does not weight diagnoses from some settings over others. However, some sources of diagnoses remain excluded from risk adjustment because they are not as reliable as other sources. Diagnoses from SNF facilities are not eligible for risk adjustment, however diagnoses associated with acceptable Medicare CPT/HCPCS are risk adjustment eligible when they are on a professional encounter that occurred during a visit at a SNF.

Comment: A number of plans asked about how deletes will work with encounter data. For example, some plans were confused about whether deleting a diagnosis through a chart review record would delete the diagnoses for a single encounter or for the whole year. Several plans asked if they need to delete a diagnosis from both RAPS and encounter data, if they can delete diagnoses from encounter data retroactively, and whether they should use a chart review record to delete a diagnosis.

Response: MAOs must delete unsupported diagnoses from both encounter data and from RAPS. Just as with RAPS, deletes from encounter data can be made retroactively. For overpayment purposes, diagnoses should be deleted within the appropriate timeframe once an overpayment is identified. A diagnosis that is deleted from encounter data will be deleted only from the specific encounter that is identified, either through the replacement of a previously-submitted encounter or through a chart review record. Please note that, when deleting diagnoses through a chart review record, the chart review record must identify, by providing the ICN, the encounter (or previously-submitted chart review record) from which the diagnoses are being deleted. Without the ICN of the prior record, CMS will be unable to identify the encounter (or chart review record) the diagnoses should be deleted from.

Comment: We received a number of comments regarding the submission of chart review records and their use in filtering, including whether chart review records will be filtered if they do not contain the bill type and CPT/HCPCS codes and if diagnoses from unlinked chart reviews are eligible for risk adjustment. Several plans asked that if they can use chart reviews to report excess diagnoses when encounters exceed the current file size limitation (i.e. 12 for professional and 25 for inpatient) on the 5010.

Response: If the linked and unlinked chart review submissions do not contain acceptable Type of Bill (TOB) and CPT/HCPCS codes, the encounter data system will still process and store these chart review records, but any diagnoses that do not meet our risk adjustment criteria will not be considered risk adjustment eligible. Chart review records can be used by MAOs to report excess diagnoses when encounters exceed the current file size limitation (i.e. 12 for professional

and 25 for inpatient) on the 5010. CMS will apply filtering logic to chart review records that are adding diagnoses, including chart review records that are linked and (currently) those that are unlinked to an encounter.

CPT/HCPCS list:
Comment: Many commenters asked for information about the methodology that CMS used to determine which codes were included in the Medicare acceptable CPT/HCPCS list. Some commenters wanted to know how CMS will conduct the future review process and wanted a review period prior to future updates. One commenter stated that, if CMS is responsible for filtering EDS diagnoses for risk adjustment purposes, this could potentially impact the current compliance operations of plans. The commenter opined that CMS must, not only publish a complete and accurate Medicare CPT/HCPCS code list, but also publically establish the methodological framework for code(s) inclusion and exclusion in order for plans to maintain internal compliance and oversight consistent with CMS filtering policy.

Response: In conjunction with this memo, CMS is also releasing the final list of acceptable CPT/HCPCS codes for PY 2015 (dates of service 2014). Appendix A of this memo lays out objectives and criteria used to create the list. Future updates to the list will continue to utilize these criteria. The updated list of Medicare acceptable CPT/HCPCS codes will be published at least annually on the risk adjustment webpage: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html.

Comment: Several commenters asked CMS to expand the Medicare CPT/HCPCS list so that it includes additional codes that are in the HHS Risk Adjustment CPT/HCPCS list, and made recommendations to include (or exclude) specific codes. Plans recommended the addition of a variety of procedure codes, including those related to biopsies, discharge services, therapeutic procedures, substance interventions, and wheelchair evaluation, and codes associated with cardiac catheterization and coronary angiography.

Response: CMS reviewed the codes submitted by commenters. The inclusion/exclusion criteria presented in Addendum A explain why many of the codes (including those within a code category) suggested by commenters are not included on the Medicare Risk Adjustment acceptable CPT/HCPCS list. Regarding the codes included on the HHS Risk Adjustment CPT/HCPCS acceptable code list that are not on the Medicare Risk Adjustment acceptable CPT/HCPCS list, codes that are designed for use by specific payers (e.g. commercial payer types) are not on the Medicare acceptable CPT/HCPCS list. In addition, the inclusion/exclusion criteria described in Addendum A have been applied to the HHS Risk Adjustment CPT/HCPCS list and, therefore, effective in 2015, the HHS Risk Adjustment CPT/HCPCS filtering list no longer includes a majority of the codes that were cited.

The final Medicare Risk Adjustment CPT/HCPCS code list for PY 2015 (dates of service 2014) includes some revisions from the posting we did in conjunction with the July 21st memo. A number of codes were added as a result of a mid-2014 release of CPT/HCPCS codes. In addition, a few codes were added as a result of the review of the inclusion criteria described in Addendum A.

Comment: One plan commented that CMS should remove 6 CPT codes, including those related to Home Health Procedures/Services.

Response: We did not remove these codes because, according to CPT codebook guidelines, it would be likely or possible for qualified health professionals to use those codes. For example, for the code subset relating to Home Health Procedures/Services, the CPT codebook notes that professionals who are authorized to use E/M Home Visit codes may additionally report the home health procedures if both services are performed.

Comment: Several commenters recommended that CMS consider modifiers (2 digit numeric and/or alpha codes) to the set of Medicare acceptable CPT/HCPCS codes list.

Response: CMS did consider adding modifiers to the Medicare acceptable CPT/HCHCPS list, but determined that there are extensive complexities involved in evaluating modifiers in the context of identifying acceptable CPT/HCPCS codes. In addition, incorporating modifiers into the filtering logic would not improve the accuracy of the diagnoses determined risk adjustment eligible.

Comment: Some commenters suggested that CMS should expand the outpatient TOBs to Outpatient Diagnostic, Clinic and Comprehensive Outpatient Rehabilitation Facility, Licensed Free Standing Emergency Medical Facility, Clinic – other, ASC, and Specialty Facility Ambulatory Surgery.

Response: The current TOB code list is based on a crosswalk from the current Medicare filtering methodology that relies on acceptable provider numbers to a list of comparable TOB codes. As we mentioned above, CMS is not changing its rules regarding how we determine risk adjustment eligible diagnoses. CMS will continue to exclude these sources of diagnoses because of the reliability of the diagnoses from these sources.

Comment: One plan asked how CMS will filter Institutional Outpatient encounters that do not have CPT/HCPCS codes at service line level because HCPCS are situational (reference: INST TR3 [x223] Addendum A2) on Institutional Outpatient encounters.

Response: If none of the lines on an outpatient encounter data record has a HCPC, we would not accept the diagnoses from that record. We note that, typically, supplies and pharmacy may not necessarily have codes, but we would not consider diagnoses from these records to be risk adjustment eligible anyway.