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DATE: November 27, 2007

TO: All MA, MA-PD and PDP Plan Sponsors

FROM: Tom Hutchinson, Director, Medicare Plan Payment Group

RE: CMS Implementation of a standardized set of valid ICD-9 diagnosis codes relating to Payment Year 2009

This memorandum provides information and guidance related to the submission of diagnosis codes by plan sponsors that are used for risk adjustment payment purposes. As discussed in the Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies, released April 2, 2007, CMS is implementing the use of a standard set of valid codes to apply in determining which plan-submitted diagnosis codes are acceptable for use in CMS's Risk Adjustment System (RAS). The goal is for RAS to accept and store only those diagnoses codes that are valid. Currently, RAS accepts invalid codes because RAS still accepts and stores old ICD-9 codes that have been superseded by more recent NCHS codes and does not send error messages to the plans. Having a standard set of valid codes for each year will make it easier for CMS and plans to manage risk adjustment processing, editing, and error reporting.

Starting with diagnosis codes to be used in calculating 2009 final payment (diagnosis codes for service dates between January 1, 2008 and December 31, 2008), RAS will accept only codes that are valid for Fiscal Year 2008 and Fiscal Year 2009. In other words, for the CMS-HCC, ESRD, and RxHCC risk adjustment models, only valid ICD-9-CM codes for two fiscal years -- the fiscal year prior to the payment year and the fiscal year that corresponds to the payment year -- will be accepted into CMS's risk adjustment payment system. Refer to Table I for the implementation schedule of the new rules regarding the acceptance of diagnosis codes; please note that Table 1 supersedes the table in the FY2008 Announcement. The list of currently acceptable diagnosis codes, can be found on our website at

[http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06\\_Risk\\_adjustment.asp#TopOfPage](http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage).

While this memo addresses final payment for 2009, please note that CMS will use valid diagnosis codes from FY 2007 and FY 2008 (services dates between July 1, 2007 and June 30, 2008) for the initial risk score run for payment year 2009.

**Table I. Schedule of Acceptance of Valid Diagnosis Codes for Risk Adjustment Payment Purposes**

<b>Year of Payment</b>	<b>Date of Service</b>	<b>Source of codes</b>
2007	1/06 – 12/06	The list of codes published on our website at <a href="http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage">http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage</a> (which lists acceptable codes by year)
2008	1/07 – 12/07	The list of codes published on our website at <a href="http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage">http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage</a> (which lists acceptable codes by year)
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2008, 2009
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2009, 2010
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2010, 2011

Plan-submitted diagnoses are processed in the Risk Adjustment Payment System (RAPS). Each diagnosis code is either accepted or rejected. Codes that do not meet the requirements above will be rejected. Diagnoses that are rejected or not included in the model are reported to the submitting plan sponsor with an error code. For diagnosis codes to be used in FY 2009 payment, Table II shows the error codes that will be issued by RAPS. There are 4 newly-defined error codes that can be used when a diagnosis code is rejected or not included in the model:

- 450 errors will be issued when a diagnosis does is not valid
- 451 errors will be issued when the diagnosis service date is more than 92 days after the diagnosis end date, i.e., after December 31<sup>st</sup> of a given calendar year.
- 453 errors will be issued when the sex of the beneficiary is not the same as the sex of a gender specific diagnosis.
- 501 errors will be issued when the diagnosis is a valid code but is not a RAS diagnosis, meaning that the diagnosis is not included in the model that is used for payment.

**Table II. Error Codes issued by Risk Adjustment Payment System**

<b>ERROR CODE</b>	<b>RECORD ID</b>	<b>Short Description</b>	<b>ERROR DESCRIPTION</b>
450	CCC	Dgns is not valid	DIAGNOSIS Code is not Valid
451	CCC	Srvc Thru Dt GT Dgns End Dt	Diagnosis is not valid on the srvc thru dt
453	CCC	Dgns does not apply to gender	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX
501	CCC	Dgns not RAS Dgns	VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT ON THE SRVC THRU DT