Medicare Part C and Part D Reporting Requirements

Data Validation Procedure Manual

Appendix F: Interview Discussion Guide

Version 3.0

Prepared by:

Centers for Medicare & Medicaid Services

Center for Medicare

Medicare Drug Benefit and C & D Data Group

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# Overview

The *Interview Discussion Guide* is a supplemental tool to the *Organizational Assessment Instrument* (*OAI, Appendix E*) that data validation contractors (reviewers) may use to obtain further information about the sponsoring organization (SO) and its reporting processes. It is intended to facilitate discussions during the site visit and includes both general and selected reporting section questions that the reviewer may choose to ask of the appropriate SO staff. The reviewer may alter these questions depending on the information needed, and may combine the reporting section questions as appropriate to allow for efficient use of time should the SO’s staff be involved with reporting for more than one reporting section. The reviewer is expected to include additional reporting section questions as needed and should not rely solely on the questions provided in the *Interview Discussion Guide*.

All revisions since the April– June 2012 data validation (DV) cycle are identified by underlined and/or strikethrough text. The terms “section” and “measure” that previously appeared in the *Part C and Part D Reporting Requirement Technical Specifications* have been replaced with the term “reporting section.” To ensure alignment with this new terminology, all references in the DV documents to the term “measure” have been replaced with the term “reporting section.” In addition, the term “measure-specific criteria” has also been revised and replaced with “reporting section criteria.”

# Interview Discussion Guide: Questions Applicable to All Reporting Sections

Interview Discussion Guide for Data Validation Review

Reporting Section: <REPORTING SECTION>

**INTERVIEWEE INFORMATION**

Name:

Title:

Primary Phone Number:

Email:



**INTERVIEWER INFORMATION**

Name:

Date:        Time:

## Introduction/Background

### What are your roles and responsibilities in your current position?

### Describe your expertise and experiences with *CMS Part C and/or Part D Reporting Requirements Technical Specifications*.

## Data Production and Underlying Data Sources

### Describe the processes your organization uses to produce, maintain and update the data contained in the underlying data sources. Indicate all underlying data sources involved in the reporting process, beginning with the originating data systems (e.g., claims adjudication system, enrollment system) and including all other data sources used for data collection and storage, data processing, analysis, and reporting. For each data source, discuss the following:

* + Data Source Name
  + Data Collection/Production Process and Schedule
  + Data Validation Process (for both electronic and manual processed data)
  + Responsible Entities (if external, describe how they are managed.)

## Report Production Questions

### Describe the processes involved with producing the reporting sections, including:

* + Data Collection
  + Data Analysis
  + Data Validation (for both electronic and manually produced reports)
  + Report Submission (for both electronic and manually submitted reports)
  + Data Sources Used
  + Responsible Entities (if external, describe how they are managed.)

## Data Processing/Quality

### Has your organization encountered reporting issues with any of the data elements? If yes, describe the issues and how the organization resolved them.

### What unique identifiers does your organization use for tracking purposes (e.g., Member ID, Provider ID, Agent ID)?

### How does your organization ensure the appropriate date ranges for each reporting section are being reported?

### Has your organization experienced any problems with data completeness? If yes, describe the problems and how your organization resolved them.

### Describe your organization’s internal control processes for assessing data completeness and accuracy (e.g., for a claims-based reporting section, describe how your organization ensures that all data from a claim is submitted and claims for all visits are submitted).

* + How does your organization handle cases where data are incomplete due to delays in obtaining the data?
  + When data are questionable or invalid (e.g., claim appears inaccurate), what are the processes for determining whether the data are accurate and should be included for reporting purposes?
  + How does your organization address duplicate records identified to ensure that they are excluded from final reporting?

### How does your organization address and correct missing or invalid data (e.g., missing data values)?

### What edit checks are in place to validate data entry in HPMS (for both data submitted electronically (i.e., direct file upload) and data manually entered)?

### Has your organization implemented process or system improvements as a result of previously encountered problems with data processing, data management, reporting requirements or deadlines? If yes, describe these improvements.

## Additional Reporting Section Questions

See Sections 3 and 4 below for additional reporting section questions to incorporate into applicable interviews. Note that not every reporting section included in the data validation review has additional questions in this *Interview Discussion Guide*. The reviewer may create additional reporting section questions depending on the information needed.

# Part C Additional Reporting Section Questions

## ~~3.1 Procedure Frequency~~

### ~~3.1.1 How many diagnosis and procedure codes are captured by your organization’s claims data systems? To what digit are the diagnosis and procedure codes specified?~~

### ~~3.1.2 Does your organization map non-standard codes to the standard codes provided by CMS in the Part C Reporting Requirements Technical Specifications? If yes, provide details on the mapping schema.~~

### ~~3.1.3 Does your organization use global billing for any of the services identified in this measure?~~

### ~~3.1.4 Does your organization include services based on claims that were denied for payment?~~

## Serious Reportable Adverse Events (SRAEs)

### How many diagnosis and procedure codes do your organization’s claims data systems capture? To what digit are the diagnosis and procedure codes specified?

### Does your organization map non-standard codes to the standard codes CMS provides in the *Part C Reporting Requirements Technical Specifications*? If yes, provide details on the mapping schema.

### Does your organization include services based on claims that were denied for payment?

### How does your organization determine whether the adverse event (signified by ICD-9 Diagnosis E876.5) was related to Surgery on Wrong Body Part, Surgery on Wrong Patient, or Wrong Surgical Procedures on a Patient?

### How does your organization capture and track the date that an SRAE/HAC was diagnosed?

### How does your organization capture multiple SRAEs/HACs that occur for one patient who undergoes multiple procedures during his/her stay?

## ~~3.2 Provider Network Adequacy~~

### ~~3.2.1 When a provider is no longer part of the network (e.g., provider does not renew contract), how is this monitored and tracked?~~

### ~~3.2.2 How do you determine validity of data? For example, how do you determine whether the provider is contracted to provide services in a specific network? What is the schedule for this type of data validation?~~

### ~~3.2.3 If contracting issues are encountered (e.g., expired contracts, new contracts), how are these addressed? How do you ensure that these updates are made and incorporated into the final data reported to CMS?~~

## Grievances (PART C)

### How does your organization identify a grievance (i.e., distinguishing between grievances, inquiries, organization determinations, and reconsiderations)? Describe any internal processes your organization uses to ensure it captures grievances appropriately.

### How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes your organization uses to ensure it categorizes member issues correctly.

### How does your organization log/track/respond to identical grievances reported by the same member multiple times and/or to multiple departments?

## Organizational Determinations/Reconsiderations

### How does your organization identify an organization determination (i.e., distinguishing between grievances, inquiries, organization determinations, and reconsiderations)?

### How does your organization assign a final disposition category (i.e., definitions for fully favorable, partially favorable, adverse)?

### ~~How does your organization define contract and non-contract providers/suppliers?~~

## Special Needs Plans (SNPs) Care Management

### How does your organization identify enrollees that are eligible for an annual reassessment?

### How does your organization identify the health risk assessments that are performed on enrollees to determine whether they are initial assessments or annual reassessments?

### What standardized health risk assessment tool does your organization use?

### How does your organization define a health risk assessment/re-assessment as “complete?”

# Part D Additional REPORTING SECTION Questions

## ~~4.1 Retail, Home Infusion, and Long-Term Care Pharmacy Access~~

### ~~4.1.1 When a pharmacy is no longer part of the network (e.g., pharmacy does not renew contract), how is this monitored and tracked?~~

### ~~4.1.2 How do you determine validity of data? For example, how do you determine whether the pharmacy is contracted to provide long-term care services or home infusion services? What is the schedule for this type of data validation?~~

### ~~4.1.3 If contracting issues are encountered (e.g., expired contracts, new contracts), how are these addressed? How do you ensure that these updates are made and incorporated into the final data reported to CMS?~~

## Medication Therapy Management (MTM) Programs

### How does your organization identify members as being eligible for the MTM program?

### How does your organization identify and track MTM interventions, including comprehensive medication reviews, targeted medication reviews, prescriber interventions, and drug therapy changes as a result of MTM interventions?

### How does your organization determine the validity of data? For example, how do you determine whether the beneficiary’s MTM program enrollment status is current? What is the schedule for this type of data validation?

### How does your organization address incorrect beneficiary enrollment status? How does your organization ensure that invalid enrollees are excluded from the final cleaned database used for the data reported to CMS?

### How does your organization track and follow-up on offers for Comprehensive Medication Reviews (CMRs)? By what means does your organization determine whether or not an offer has been made and received by the beneficiary?

## Grievances (Part D)

### How does your organization identify a grievance (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and appeals/ redeterminations)? Describe any internal processes your organization uses to ensure it captures grievances appropriately.

### How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes your organization uses to ensure it categorizes member issues correctly.

### How does your organization log/track/respond to identical grievances reported by the same member multiple times and/or to multiple departments?

## Coverage Determinations and Exceptions

### How does your organization identify a coverage determination/exception (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and redeterminations)? Describe any internal processes your organization uses to ensure it categorizes coverage determinations/exceptions correctly.

### How does your organization determine whether a request is subject to the coverage determinations or the exceptions process?

### How does your organization log/track/respond to identical coverage determinations/exceptions requests for the same member multiple times?

## ~~Appeals~~Redeterminations

### How does your organization identify a~~n appeal~~ redetermination (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and ~~appeals/~~redeterminations)? Describe any internal processes your organization uses to ensure it categorizes redeterminations ~~appeals~~ correctly.

### How does your organization assign a final disposition category (e.g., definitions for ~~full reversal and partial reversal~~ fully favorable, partially favorable, and adverse)?

## Long-Term Care (LTC) Utilization

### How does your organization determine whether a member resides in a long-term care facility at the time a Part D claim for that member is processed?

### How does your organization distinguish between network LTC pharmacies and network retail pharmacies?

### Does your organization make changes to the formulary that takes effect during the calendar year? If so, how does your organization track these changes?