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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

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

FROM: Jennifer Harlow, Deputy Director, Medicare Plan Payment Group

SUBJECT: Guidance for Chart Review Record (CRR) Submissions

This memo provides clarifying guidance on submitting Chart Review Records (CRRs) to the Medicare Advantage Encounter Data System (EDS). Similar to RAPS, the role of a CRR is to allow Medicare Advantage Organizations (MAOs) to add risk adjustment eligible diagnoses, or delete diagnosis codes for plan enrollees. Accordingly, diagnosis codes added through a CRR must be derived from a face-to-face visit and supported by a medical record, as discussed in Chapter 7 on Risk Adjustment in the Medicare Managed Care Manual found at:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf.

While existing guidance allows MAOs and other submitters to provide default values for CPT/HCPCS codes on CRRs, default data must be submitted consistent with the CMS filtering logic. In other words, diagnoses that are disallowed for risk adjustment should not be submitted with default HCPCS codes that would cause the diagnoses to be allowed. For example, a diagnosis code resulting from a lab test that would have been excluded from risk adjustment by the professional filtering logic, because the CPT/HCPCS code for the lab visit was not included on the list of allowable CPT/HCPCS codes for the service year, should not be submitted on a CRR with an allowable default CPT/HCPCS code.

Similarly, other data elements, such as the dates of service, should preserve the integrity of the associated encounter and medical record from which the CRR was created.

Acceptable Use of CRRs
Specifically, there are two scenarios when a CRR may be submitted:

(1) The encounter generated more diagnosis codes than the maximum number of diagnosis code spaces on an encounter data record (EDR) (12 for professional, 25 for institutional). CRRs are intended to allow for the addition of risk adjustment eligible diagnoses if the additional diagnoses do not fit on the EDR.

(2) The MAO performed a medical record review and identified risk adjustment eligible diagnosis codes that should be added or diagnosis codes that must be deleted for a beneficiary, and these diagnosis codes are related to an encounter that has already been reported on an EDR.

MAOs should report items and services on an EDR, whether or not the items and services resulted in the creation of a claim from the provider to the MAO. Items or services provided to an enrollee under the plan must be reported on an EDR. A CRR **should not** be the only record with information about a healthcare item or service provided to a plan enrollee. As stated above, a CRR may be used to add risk adjustment eligible diagnosis codes or delete diagnosis codes to a previously submitted and accepted EDR.

Linked and Unlinked CRRs

There are two ways to submit a CRR in a 5010 format: linked and unlinked. Linking a CRR to a previously accepted EDR allows an MAO to associate risk adjustment eligible diagnoses with specific items or services provided to a beneficiary. While we do not edit to ensure the linked CRR matches the encounter to which it is linked, it is necessary that identifying information, such as the beneficiary HICN or MBI, should match in order to associate the diagnoses on the CRR with the beneficiary who received the associated services.

A linked CRR can be submitted to add diagnosis codes to a previously submitted and accepted EDR or CRR, or it can be submitted to delete diagnosis codes from a previously submitted and accepted EDR or CRR. Any CRR submitted to delete diagnosis codes from a previously accepted EDR or CRR must be linked.

An unlinked CRR may only be submitted to add risk adjustment eligible diagnosis codes, and does not identify a previously submitted EDR that the submitted diagnoses should be associated with.

Note: EDRs cannot be submitted to replace CRRs, and CRRs cannot be submitted to replace EDRs.

Additional guidance specific to linked and unlinked CRRs is provided below.

Linked CRRs

While a single CRR is subject to the 837 5010 limit on the number of diagnosis codes, there is no limit on the number of CRRs that may be linked to an EDR or CRR.

1. Linked CRR-Add

   A *Linked CRR-Add* contains the ICN of a previously submitted and accepted EDR or CRR. Further, the value in field "CLM05-3 Claim Frequency Type Code" (Loop 2300) must not equal '7' (replace) or '8' (void/delete), unless the intention is to replace ('7') or void ('8') another previously accepted CRR.

2. Linked CRR-Delete

A *Linked CRR-Delete* contains the ICN of a previously submitted and accepted EDR or CRR and the patient medical record number equal to '8' in the Loop 2300 segment (REF01= 'EA'/ REF02= '8'). If an MAO wishes to delete one or more diagnosis codes from a previously accepted EDR or CRR, each diagnosis code to be deleted must be listed on the *Linked CRR-Delete* record.

For example, if diagnosis AAA and BBB were submitted on the EDR or CRR and are to be deleted, then the CRR-Delete must also be submitted with diagnoses AAA and BBB.

Unlinked CRRs

As noted above, *Unlinked CRRs* can only be used to add risk adjustment eligible diagnoses. There is no limit to the number of unlinked CRRs that may be submitted. An *Unlinked CRR* should not contain the ICN of a previously submitted and accepted EDR or CRR. *Unlinked CRRs* attempting to delete diagnoses will be rejected with edit code 00805 - Deleted Diagnosis Code Not Allowed.