Medicare Managed Care Manual

Department of Health and Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal No 2 **Date: October 1, 2001**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7	30.1.2	---	---
7	70.1	---	---
7	70.2	---	---
7	90.6	---	---
7	100.2.1	---	---
7	100.2.2	---	---
7	100.2.3	---	---
7	100.2.4	---	---
7	100.2.5	---	---
7	100.3	---	---
7	100.4	---	---
7	110	---	---
7	110.1	---	---
7	110.3	---	---
7	110.4	---	---
7	110.5	---	---
7	110.6	---	---
7	120	---	---
7	170.2	---	---
7	---	170.3	---
7	180.1	---	---
7	180.3	---	---
7	210	---	---
7	210.1	---	---
7	Exhibit 6	---	---

NEW/REVISED MATERIAL --EFFECTIVE DATE: Not Applicable
IMPLEMENTATION DATE: Not Applicable

This transmittal includes the following:

Section 30.1.2, Minimum Specified Amount or "Floor Rate - is updated to show the current CMS web site address for minimum amount rates.

Section 70.1, Transition to a Comprehensive Risk Adjustment Method - the second paragraph is updated to reflect that the system is based on discharge data instead of admission data, and the Note is clarified to more accurately reflect that MCOs are not required to submit physician and outpatient encounter data. MCOs may submit such data but are not required to do so.

Section 70.2, Transition Schedule for Implementation of the Risk Adjustment Method - row two of the table is revised to clarify that BIPA is also included.

CMS Pub. 86

Section 90.6, Exclusions from Risk Adjustment Factor - is corrected to remove the reference to End Stage Rena; Disease (ESRD) and to change the word "payment" to "rate".

Section100.2.1, Two Required Quality Indicators - the cross reference is changed to 100.2.2, and the two quality indicators are labeled Quality Indicator 1 and Quality Indicator 2.

Section 100.2.2, Designated Measurement Population - is clarified to show that October 1 is included in the 180 day period.

Section 100.2.3, Thresholds Must be Met - the cross reference is corrected , the language is clarified to show that the quality indicator threshold levels have been established, and to announce and describe the threshold levels of 75% for level one and 80% for level two.

Section 100.2.4, Reporting - is updated to replace HCFA with CMS, clarify that MCOs may report electronically, and change the due date from 1/31/02 to 2/28/02 for payment in 2002.

Section 100.2.5, Extra Payment - is clarified to include the 10% phase-in level of the risk adjustment payment methodology, the example for 2002 is changed to reflect the 10% level, and to change the multiplication symbol (X) to lower case (x).

Section 100.3, Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care - is revised to describe situations in which the MCO may obtain assistance from the Peer Review Organization (PRO).

Section 100.4, Implementation of 100 Percent Risk-Adjusted Payment for Qualifying Congestive Heart Failure Enrollees in 2001 - is changed to expand eligibility for 100 % risk-adjusted payment in 2001 to include qualifying CHF enrollees who are enrolled in a coordinated care plan that was the only plan, as of January 1, 2001, offered in the area where the enrollee lives. Previously if another coordinated care plan was offered anywhere in the county, the MCO could not receive the 100% risk adjusted payment.

Section 110, Encounter Data Collection for the Risk Adjustment Model - the **NOTE** is clarified to more accurately reflect that MCOs are not now required to submit physician and outpatient encounter data. MCOs may submit such data but are not required to do so.

Section 110.1, Overview of Encounter Data - the reference to additional CMS uses for encounter data is **deleted**.

Section 110.3, Validation of Data - the reference to practitioners submitting medical records to support encounter data is **deleted**.

Section 110.4, Hospital Inpatient Encounter Data Requirements - the reference to fiscal intermediaries is replaced with Customer Service and Support Contractor.

Section 110.5, Data Formats and Processing - the second sentence, which specifies that encounter data will be priced only for discharges on or after July 1, 1998, is **deleted**, and the paragraph that describes teaching hospital billing to intermediaries is also **deleted**.

Section 110.6, Deadlines for Submission of Encounter Data - the note is clarified to more accurately reflect that MCOs are not now required to submit physician and outpatient encounter data. MCOs may submit such data but are not required to do so. Also the table is expanded to include the schedule for submission of encounter data for periods before July 2000, and to show deadlines for submission for each period.

Section 120, Announcement of Annual Capitation Rates and Methodology Changes - the incorrect phrase "of the same year" has been **deleted**.

Section 170.2, Clarification of the Definition of "Certified Institution" for Adjusting Payments Under the Demographic-Only Method - the examples are **deleted**. The new examples are added to a new section, 170.3.

Section 170.3, Payment for Institutional Status - is a new subsection to describe payment for institutional status.

Section 180.1, Previously Unserved Payment Area - is clarified to better describe that BIPAA, section 508, extended the time period during which an area could become an unserved payment area.

Section 180.3, Eligibility for Bonus Payment - the Period of Application - an incorrect reference to Table 1 is changed to Table 4.

Section 210, Reconciliation Process for Changes in Risk Adjustment Factors - the fifth bullet is clarified by deleting "encounter data consisting of"; and the reference to Medicaid is removed from the note.

Section 210.1, Reconciliation Schedule and Late Submission of Encounter Data - a reference to the table in 110.6 is added, the example for CY 2001 is **deleted**, and the reference to CY 2000 is changed from present tense to past tense.

Exhibit 6, Quality Indicators for Extra Payment in Recognition of the Costs of Successful Outpatient Treatment of Congestive Heart Failure - is completely revised.

The MMCM is an Internet document and may be accessed from the CMS Web site: http://www.hcfa.gov/pubforms/progman.htm.

These instructions should be implemented within your current operating budget.

NOTE*:* **Red italicized font identifies new material.**

30.1.2 - A Minimum Specified Amount or "Floor" Rate

(Rev. 2, 10-01-01)

The BBA set the floor rate for 1998 at $367 per month. For areas outside of the 50 states and the District of Columbia, for 1998 the minimum amount is the lesser of $367 or 150 percent of the 1997 standardized rate. For each succeeding year, the minimum amount rate equals the rate for the preceding year increased by the national per capita M+C growth percentage for the year (defined in §30.3.1).

BIPA §601 amends §1853(c)(1)(B) of the Act by establishing new minimum payment amount rates (floor rates) in CY 2001 for months after February. The new monthly minimum rates are as follows:

- $525 for any payment area in a Metropolitan Statistical Area (MSA) within the 50 States and the District of Columbia with a population of more than 250,000;

- $475 for any other area within the 50 states; or

- For any area outside the 50 states and the District of Columbia, $525 or $475 (depending on population size), only to the extent that this is not more than 120 percent of the minimum amount rate determined for CY 2000, which is the maximum established for these areas.

For January and February of 2001, the minimum amount rate is the minimum amount rate for the previous year increased by the national per capita M+C growth percentage, as described in §30.3.1 and 42 CFR 422.254(b), for the year. Minimum amount rates for January and February 2001 are based on the M+C rate book published in the March 1, 2000 "Announcement of Calendar Year (CY) 2001 Medicare+Choice Payment Rates".

Minimum amount rates established by the BIPA for March through December 2001, are published in the January 4, 2001 "Revised Medicare+Choice (M+C) Payment Rates for Calendar Year (CY) 2001."

Both documents can be found at *http://www.hcfa.gov/stats/hmorates/aapccpg.htm*

The BIPA mandated that a single floor rate is now assigned to all counties within MSAs of a certain size, and another floor rate is assigned to all other counties. If a county is located in an MSA with a population greater than 250,000, the BIPA changed the floor rate for that county, effective March 1, 2001. As a result, pre-BIPA revisions to prior years' growth estimates for that county cannot be linked to post-BIPA revisions for that county. Thus, revisions to prior years' growth estimates for area-specific rates will differ from revisions to prior years' growth estimates for floor rates.

70.1 - Transition to a Comprehensive Risk Adjustment Method

(Rev. 2, 10-01-01)

The BBA specifically requires implementation of a risk adjustment method no later than January 1, 2000. Under §1853(a)(3)(B), the BBA also requires "Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under §1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998."

The timing of this data collection authority indicated that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. Thus, CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made, beginning January 1, 2000. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year. The system recognizes *hospital discharges* for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

BIPA §603 amended §1853(a)(3)(C) of the Act by extending until 2007 the phase-in of risk adjustment. Between 2000 and 2007, the PIP-DCG-based risk adjustment method is used to adjust a portion of payment, and the demographic-only method is used to adjust the other portion. At the conclusion of the transition schedule described below in Table 2, a risk adjustment method centered on health status is scheduled to replace the demographic-only method.

Thus, under the current schedule, there are two methods comprising the M+C payment system until 2007. The demographic-only method is described in §80 and the PIP-DCG risk adjustment method is described in §90.

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002 the required filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of policy related to these types of encounter data have been deleted from this release.

70.2 - Transition Schedule for Implementation of the Risk Adjustment Method

(Rev. 2, 10-01-01)

Payment amounts for each enrollee are separately determined using the demographic-only method and the PIP-DCG risk adjustment method. These separate payment amounts are then blended according to the percentages for the transition year, summarized in Table 2.

NOTE: For 2001 only, 100 percent of the payment made for certain enrollees with congestive heart failure (CHF) is risk-adjusted. See §*100*.4 for information

on this special rule.

Table 2 - Transition Schedule for Implementation of the Risk Adjustment Method

YEAR	Demographic-only Method (%)	Risk Adjustment Method (%)
CY 2000	90%	10% PIP-DCG model
CY 2001	90%	10% PIP-DCG model [BBRA *and BIPA* amendment]
CY2002	90%	10% PIP-DCG model [BIPA amendment]
CY2003	90%	10 PIP-DCG model [BIPA amendment]
CY2004	70%	30% risk-adjusted model [BIPA amendment]
CY 2005	50%	50% risk-adjusted model [BIPA amendment]
CY 2006	25%	75% risk-adjusted model [BIPA amendment]
CY 2007 & succeeding years	0	100% risk-adjusted model [BIPA amendment]

90.6 - Exclusions from Risk Adjustment Payment

(Rev. 2, 10-01-01)

M+C organizations with Cost or Health Care Pre-payment Plan (HCPP) contracts will be excluded from payment under risk adjustment, but risk adjustment rates will be reported to these organizations as “risk equivalent” rates. This will replace the current reporting of the “risk equivalent” demographic-only rates to the Cost and HCPP plans.

M+C enrollees who are capitated at the hospice rates are excluded from payment under risk adjustment method. M+C organizations will receive the applicable demographic-only *rate* for these members. CMS has separate reconciliation processes for ESRD (§230) and hospice (§220).

100.2.1 - Two Required Quality Indicators

(Rev. 2, 10-01-01)

M+C organizations seeking the extra payment must measure two quality indicators for the entire CHF population (defined below in §100.2.*2*). No alternative quality indicators may be substituted for the two quality indicators. The required quality indicators are:

- **Quality Indicator 1** - Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year.

- **Quality Indicator 2** - Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) and, as of October 1 of the reporting year: **(**1) Are prescribed angiotens in converting enzyme inhibitors (ACEI); or (2) Have documented reason for not being on ACEI .

Additional information on the required quality indicators for extra payment may be found in Exhibit 6.

100.2.2 - Designated Measurement Population

(Rev. 2, 10-01-01)

For payment in 2002 - The population for which the required quality indicators will be measured must consist of M+C *organization's* enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to *and including* October 1, 2001, who were discharged from an acute care hospital between 7/1/99 and 6/30/01, with a greater than one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organization at the time of the hospitalization).

Where information on an inpatient hospital discharge has been received by CMS, CMS will flag enrollees with CHF diagnoses codes (defined in §100.2.1) on Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

For payment in 2003 - The population for which the required quality indicators will be measured must consist of M+C *organization's* enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to and *including* October 1, 2002, who were discharged from an acute care hospital between 7/1/99 and 6/30/02, with greater than a one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organization at the time of the hospitalization).

Note that the beginning discharge date for payment in 2003 is the same as the beginning discharge date for payment in 2002 (7/1/99) so that M+C *organizations* can continue to manage the health care of those hospitalized between 7/1/99 and 6/30/00, as well as those hospitalized between 7/1/00 through 6/30/02. Where information on an inpatient hospital discharge has been received by CMS, CMS will flag enrollees with CHF diagnoses codes, (defined in §100.2.1) on

Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

100.2.3 - Thresholds Must Be Met

(Rev. 2, 10-01-01)

The M+C organization must meet threshold levels on both quality indicators defined in 100.2.*1* and Exhibit 6 in order to qualify for the extra payment. Quality indicator threshold levels *were* established by CMS after input from a national clinical expert panel.

The threshold for extra payment for Quality Indicator 1 is 75 percent, and the threshold for Quality Indicator 2 is 80 percent. M+C organizations must meet or exceed the threshold level on both quality indicators to qualify for the extra payment.

The thresholds were announced by CMS in the "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year (CY) 2002", published on January 15, 2001 (see http://www.hcfa.gov/stats/hmorates/45d2001/).

100.2.4 - Reporting

(Rev. 2, 10-01-01)

For payment in 2002 - M+C organizations shall report to CMS on or after October 1, 2001 for payment in 2002. (Exhibit 7 provides a draft format for reporting, pending OMB approval). Paper copies of the reports should be sent to the attention of Angela Porter, *Centers for Medicare and Medicaid Services*, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. *M+C organizations may also report to CMS electronically using the Health plan Management System (HPMS) beginning October 1, 2001.* The report must include the following:

- M+C organizations must submit a brief (e.g., two-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.

- M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in 100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. CMS expects that few M+C organizations will have sufficient CHF enrollees to sample their CHF population for reporting. M+C organizations doing sampling must report their sampling methodology on the reporting form in Exhibit 7.

- The M+C organization must report its performance (including numerator, denominator, and proportion) on both of the required quality indicators as of October 1, 2001. The report must be submitted before *2/28*/02 to qualify for payment in 2002. For each member of the designated population, M+C organizations must maintain records of the Health Insurance Claim (HIC) numbers, and whether the member appears in the numerator and denominator for each measure. In the event that the M+C organization is subject to an audit, the M+C organization must furnish beneficiary-level results for both of the quality indicators in a format to be designated by CMS (see 100.2.7 below).

- Depending upon when M+C organizations report their performance, CMS will make payment in one of two ways: For reports received from M+C organizations between 10/1/01 and 11/30/01, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/01. Extra payments will be retroactive to 1/1/02. For reports received from M+C organizations between 12/01/01 and *2/28*/02, extra payment will be made no later than 90 days after *2/28*/02. Extra payments will be retroactive to 1/1/02. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. M+C organizations must not report their performance any later than *2/28*/02 for extra payment in 2002.

For payment in 2003 - M+C organizations shall report to CMS on or after October 1, 2002 for payment in 2003. (Exhibit 7 provides a draft format for reporting, pending OMB approval). Paper copies of the reports should be sent to the attention of Angela Porter, Center for Medicare Services, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. *M+C organizations may also report to CMS electronically using the Health plan Management System (HPMS) beginning October 1, 2001.* The report must include the following:

- M+C organizations must submit a brief (e.g., two-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.

- M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in 100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. CMS expects that few M+C organizations will have sufficient CHF enrollees to sample their CHF population for reporting. M+C organizations doing sampling must report their sampling methodology on the reporting form in Exhibit 7.

- The M+CO must report its performance (including numerator, denominator, and proportion) for both of the required quality indicators as of October 1, 2002. The report must be submitted before 1/31/03 to qualify for payment in 2003. For each member of the designated population, M+C organizations must maintain records of the HIC number and whether the member appears in the numerator for each measure. In the event that the M+CO is subject to an audit, the M+CO must furnish these beneficiary-level results for both of the quality indicators (see 100.2.7).

- Depending on when M+C organizations report their performance, CMS will make payment in one of two reporting ways: For reports received from M+C organizations between 10/1/02 and 11/30/02, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/02. Extra payments will be retroactive to 1/1/03. For reports received from M+C organizations between 12/01/02 and 1/31/03, extra payment will be made no later than 90 days after 1/31/03. Extra payments will be retroactive to 1/1/03. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. M+C organizations must not report their performance any later than 1/31/03 for extra payment in 2003.

100.2.5 - Extra Payment

(Rev. 2, 10-01-01)

Assuming the M+C organization's report on quality indicators shows attainment of the required threshold levels for both quality indicators, extra payments will be made to the M+C organization in 2002 for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/00, with a greater than one-day stay for a principal inpatient diagnosis of CHF, and who are enrolled in the M+C organization at the beginning of each payment month in 2002.

In 2002 - M+C organizations with enrollees hospitalized with a greater than one-day stay for a principal diagnosis of CHF between 7/01/00 and 6/30/01, will receive the regular PIP-DCG-16 amount at the 10% phase-in level under the risk adjustment payment methodology. The extra payment to qualifying M+C organizations for those enrollees discharged between 7/1/99 and 6/30/00, will be based on approximately one-third the full PIP-DCG-16 amount, subject to the risk adjustment transition schedule.

Assuming a payment blend of *9*0% demographic payment and *1*0% risk adjusted payment in 2002, the additional payments to qualifying M+C organizations would be based approximately on the following formula: .33 (one third of PIP-DCG 16 amount) *x* 2.4 (PIP-DCG-16 risk factor) *x* 0.*1*0 (the payment blend in 2002) of the risk adjusted county rate.

In 2003 - Payments will be made to a qualifying M+C organization for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/02, with a greater than one-day stay for a principal inpatient diagnosis of CHF, and who are enrolled in the M+CO at the beginning of each payment month in 2003. M+C organizations with enrollees hospitalized with a principal diagnosis of CHF between 7/01/01 and 6/30/02, will receive the *regular* PIP-DCG-16 amount at the 10% phase-in level under the risk adjustment payment methodology. Extra payment to qualifying M+C organizations will be for those enrollees discharged between 7/1/99 and 6/30/01, and will be based on a portion of the full PIP-DCG-16 amount.

The extra payment amount for 2003 will be determined in 2001 and announced in the January 15, 2002 "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year 2003."

100.3 - Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 2, 10-01-01)

Assistance from the Peer Review Organizations (PROs) is *available to M+C organizations for data abstraction for extra payment as long as the M+C organization is working collaboratively with the PRO on their QAPI project*. For questions regarding the requirements for this extra payment, please contact Jane Andrews *at CMS's Center for Beneficiary Choices,* Demonstrations and Data Analysis Group, (410) 786-3133.

100.4 - Implementation of 100 Percent Risk-Adjusted Payments for Qualifying Congestive Heart Failure Enrollees in 2001

(Rev. 2, 10-01-01)

BIPA §607 amends §1853(a)(3)(C) of the Act to provide for full implementation of risk adjustment for qualifying congestive heart failure enrollees for 2001. Under the BBRA, the phase-in amount for risk adjustment was 10 percent in 2001. BIPA §607 provides for 100 percent implementation of risk adjustment for each enrollee with a qualifying congestive heart failure inpatient hospital discharge diagnosis that occurred July 1, 1999 through June 30, 2000.

Each of these enrollees must be enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001 in the service area of the enrollee, for CY 2001 only. Full implementation of risk adjustment for congestive heart failure began January 1, 2001, and is excluded from the determination of the budget neutrality factor. Payments will begin in the spring of 2001, retroactive to January 1, 2001, and will end on December 31, 2001.

Previously, we had determined that M+C organizations would receive this payment only for those qualifying CHF enrollees who lived in counties where no other coordinated care plan was offered. Upon review, we are expanding eligibility for the 100 percent risk-adjusted payment in 2001 to include qualifying CHF enrollees who are enrolled in a coordinated care plan that was the only coordinated care plan, as of January 1, 2001, offered in the area where the enrollee lives. For example, consider a county that is partially served by M+CO 1 and fully served by M+CO 2. If M+CO 2 has qualifying CHF enrollees who live in the part of the county that is not served by M+CO 1 (or any other coordinated care plan) as of January 1,2001, then M+CO 2 will receive the 100% risk-adjusted payments for their qualifying CHF enrollees (for 2001 only). However, M+CO 2 will not receive this payment for their CHF enrollees who live in the part of the county also served by M+CO 1.

M+C organizations that are currently receiving this payment for their CHF enrollees will continue receiving these payments. M+C organizations that are newly eligible for the full risk-adjusted payments under this revised policy (effective July 1, 2001) will receive these payments in 2002 for all applicable enrollment periods during Calendar Year 2001, as part of the reconciliation process for 2001.

The definition of a qualifying CHF diagnosis can be found in Section 100.2.

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110 - Encounter Data Collection for the Risk Adjustment Method

(Rev. 2, 10-01-01)

This section provides an overview of encounter data used for risk adjustment of M+C payments, and also includes information on **hospital inpatient** encounter data requirements. Additional information on hospital inpatient encounter data requirements can be found in http://www.hcfa.gov/medicare/opl070.htm, which is Operational Policy Letter 1998.70. In general, information on CMS's M+C encounter data policies, methods, and training materials can be found at http://www.hcfa.gov/medicare/encountr.htm

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, *the required* filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of CMS policy related to these types of encounter data have been deleted from this release.

110.1 - Overview of Encounter Data

(Rev. 2, 10-01-01)

CMS uses encounter data to: (1) Calculate each beneficiary's risk adjustment factor; and (2) Adjust the area-specific capitation rate assigned to each beneficiary (county of residence) by the beneficiary's risk adjustment factor. This produces the amount paid the M+C organization for each beneficiary. (See §90.4.3.)

Accordingly, the BBA requires each M+C organization, as well as eligible organizations with risk-sharing contracts under §1876 of the Act, to submit to CMS, in accordance with CMS instructions, all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Requirements concerning collection of encounter data apply to M+C organizations with respect to all their M+C plans, including private fee-for-service plans, with the exception of certain demonstration projects discussed in §90.5.

To the extent required by CMS, encounter data must account for services covered under the original Medicare program, for Medicare covered services for which Medicare is not the primary payer, or for other additional or supplemental benefits that the organization must provide.

M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate encounter data that conforms to the format used under original Medicare. These provisions may include financial penalties, including withholding payment, for failure to submit complete and accurate data, or for failure to submit data that conform to the requirements for submission.

Upon enrollment, M+C organizations may obtain permission from the beneficiary to have access to past medical records of their enrollees. However, diagnostic information cannot be passed from CMS to the M+C organizations because of privacy concerns.

NOTE: The policy discussed in §110.2 is current; however, CMS is conducting a review of policy pertaining to certification

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110.3 - Validation of Data

(Rev. 2, 10-01-01)

M+C organizations and their providers are required to submit medical records for validating encounter data, as prescribed by CMS. Medical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information. Independent contractors will conduct the reviews.

110.4 - Hospital Inpatient Encounter Data Requirements

(Rev. 2, 10-01-01)

As discussed in §70, the timing of encounter data collection set forth in the BBA signaled to CMS that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made, beginning January 1, 2000. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year.

The hospital inpatient encounter data requirements entail submission of data for discharges from inpatient hospitals, including facilities reimbursed under the prospective payment system (PPS), long stay hospitals, psychiatric and rehabilitation hospitals, and psychiatric/rehabilitation distinct parts of hospitals. Encounter data are not currently required for discharges from skilled nursing facilities (SNFs).

NOTE: In order to participate as a Medicare provider, a hospital must meet certain conditions specified in the Medicare regulations at 42 CFR 482.12. Generally, these conditions pertain to issues such as compliance with applicable Federal, State, and local laws, make-up of the medical staff, and quality assurance plans.

All discharges reflecting inpatient stays should be submitted. If a patient moves from a one-day hospital stay to a swing bed or skilled nursing facility bed, then this is simply a one-day stay (see §90.2.1). If the patient is transferred to a rehabilitation facility, then the diagnoses from the rehabilitation facility stay may be used to determine the risk adjustment payment.

Contracted and Non-contracted Facilities - The M+C organization must ensure that CMS receives a record of each hospital discharge for each managed care enrollee, regardless of whether the hospital is a contracted or non-contracted facility. M+C organizations may need to modify their contracts with hospitals to ensure that all managed care discharges are identified.

Coding Guidance - The records that M+C organizations submit should reflect the original diagnosis that the provider submitted to the M+C organization. M+C organizations should not modify, supplement, or re-sequence diagnosis codes received from hospitals.

Encounter data should be substantiated by the hospital's medical record. If the M+C organization receives a record from a provider that contains an incorrect code in a critical field (i.e., diagnosis code, procedure code, admission date or discharge date), the organization must make sure that its database matches and supports the provider's database for these fields. Thus, it is recommended that the M+C organization return the record to the provider for correction and resubmission. For other items on the record, the M+C organization may use its own databases to fill in or correct these items.

Secondary Diagnoses - If an M+C organization does not report secondary diagnoses, it may not receive the payment to which it is entitled. Generally, the PIP-DCG model uses only the principal diagnosis to assign a beneficiary to a PIP-DCG category. However, there are two exceptions (see §90.2.2). For beneficiaries with a principal diagnosis related to chemotherapy (ICD-9 codes V58.1 and V66.2), the PIP-DCG category is assigned based on the type of cancer,

using a secondary diagnosis. Also, all beneficiaries with a secondary diagnosis of AIDS will be placed in the same PIP-DCG category as those with a principal diagnosis of AIDS. M+C organizations should assure that they obtain all diagnostic information from their providers and submit all diagnoses to the Customer Service and Support Contractor (CSSC).

110.5 - Data Formats and Processing

(Rev. 2, 10-01-01)

A record of each enrollee discharge should be submitted, from contracted as well as non-contracted hospitals. M+C organizations may submit to CMS electronic records using either a complete or abbreviated UB-92 format. M+C organizations may also submit using a Medicare Part A ANSI ASC X12 837 format, also called the "ANSI 837.

Abbreviated UB-92 Version 6.0 format - To indicate that the format being submitted is abbreviated, the "Z" code must be included in the third digit of "Type of bill." The abbreviated UB-92 will not be discontinued. Version 6.0 has been approved by CMS for submission of inpatient encounter data. M+C organizations could begin using Version 6.0 effective August 1, 2000 to submit data to their current FI. All M+C organizations are required to transition from Version 5.0 to Version 6.0 for submissions after December 31, 2000.

110.6 - Deadlines for Submission of Encounter Data

(Rev. 2, 10-01-01)

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, *the required* filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of policy related to these types of encounter data have been deleted from this release.

The BBA requires that M+C organizations submit data regarding inpatient hospital services for all enrollee discharges that occur on or after July 1, 1997. Table 3 presents the submission schedule.

TABLE 3. Submission Deadlines for Hospital Inpatient Encounter Data

Data Collection Year (Service Dates)	*Payment Year (CY)*	*Deadline for Submission**	*Late Encounter Data Deadline***
July 1, 1997 – June 30, 1998	*start-up year; not used for payment*	*NA*	*NA*
July 1, 1998 – June 30, 1999	*2000*	*Sept. 10, 1999*	*Sept. 30, 2000*
July 1, 1999 – June 30, 2000	*2001*	*Sept. 8, 2000*	*Dec. 31, 2001****
July 1, 2000 - June 30, 2001	*2002*	*Sept. 7, 2001*	*Sept. 30, 2002*
July 1, 2001 - June 30, 2002	*2003*	*Sept. 6, 2002*	*Sept. 30, 2003*
July 1, 2002 - June 30, 2003	*2004*	*Sept. 5, 2003*	*Sept. 30, 2004*
July 1, 2003 - June 30, 2004	*2005*	*Sept. 3, 2004*	*Sept. 30, 2005*

** Any data received by CMS after September 30 will be processed as late encounter data.*
*** Data used for reconciliation; also see Section 21 on the reconciliation process.*
****Extended 3 months.*

Risk adjustment factors for each payment year are based on encounter data submitted for services furnished during the 12-month period ending 6 months before to the payment year. (For example, risk adjustment factors for CY 2000 were based on data for services furnished during the period July 1, 1998 through June 30, 1999).

Reconciliation of Payments - Monthly payments during a payment year are based on the encounter data received by CMS by the annual deadlines for the data collection periods listed in Table 3. CMS conducts a reconciliation process to take into account late encounter data submissions, so that total payment for a year will reflect these late submissions. Under the reconciliation process, the deadline for submission of all data for a payment year will be September 30 of that payment year for the period ending the previous June 30. For example, data for CY 2001 payments consists of encounters that occurred between July 1, 1999 to June 30, 2000. The final deadline for late submission of encounter data used to calculate risk factors for CY 2001 payments is September 30, 2001.

See §210 for further detail on reconciliation.

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120 - Announcement of Annual Capitation Rates and Methodology Changes

(Rev. 2, 10-01-01)

By January 15 of each year, CMS notifies M+C organizations of any proposed changes to the payment methodology and publishes the preliminary estimates of the national growth rate. M+C organizations have 15 days to comment on the proposed changes. CMS accepts comments through January 31.

By March 1 of each year, CMS releases the annual announcements of the payment rates for the following calendar year. This announcement must include the final county rates, a description of the risk and other factors, and other information necessary to ensure that M+C organizations can calculate the monthly-adjusted capitation rates for individuals in each of their payment areas.

170.2 - Residency Requirements

(Rev. 2, 10-01-01)

A Medicare enrollee must have been a resident of one or more of the above certified institutions for a minimum of 30 consecutive days, which includes, as the 30th day, the last day of the month prior to the month for which the higher institutional rate is paid. This qualifying period of residency must be satisfied each month in order for the M+C organization to be paid at the higher institutional rate.

The term "calendar month" cannot be used. A calendar month can have 28 to 31 days and thus cannot be substituted for 30 days. For example, in a month with 31 days, a beneficiary would have to be institutionalized from the 2nd - 31st day of the month to meet the requirements for reporting institutionalized status.

Temporary Absences - CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, if the member returns to a certified institution, or distinct part of an institution. Temporary absences (less than 15 days) for medical necessity will be counted toward the 30-day requirement.

NOTE "Therapeutic" means requested or supported by a physician; site of service is irrelevant.

170.3 - Payment for Institutional Status

(Rev. 2, 10-01-01)

CMS determines whether an M+C organization should be paid at the institutional rate for an enrollee by asking two questions:

- *Did the enrollee fulfill the 30-day residency requirement in a certified institution (where the 30th day is the last day of the month)?*
- *Is the M+CO entitled to payment based on this qualifying residency?*

Conceptually, the institutional payment is prospective. Generally, for example, when an enrollee satisfies the residency requirement in April, the M+C organization is entitled to an institutional payment in May. In practice, however, the payment mechanism is retroactive. Given the residency requirement, where the 30th day must be the last day of the month, our payment system could not receive and process monthly status information in time to use a prospective payment mechanism. As a result, CMS makes a retroactive payment adjustment two months after the month when an enrollee satisfies the residency requirement. For example, when an enrollee satisfies the residency requirement in April, the June 1 capitation payment for this enrollee is adjusted to bring the May 1 payment retroactively up to the full amount owed the M+C organization in May because of the enrollee's qualifying residency.

Death or discharge on the last day of the month. If an M+C enrollee is discharged or dies on the last day of the month (and this is the 30th consecutive day of residency in a certified institution), then the beneficiary has satisfied the residency requirement.

Original Medicare does not count the day of discharge towards residency requirements. However, capitated payments made to M+C organizations are not for units of service or treatment, as in original Medicare. Under the M+C program, institutional status is a proxy for health status, not a unit of service. In this context, it is appropriate to count the day of discharge toward the residency requirement.

The next step is to determine whether the M+C organization is entitled to a prospective payment at the institutional rate for the qualifying residency. The M+C plan elected by the beneficiary for the month subsequent to the qualifying period of residency is entitled to receive the institutional payment amount. This is not necessarily the same M+C plan elected by the beneficiary while a resident of the institution. For example (assuming the beneficiary has satisfied the residency requirement):

- *If the beneficiary is discharged on the last day of the month of the qualifying period of residency and the beneficiary is enrolled in the same plan on the first day of the subsequent month, payment would be made to that plan.*

- *If the beneficiary is discharged on the last day of the month of the qualifying period of residency and the beneficiary is enrolled in a new plan on the first day of the subsequent month, payment would be made to the new plan.*

- *However, if the beneficiary dies on the last day of the qualifying period of residency, that beneficiary would not be enrolled in any plan on the first day of the subsequent month. Therefore, payment would not be made to any M+C plan.*

Payment examples. Below are examples clarifying when M+C organizations are entitled to payment at the institutional status rate.

1. On March 2, a member of an M+C organization enters a certified institution. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residency requirement (March 2 through March 31) and has remained in the same plan for the subsequent month. The M+C organization is paid the institutional rate for the month of April through a retroactive adjustment to the capitated payment for May.

2. Mr. X, whose M+C enrollment is effective April 1, enters a certified institution on April 15 and remains there continuously until his discharge on May 25. He does not meet the criteria for reporting institutionalized status for May or June. Although he was institutionalized for at least 30 consecutive days, in both April and May his residency was less than 30 days, and in May his residency did not include the last day of the month as the 30th day. His stay would have had to continue through May 31 in order to be reported for an institutional payment for the month of June. If Mr. X had been discharged on May 31, his M+C organization would be entitled to payment at the institutional rate in June.

3. Ms. Y, whose M+C enrollment is effective April 1, enters a certified institution on February 28 and remains there continuously until her discharge on April 25. She does meet the qualifying period of residency for reporting institutionalized status for April (March 2 through March 31) but not for May. The qualifying period of residency for a payment in May at the institutional rate is April 1 through April 30. Note that Ms. Y was not a member of the M+C organization during the qualifying period of residency (March 2 through March 31). It is not required that Ms. Y be a member of the M+C organization during the qualifying period of residency. Thus, the M+C organization in which she is enrolled on April 1 is paid the institutional rate in April for her qualifying period of residency in March. The M+C organization would not be paid the institutional rate for the month of May because the qualifying period of residency (April 1 through April 30) was not satisfied.

180.1 - Previously Unserved Payment Area

(Rev. 2, 10-01-01)

The BBRA defined a previously unserved payment area as:

- A payment area in which an M+C plan had not been offered since 1997; or

- A payment area in which an M+C plan had been offered since 1997, but in which every M+C organization offering an M+C plan in that payment area since then has notified CMS (no later than October 13, 1999) that it would no longer offer M+C plans in that payment area as of January 1, 2000.

BIPA §608 extended by 1 year *(to January 31, 2001)* the time period during which an area must have had no M+C plan(s) offered in order for that area to be eligible for the bonus. The BIPA mandates that a payment area now will be considered unserved for purposes of bonus payments if:

- An M+C plan (or plans) had been offered since 1997; and

- Every M+C organization offering an M+C plan in that payment area then notified CMS no later than October 3, 2000 that it would no longer offer M+C plans in that payment area as of January 1, 2001.

The effect of this section of the BIPA was to include additional payment areas in the definition of previously unserved payment areas.

M+C organizations entering a payment area that is a county which is partially unserved are not eligible for a New Entry Bonus. CMS does not have that discretion under the law. The statute refers to a payment area, and most payment areas are counties. Therefore, if a plan already is offered in part of a county, any M+C organization offering a plan in that county could not be considered entering a previously unserved payment area since there is already a plan serving that county.

NOTE: A payment area that has §1876 cost plans only, but no M+C plans, would be considered a "previously unserved payment area," justifying the bonus payment.

180.3 - Eligibility for Bonus Payment - The Period of Application

(Rev. 2, 10-01-01)

The BBRA specified that the new entry bonus would only apply to M+C plans that are first offered during the period of application, which is the period beginning January 1, 2000 and ending on December 31, 2001. This period of application is a 2-year window during which an M+C organization that enters a previously unserved payment area and offers the first M+C plan in that area, will be eligible for bonus payments.

Note that although the BIPA changed the time period defining a previously unserved payment area, it did not change the time period defining the period of application. The result of this change is that now the time periods defining “previously unserved” payment area and “period of application” are the same: from January 1, 2000 through December 31, 2001. (The BIPA amendment applies as if it were included in the enactment of the BBRA.) Table 1 shows a comparison of the two different time periods in effect for the new entry bonus.

Table 4 - Comparison of BBRA and BIPA Provisions on New Entry Bonus

Provision	BBRA	BIPA
Time period defining a previously unserved payment area	*By* January 1, 2000	*By January 1, 2000 or by January 1, 2001*
Period of application (the window for M+C organizations to first offer an M+C plan in an unserved area)	January 1, 2000 through December 31, 2001	January 1, 2000 through December 31, 2001

We discussed the BIPA amendment to the new entry bonus in the January 12, 2001 "Advance Notice of Methodological Changes for Calendar Year 2002 Medicare+Choice Payment Rates", published on our website at http://www.hcfa.gov/stats/hmorates/cover01, and in the March 1, 2001 "Announcement of Calendar Year 2002 Medicare+Choice Payment Rates". In the March 1 announcement, we indicated that the 1-year extension in the time period defining an unserved area mandated by the BIPA also applied to the 2-year period of application. In effect, this would extend the end of the period of application window from December 31, 2001 to December 31, 2002. As a result, we stated that an M+C organization first offering a plan in a previously unserved payment area on January 1, 2002, would be eligible for the bonus payments.

After further analysis, we have determined that while the BIPA did expand the time period used to define a previously unserved payment area, it did not extend the period of application window during which an M+C organization must first offer a plan in a previously unserved area. The period of application remains January 1, 2000 through December 31, 2001. For example, an M+C organization that first offers a plan in a previously unserved payment area on January 1, 2002 would not be eligible for the new entry bonus payments. However, if the M+C organization first offers a plan in a previously unserved payment area prior to January 1, 2002, then the M+C organization would have first offered an M+C plan within the period of application and the organization would be eligible for new entry bonus payments.

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210 - Reconciliation Process for Changes in Risk Adjustment Factors

(Rev. 2, 10-01-01)

Unlike the demographic-only method, the risk adjustment method generates a beneficiary-specific factor that is effective for a calendar year. This annual risk factor is used to adjust county per capita payment rates to determine per enrollee M+C payment amounts, and is based on the following classes of information:

- Age;
- Gender;
- Medicaid Status;
- Disability Status (“previously disabled”); and
- *I*npatient diagnoses (PIP-DCGs).

Adjustments to beneficiary risk factors due to corrections in the statuses listed above will not occur during the payment year. This includes encounter data submitted for Part B-only members. Making corrections to beneficiaries' statuses and processing the resulting payment adjustments are accomplished through a reconciliation process that occurs after the end of the payment year.

NOTE: There is no adjustment for institutional status under the risk adjustment methodology as it has been accounted for in the development of the risk adjustment factors.

Changes in beneficiary status that do not impact the risk adjustment factor are processed concurrently during the payment year. They are:

- Enrollment/disenrollment dates;
- Part A/B entitlement;
- State and county codes; and
- Working aged status;

CMS has separate reconciliation processes for hospice (§220) ESRD (§230). (M+C enrollees who are capitated at the ESRD and hospice rates are excluded from payment under the risk adjustment method; they are capitated at the applicable demographic-only rate.)

210.1 - Reconciliation Schedule and Late Submission of Encounter Data

(Rev. 2, 10-01-01)

Each year, M+C organizations have approximately three months after the end of the data collection year (June 30) to submit encounter data that is used to develop beneficiary risk factors (see Table 3). If organizations submit encounter data after this annual deadline, it cannot be incorporated into calculations of the beneficiary risk scores for the upcoming payment year. However, M+C organizations should continue submitting encounter data after this deadline because CMS has instituted a reconciliation process that takes into account late encounter data submissions.

Under the reconciliation process for risk adjustment, the deadline for submission of all *late* encounter data for a payment year will be September 30 of that payment year for the encounter data collection period ending the previous June 30. *(See Table 3 in Section 110.6 for these deadlines. Notes that the deadline for CY 2001 was extended.)* Encounter data submitted for Part B-only members also will be included

Reconciliation will occur in the first six months of each year until CMS systems have the capacity to conduct concurrent processing of all updates in beneficiary status that affect the risk adjustment factors. For example, CY 2000 ha*d* a September 30, 2000 cut-off date for submission of late encounter data - for discharges between July 1, 1998 and June 30, 1999. Recalculation of CY 2000 risk adjustment factors and processing of the resulting reconciled payment adjustments occur*red* during the first six months of CY 2001.

Exhibit 6 - Quality Indicators For Extra Payment In Recognition Of The Costs Of Successful Outpatient Treatment of CHF.

September 2001 release: clarifies specifications for quality indicators using material posted 5/16/2001 at http://www.hcfa.gov/medicare/hfqixpay.htm

DATA SOURCES

Any reviewable data source may be used to obtain the requisite information.

POPULATION/SAMPLING FRAME

Inclusion criteria:
Greater than 1-day stay for a principal inpatient discharge diagnosis of heart failure (ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x) during the following time periods:

- *For reporting on October 1, 2001, discharged July 1, 1999 through June 30, 2001;*
- *For reporting on October 1, 2002, discharged July 1, 1999 through June 30, 2002.*

AND
Continuously enrolled for at least 180 days prior to and including date of reporting (October 1).

Exclusion criteria:
Any documentation during the 12 months prior to and including the date of reporting suggesting chronic renal dialysis, including any bill/encounter record/discharge record with one or more of the following codes: ICD-9-CM diagnosis codes V56.0, V56.8; ICD-9-CM procedure codes 39.95, 54.98; CPT codes 90935, 90937, 90940, 90945, 90947, 90989, 90993.

Quality Indicator EP 1: Proportion of eligible population who has evaluation of left ventricular function as of date of reporting.

Denominator: *Entire population meeting inclusion and exclusion criteria. If this number is greater than 400, then the M+CO may select a random sample of no fewer than 400.*

Numerator: *Those in denominator with documentation of left ventricular function (LVF) evaluation anytime on or before October 1 of reporting year.*

Notes: Billing codes likely to represent LVF assessment include: ICD-9-CM code - 88.72; CPT codes - 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350.

Billing codes, which may possibly represent LVF assessment tests: ICD-9-CM codes - 88.5x, 92.05; CPT code - 78414.

LVF may be presumed to be previously assessed if one or more of the following is present anytime before the date of reporting:

- *Report from one of the following diagnostic tests: echocardiogram (echo), MUGA scan, or cardiac catheterization - left ventriculogram (LV gram),* ***OR***
- *Physician/nurse practitioner/physician assistant reference to one of the above diagnostic tests,* ***OR***
- *Physician/nurse practitioner/physician assistant notation of LVF, either as an ejection fraction (EF) or a narrative description, without reference to an actual assessment test. Example - "known systolic dysfunction"*

Quality Indicator EP 2: Proportion of eligible population with left ventricular systolic dysfunction (LVSD) who:

- *are prescribed angiotensin converting enzyme inhibitors (ACEI);* ***OR***
- *have documented reason for not being prescribed ACEI*

Denominator: *Those in numerator of Quality Indicator EP 1 with ejection fraction less than 40%, or equivalent narrative description (see note)*

Numerator: *Those in denominator who have:*

- *Been prescribed ACEI at any time in the 12 months prior to the date of reporting;* ***OR***
- *Any documentation of aortic stenosis or any coded diagnosis of aortic stenosis (395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22) anytime before the date of reporting;* ***OR***
- *Any documentation of bilateral renal artery stenosis or any coded diagnosis of renal artery stenosis (ICD-9-CM code 440.1) anytime before the date of reporting;* ***OR***
- *Any documented history of angioedema, hives, or severe rash with ACEI use anytime before the date of reporting;* ***OR***
- *Serum potassium >5.5 mg/dL on three or more occasions in the 12 months prior to the date of reporting (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit);* ***OR***
- *Serum creatinine >3.0 mg/dL on three or more occasions in the 12 months prior to the date of reporting (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit);* ***OR***
- *Systolic blood pressure less than 80 mm Hg on three or more occasions in the 12 months prior to the date of reporting (excluding blood pressures measured during an acute care admission, an observation unit stay, or an emergency room visit).* ***OR***
- *Any documentation of any specific reason why ACEI not used (e.g., cough, hyperkalemia, hypotension, renal insufficiency/failure, other physician-noted reason) anytime before the date of reporting;* ***OR***

- *Chart documentation of participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy in the 12 months prior to the date of reporting.*

Note: Narrative descriptions from diagnostic test reports or physician/nurse practitioner/physician assistant notes that SHOULD be considered equivalent to an ejection fraction less than 40% include the following:

- *contractility described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*
- *ejection fraction (EF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*
- *hypokinesis described as diffuse, generalized, or global;*
- *left ventricular dysfunction (LVD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified;*
- *left ventricular ejection fraction (LVEF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*
- *left ventricular function (LVF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*
- *left ventricular systolic dysfunction (LVSD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified;*
- *systolic function described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*
- *history or finding of moderate/severe left ventricular systolic dysfunction (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of."*

Narrative descriptions from diagnostic test reports or physician/nurse practitioner/physician assistant notes that SHOULD NOT be considered equivalent to an ejection fraction less than 40% include the following: history or finding of moderate/severe left ventricular systolic dysfunction (or any of the other LVSD inclusive terms above) described as "possible" or "questionable."

These narrative descriptions may not represent the universe of possible narrative descriptions. Therefore, if you have other narrative descriptions that you believe meet the LVSD definition and are defensible, then you may use them.