BlueCross BlueShield of Alabama

Complete Picture of Health
Documentation and Coding Improvement Initiative

What is Risk Adjustment?

Risk adjustment models organize diagnosis codes, and sometimes prescription drug claims, into discrete categories to show the overall health status of the patient.

For various reasons, it is critical that Blue Cross and Blue Shield of Alabama receive complete and accurate coding data to properly indicate our members' health status.

Accurate and specific claims data helps Blue Cross better understand the overall health of the Plan membership. Currently, the Centers for Medicare & Medicaid Services (CMS) and health plans, such as Blue Cross, utilize member risk scores for various purposes. For example, member risk scores allow Blue Cross to target members that are more complex and assist them in navigating the healthcare system to find the most appropriate care.

In order for Blue Cross to maintain competitive premium rates, it is critical that accurate and specific coding is received in order to reflect the actual health complexity of the patient population. In 2014, each health plan shared premium revenue with other health plans in the market based on the relative complexity of its members. Some plans will receive funds and others will make payments. The goal of the exchange payment model is to offset adverse selection in the marketplace.

Why the details really matter...

Specificity of Coding

Providing specific codes on encounters allows Blue Cross to identify members who may benefit from disease and medical management programs. Coding conditions in addition to signs and symptoms provides a complete picture of a member's health, which aids in planning, analyzing and designing programs to manage chronic conditions.

Important Points to Remember

Specificity of coding conveys accuracy of health status (complexity) on patients.

Under the current Medicare and commercial model, member health status is calculated for each calendar year.

- **All diagnoses reset on December 31. Chronic conditions must be re-evaluated, documented and submitted by the Plan every year.**
- Chronic conditions that are being medically managed should be reported, even if they are not the principal reason for the patient's visit that day.
- Documentation for current chronic condition should be included in the medical record assessment and J13 plan section.

Example: 68-year-old man with pneumonia, emphysema, diabetes with retinopathy, and respiratory failure.

This data represents an example of a relative risk score calculation.

ICD-10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
J43.9: Other emphysema	0.346
E13.39: Diabetes with ophthalmic manifestations	0.368
J96.00: Acute respiratory failure	0.329
Demographic Component	
68-Year-Old Male	0.288
Relative Risk Score	**1.531**

If this member's risk score is 1.531, he is 53 percent more complex than the average patient.

ICD-10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
~~J43.9: Other emphysema~~	~~0.346~~
E11.9: Diabetes mellitus without mention of complication	0.118
J96.00: Acute respiratory failure	0.329
Demographic Component	
68-Year-Old Male	0.288
Relative Risk Score	**0.935**

One missing diagnosis code and one unspecified code reduces the relative risk score by 61 percent!

Importance of ICD-10-CM Diagnosis Coding

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is the official diagnosis code set for Medicare Advantage and ACA members, and is used as a key indicator to adjust risk.

- Appropriate coding requires use of the most specific code available for the member's condition, including any additional diagnoses.
- Medical record documentation dictates what code is assigned to the member's claim.
- On the claim, include the ICD-10-CM code of every diagnosis that was assessed, treated or considered in the medical decision making for that encounter.

OLD Approach

- File only diagnosis codes specific to the main reason for the episode of care.
- File up to four diagnosis codes.
- File only the minimum data necessary for payment.

NEW Approach

- **File professional services coded accurately and completely to reflect a patient's health status, which includes:**
  - ✓ The main reason for the episode of care
  - ✓ All co-existing, acute or chronic conditions
  - ✓ Past conditions impacting clinical evaluation and therapeutic treatment
- **File up to 12 diagnosis codes.**
- **File diagnosis codes that are specific up to the 7th digit.**

Did you know?

We can receive up to 12 diagnosis codes on a professional electronic claim, and 24 diagnosis codes on facility claims.

- Over 55% of Medicare Advantage members have a chronic condition.
- Less than 30 percent of claims contain 5 or more diagnosis codes.
- Over 30 percent of Medicare beneficiaries have 3 or more chronic conditions.

Blue Cross Coding Guidelines

A physician's ability to document all conditions related to the member's health is key in obtaining a complete picture of a member's health status. Documentation should be consistent in a member's medical record, chart and claims.

It is important for the physician's office to fully code each encounter. The claim should report the ICD-10-CM code of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed or have material impact on the health status of the patient.

Contributory (co-morbid) conditions should be reported if they impact the care and are addressed at the visit. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses that were addressed were reported.

As a result, we allow up to 12 diagnosis codes to be filed on electronic claims. These diagnosis codes can represent current, chronic and acute conditions for the member.

Data Validation

Data validation helps ensure the integrity and accuracy of a member's health status. It is the process of verifying that the diagnosis codes submitted are supported by the medical record documentation for a member.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities. Medical record documentation may be requested by Blue Cross to ensure coding is complete and accurate.

Blue Cross and Blue Shield of Alabama is dedicated to working with our providers to continuously improve the quality of our partnership.

BlueCross BlueShield of Alabama

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