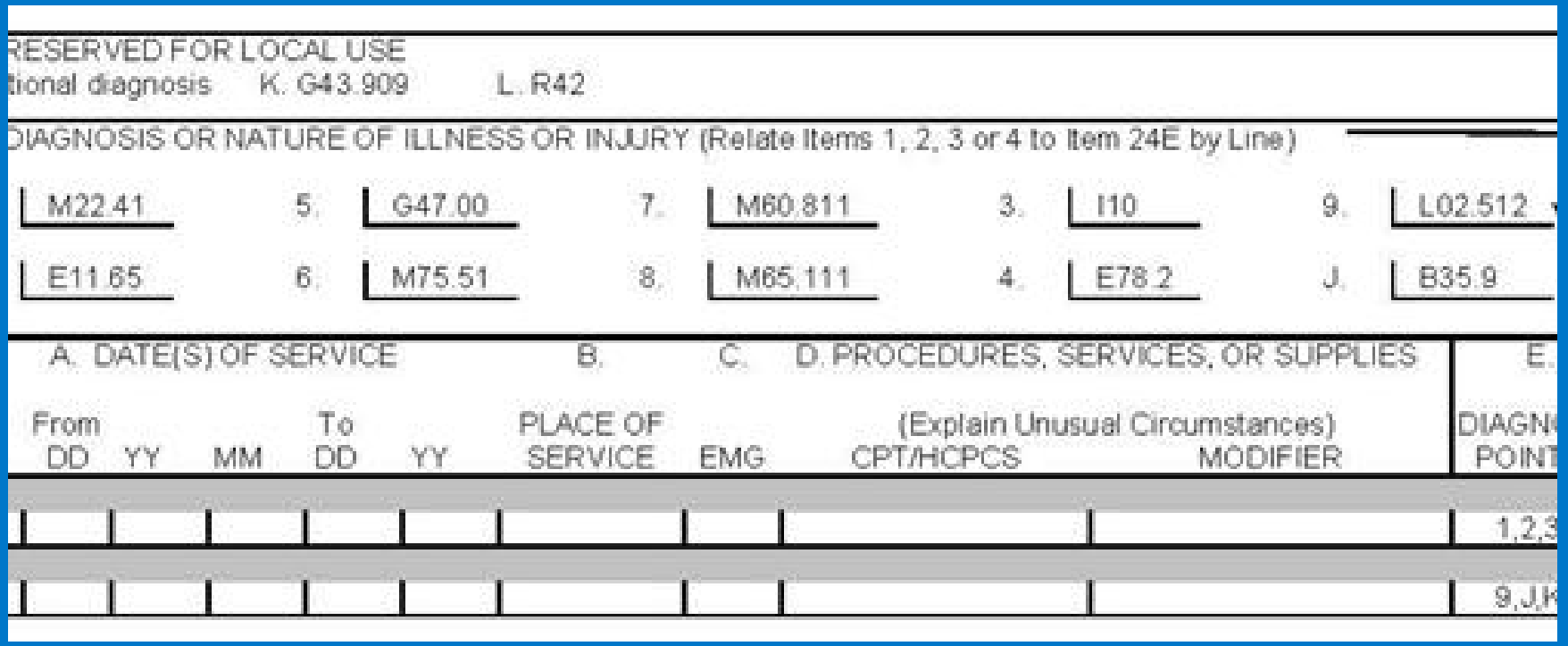

RESERVED FOR LOCAL USE
tional diagnosis K. G43.909 L. R42

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| M22.41 | 5. | G47.00 | 7. | M60.811 | 3. | I10 | 9. | L02.512 |
| E11.65 | 6. | M75.51 | 8. | M65.111 | 4. | E78.2 | J. | B35.9 |

| A. DATE(S) OF SERVICE | | | | | B. | C. | D. PROCEDURES, SERVICES, OR SUPPLIES | | E. |
|---|---|---|---|---|---|---|---|---|---|
| From DD | YY | MM | To DD | YY | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | DIAGN POINT |
| | | | | | | | | | 1,2,3 |
| | | | | | | | | | 9,J,K |

# GETTING ALL ICD-10-CM DIAGNOSES ON THE CLAIM

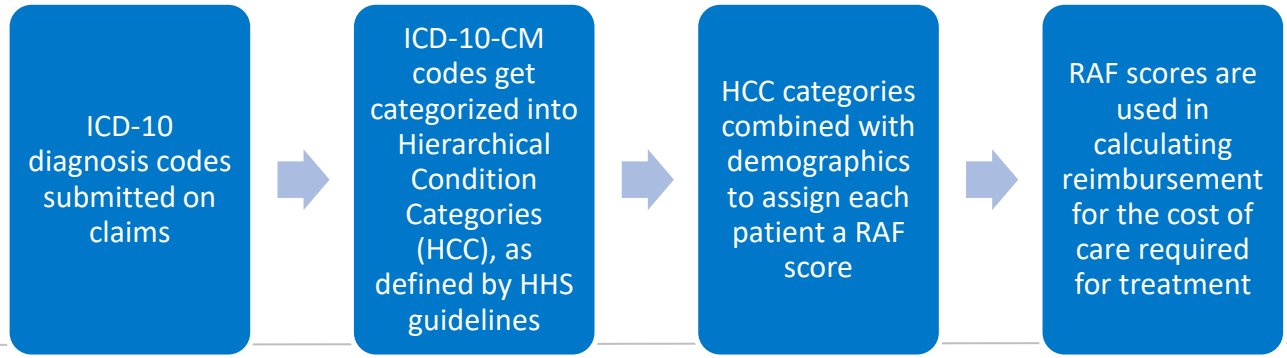
# AGENDA

- What is Qualified Health Plan (QHP)  Risk Adjustment?
- Calculating a Risk Adjustment Factor (RAF)  score
- Industry standard documentation and coding best practices
- The importance of getting all ICD-10-CM diagnoses on the claims
- Prospective vs Retrospective

# QUALIFIED HEALTH PLAN RISK ADJUSTMENT

- Risk adjustment is a methodology designed to determine the overall health status of certain populations.
  - QHP risk adjustment is required and regulated by the Department of Health and Human Services (HHS) using the Centers for Medicare and Medicaid Services (CMS) guidelines and standards.
  - This approach helps ensure that Qualified Health Plans (QHP) are funded appropriately for the burden of illness that the QHP population presents.
  - A patients' health status is measured by assigning a Risk Adjustment Factor (RAF) score based on the demographics and diagnosis[1] codes submitted by healthcare providers.

- Qualified Health Plans originated from the Affordable Care Act (ACA)
  - Individuals and small groups who have purchased a QHP through Vermont Health Connect aka Vermont Marketplace OR directly from Blue Cross and Blue Shield of Vermont (Blue Cross VT)
  - Provides essential health benefits associated with a metal level (platinum, gold, silver, bronze or catastrophic)
  - Individuals can select a Primary Care Provider when selecting a QHP
  - Covers individuals from birth to age 65






1 – Some CPT and HCPCSII codes are also used

# CALCULATING THE RAF SCORE

**Demographic Characteristics**
Factors such as age, sex, disability status, original entitlement reason, Medicaid eligibility, plan metal level

+

**Health Status**
Diagnoses/conditions, included in the appropriate risk adjustment model

= **RAF Score**

Higher RAF scores represent individuals with a greater than average burden of illness.

Lower RAF scores reveal a healthier population, but may falsely represent a group due to:

- Inadequate or incomplete documentation and coding
  - Ex. Chronic condition diagnoses not added on a claim
  - Lack of specificity in documentation/coding
- Patient not seen annually by provider

# CLINICAL DOCUMENTATION IS THE CATALYST FOR CODING, BILLING, AND RISK ADJUSTMENT

- **Each year, on January 1st, the RAF scores of patients are reset by HHS and CMS, reflecting only demographic factors at that point. It is crucial to assess, document, code and bill for all chronic/complex conditions annually.**

- Provider documentation and subsequent coding is used to capture the overall health status of a patient and calculate the healthcare costs.
  - The more complete and accurate the documentation, the more specific and thorough the coding and billing processes can be
  - It provides the providers and payor the most accurate picture as to what health challenges patients are facing and what treatment plans are already in place

# INDUSTRY STANDARD DOCUMENTATION BEST PRACTICES

**"If it isn't documented, it doesn't exist"**

- Assess chronic/complex conditions at least annually during a face-to-face encounter or video telehealth visit
- Keep the problem list and medication list up to date
  - Ensure the status of each condition is accurate (such as acute, chronic, resolved or history of)
- Document and code all diagnoses that impact the decision-making, care and treatment of each encounter
- Document and code to the highest level of specificity – avoid default or unspecified ICD-10-CM codes

# PROVIDER GROUP IMPLICATIONS

## BEST PRACTICES DOCUMENTATION IS THE FOUNDATION FOR ERROR-FREE CODING AND BILLING

**Step 1**

- Document each patient's demographic information and clinical information in the medical record.
- Use the best practices for documentation accuracy.

**Step 2**

- HHS and CMS use claim data and patient demographic information to calculate a patient's risk score (RAF score).
- Complete medical record documentation and submission of all appropriate diagnosis codes.
- Coding to the highest level of specificity.

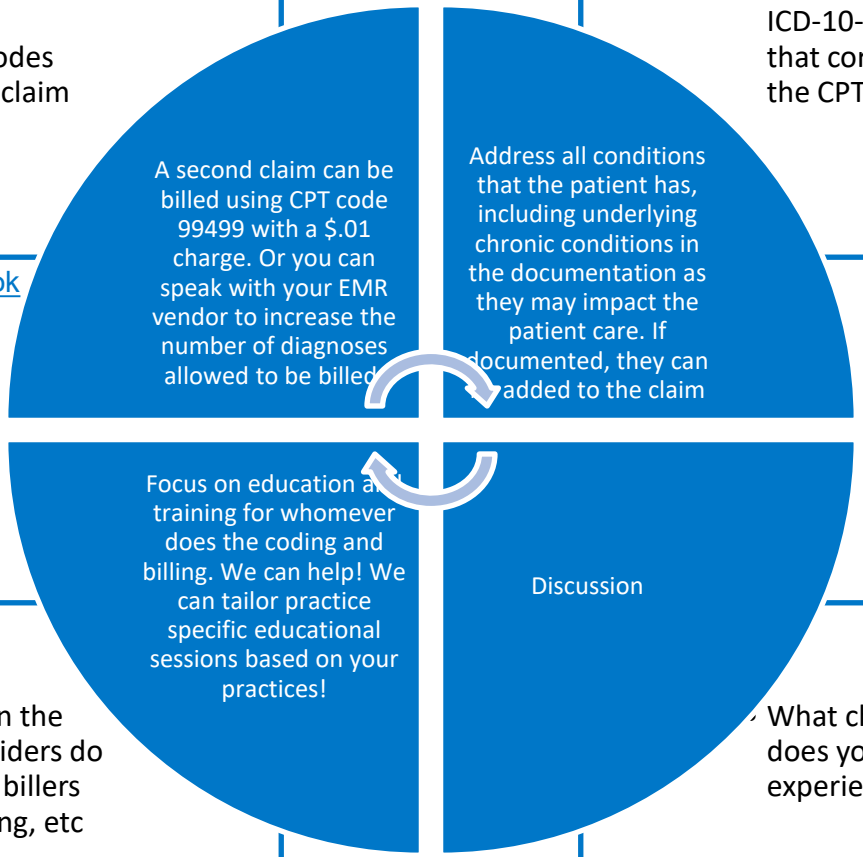
**Step 3**

- HHS and CMS review and validate risk scores through data validation audits.
- If coding is accurate and complete, provider practices are minimally disrupted, allowing greater focus on patient care and other practice aspects.
- If coding is inaccurate or incomplete, there is a higher likelihood of requests for medical records due to HHS requirements for documentation to support accurate risk score submission by insurers. More medical record requests, by HHS or a plan, means higher practice disruption, and cost inaccuracies in coding, once known, do require correction.

# CHALLENGES OF GETTING CODES ON CLAIM

- Limited amount of ICD-10-CM diagnosis codes allowed on claim

- We can only submit ICD-10-CM codes that correlate with the CPT code




[BlueCross VT 2026 Provider Handbook]

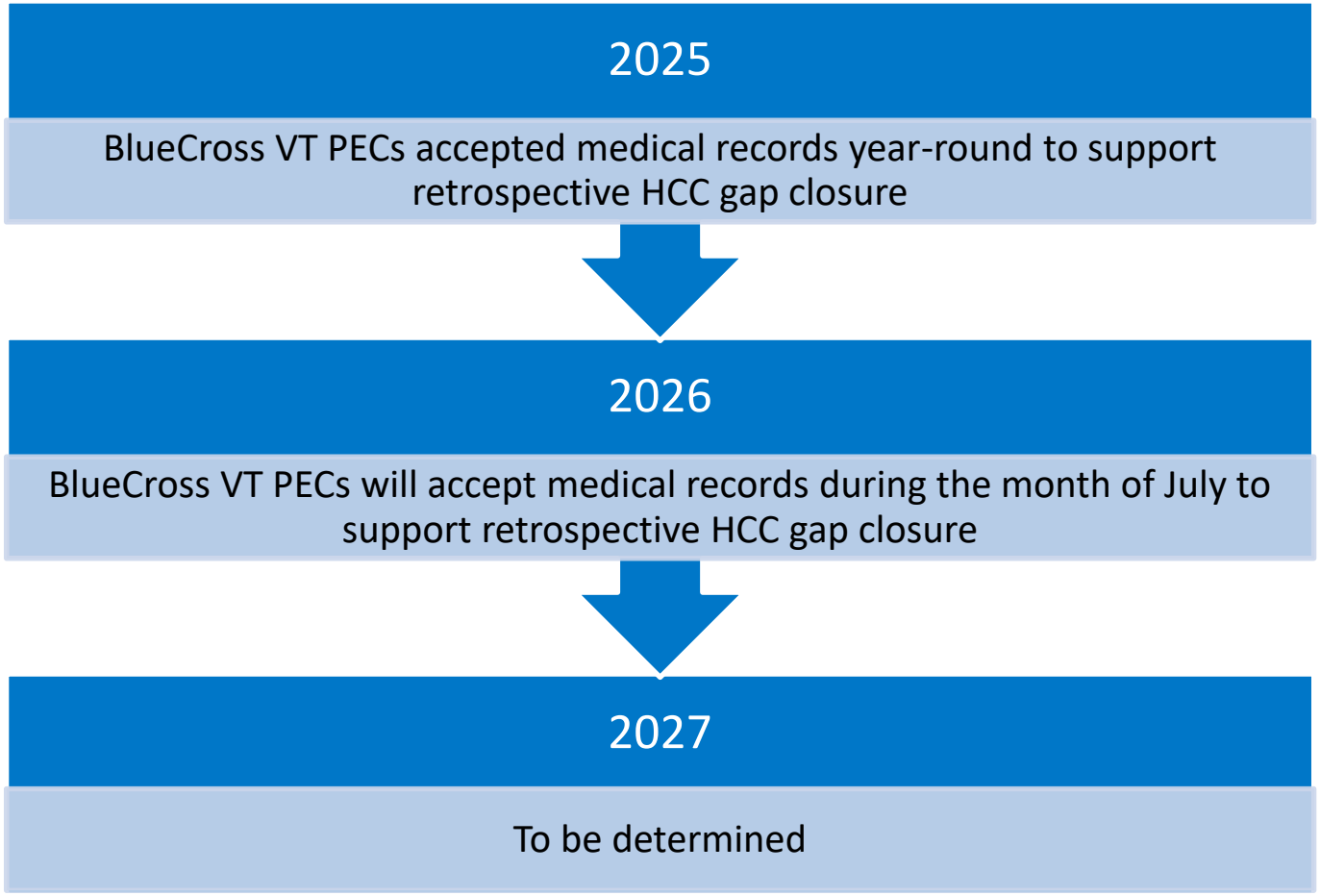
- No coders in the office- providers do the coding, billers do the coding, etc

- What challenges does your practice experience?

# PROSPECTIVE VS RETROSPECTIVE APPROACH

| Prospective -Actionable | Retrospective - Reactive |
|---|---|
| Allows for conditions to be addressed during the visit, supports real-time interventions during the point of care | Requires medical record review and claims to be analyzed to ensure diagnosis codes are captured |
| Aims to prevent coding gaps which can help to improve patient care, continuity of care, treatment planning, referrals to specialist, patient education on condition management, etc. | Aims to catch coding gaps which may identify documentation or coding issues, however often delayed or "after the fact" |
| Much less onerous process:<br>For providers:<br>• If documentation is thorough and coding is accurate there is a significant reduction in medical record requests, allows for greater focus on patient care and other practice responsibilities<br>• If documentation best practices are standardized amongst all providers, there will be a benefit to provider groups from all payors<br>For Blue Cross VT:<br>• Requires monitorization with HCC gap report and overall closure rate.<br>• Some medical records would need to be reviewed for audits to ensure documentation supports the diagnoses codes on claims, but we will not be trying to "catch the gaps" more so, verify the accuracy | Much more onerous process:<br>For providers:<br>• Requires a significant number of medical records to be sent in for coding/review<br>For Blue Cross VT:<br>• Requires Blue Cross VT coders/vendors to review medical records and capture HCC diagnosis that are supported in the documentation but not submitted via a claim |
| Achieved through pre planning visit workflow, utilizing the practice specific HCC report from your PEC, consistent education of your providers on the purpose | Achieved through Blue Cross VT Risk Coding Initiative project that requires medical record review of several charts in hopes to "catch the gaps"<br>Achieved through annual Risk Adjustment Data Validation audit where Blue Cross VT is given a random sample of about 200 members from HHS and we have to prove that the provider documentation supports the ICD-10-CM codes billed on a claim |

# WHAT TO EXPECT




*Blue Cross VT will continue with our annual Risk Coding Initiative project and accept medical records requested through that process annually

# HOW CAN WE HELP?

- Do we have the right people at the meetings?
  - Consider inviting billers, providers and coders to your meetings with your Provider Engagement Consultant (PEC)
  - Consider scheduling a meeting with a coder from the BlueCross VT team to provide some feedback/education based off medical records from your practice
- Talk with your BlueCross VT PEC about different workflows that could be incorporated, or built off to help improve your practices HCC closure rate
- PECs can help filter out and break down the HCC report to help identify ways in which you can work the report
- Join the standing monthly provider workgroup meeting to talk with peers about their processes

# KEY TAKEAWAYS

- Risk adjustment is required by the federal government for health plans participating in the Qualified Health Plan (QHP) Insurance Exchange. It helps to stabilize insurance markets and helps to ensure access and affordability for patients.

- Blue Cross VT is held responsible by HHS and CMS to prove that the provider documentation supports the burden of illness that is represented through claims diagnoses.

- Providers need to ensure that they address patients' chronic conditions, document them in the medical record with supporting assessment/plan of treatment and add them to the claim, at least once annually.

- In 2026, Blue Cross VT QHP Risk Adjustment will accept medical records that may help close open gaps in July, otherwise we will request records during our yearly Risk Coding Initiative project in December.

**Building a partnership is essential for our members/your patients to receive the highest quality care**

## QHP Risk Adjustment team:

Stacy Moran, CCS-P, CRC | Manager, QHP Risk Adjustment
Amanda Dayton, CRC | Provider Engagement Consultant, QHP Risk Adjustment
Teresa Maynard, MA, CCM, CRC, RAP | Provider Engagement Consultant, QHP Risk Adjustment
Brenda Daniels, CPC, CPMA, CRC, RAP | Coding & Auditing Specialist, QHP Risk Adjustment
Maggie Roddy, CPC, CRC, CVBA |Coding & Auditing Specialist, QHP Risk Adjustment

**Blue Cross VT Risk Adjustment Department Email:** RiskAdjustment@bcbsvt.com

**Blue Cross VT Risk Adjustment Department Phone: (802) 371-3540**

**Blue Cross VT Risk Adjustment Website:**
https://www.bluecrossvt.org/providers/qualified-health-plan-risk-adjustment-program

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