PREMERA | BLUE CROSS

Submitting Accurate Diagnoses for Risk Adjustment

Commercial and Medicare risk adjustment rely on complete and accurate coding of all chronic and complex conditions annually. You need to address each condition during a face-to-face visit; document that you monitored, evaluated, assessed, or treated the condition; and code to the highest level of specificity on the claim.

HOW TO CORRECT AN INACCURATE CLAIM

When you determine you need to correct a claim (e.g., you miscoded a diagnosis on a prior claim or didn't submit a documented diagnosis), you have two options to correct the error. These options ensure your risk adjustment performance reports and gap lists are updated, and that accurate diagnostic data is sent to Centers for Medicare and Medicaid Services (CMS).

Option 1: Submit a corrected claim

Premera considers submission of a corrected claim to add, change, or remove a diagnosis a best practice; a corrected claim supports continuity of diagnostic data between the provider, Premera, and CMS.

Option 2: Submit a supplemental file

You can submit a delimited file to Premera to add diagnoses to or remove diagnoses from data previously submitted on claims. This process only prompts Premera to consider adjusting diagnoses in the risk adjustment file submitted to CMS; it doesn't correct inaccurate diagnoses previously submitted on claims that impact the patient's permanent claims record.

There are two types of files you may send:

- Electronic Medical Record (EMR) extract: This is an extract of visit data from your EMR system and would include CPT and ICD-10 codes that were already submitted on claims as well as any that may have been inadvertently truncated from claims submission.
- Incremental ICD-10 adds/deletes: These are generated as a result of a targeted retrospective medical record review to identify:
    - Diagnosis codes that were submitted on claims but should not have been.
    - Diagnosis codes that should have been submitted on claims but were not.

Below are steps and information you need to successfully submit either type of supplemental file.

1. Generate a pipe delimited text file using column headers. All columns must have a value even if blank. Include the required fields in the file as indicated in the list below:

Seq#	Data element name	Field definition	Data type	Sample data
1	LineOfBusiness	"Medicare" or "Commercial" plan member	Text (8-9)	Commercial
2	PlanMemberID	Plan member ID, excluding the prefix and including the suffix; don't include dashes or spaces	Text (11)	12345678901
3	MemberLastName	Member last name	Text (100)	Doe
4	MemberFirstName	Member first name	Text (100)	Jane
5	MemberDOB	Member date of birth	Text (8) YYYYMMDD	20180101
6	ProviderTaxID	Provider tax identification number (TIN)	Text (9)	123456789
7	RenderingProviderNPI	Rendering provider NPI	Text (10)	1234567890
8	RenderingProviderLastName	Rendering provider last name	Text (100)	Smith
9	RenderingProviderFirstName	Rendering provider first name	Text (100)	John
10	BillingProviderNPI	Billing Provider NPI	Text (10)	1234567890
11	EDPSFormatIndicator	Specifies whether the EDPS submission should use the 837 Institutional or 837 Professional format: I – 837 Institutional P – 837 Professional	Text (1)	I
12	RiskAssessmentCode	Indicates the setting where the diagnosis originated from. Valid Values: A – Clinical Settings B – Non-clinical setting originating in a visit that meets all requirements for a First of Subsequent Annual Wellness Visit C – Non-clinical setting originating in a visit that does not meet all requirements for a First or Subsequent Annual Wellness Visit	Text (1)	A
13	POS	Place of service	Text (2)	11
14	PrimaryServiceFrom	Service start date	Text (8) YYYYMMDD	20150214
15	PrimaryServiceThrough	Service end date	Text (8) YYYYMMDD	20150214
16-39	SupplementalDiagnosisCode x24	ICD10 code identified during chart review; don't include decimals	Text (7)	E11319
40	ProcedureCode	Valid CPT/HCPCS Code	Text (10)	99499
41	AddDelete	"Add" or "Delete" diagnosis code	Text (3-6)	Add

2. Use the correct file naming convention when saving your file:
    a. EMR extract files:
    PREMERA_supplementaldiagnoses_EMRextract_[providername]_YOS_YYYYMMDDHHMMSSSS_[versionnumber]
    b. Incremental adds/deletes files:
    PREMERA_supplementaldiagnoses_Incremental_[providername]_YOS_YYYYMMDDHHMMSSSS_[versionnumber]
3. Deliver the file to Premera via your assigned secure file transfer program (sFTP). Email ProviderClinicalConsulting@Premera.com or your assigned Provider Clinical Consultant (PCC) to let them know you submitted the file.
4. We will send you a confirmation email within 2 business days indicating that we retrieved the file.
5. We will integrate accepted diagnoses in gap list and performance reports within 60-90 days of confirmation of file retrieval.

All conditions submitted to Premera are subject to review for accuracy in our medical record review processes. Contact ProviderClinicalConsulting@Premera.com to learn more.