Closing Gaps & Meeting Metrics

Coding Tips & Best Practices

October 2021

Hierarchical Condition Category (HCC) Risk Adjustment

The Centers for Medicare and Medicaid Services' (CMS) HCC risk adjustment model calculates risk scores and adjusts capitated payments for beneficiaries who are elderly or disabled and enrolled in the Medicare Advantage program. This risk model looks at the previous year's data to prospectively determine patient cost for the following year.

According to the American Academy of Family Physicians, "hierarchical condition category coding helps communicate patient complexity and paint a picture of the whole patient." The model is valuable to precisely measure cost, performance, and quality.

HCC risk adjustment depends on accurate documentation at the point of care. All conditions, including manifestations, complications, and comorbidities, must be documented to the highest level of specificity to paint an accurate picture of a patient's complexity.

The responsibility for capturing the specificity required falls mostly on physicians' clinical documentation. Coders cannot include appropriate diagnosis codes on the claim without clear and complete documentation from the physician, nor can they assume a connection between conditions listed in the medical record if the provider has not explicitly spelled out the link in the documentation.

Comprehensive and Accurate HCC Capture

With HCC risk adjustment, risk scores reset each year, so each qualifying diagnosis must be reported annually. The more chronic conditions a patient has, the more care they may require, so annual reporting is crucial to quality of care and proper funding.

A comprehensive update of HCCs and, consequently, the risk score, establishes the financial allotment provided by CMS towards the annual care of each patient.

HCC Review

HCC review is the process of ensuring the complexity of the patient is captured in terms of clinical chronic conditions that are accurately documented as practically possible. In risk adjustment this can be done by capturing insights from all available data (e.g., specialists, hospitals, etc.) to find coding gaps in the patient's clinical profile.

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Comprehensive and Accurate HCC Capture *continued*

Before the HCC coding and risk adjustment process, the population looks like this.	After accurate HCC coding, the population now looks like this, painting a more detailed picture of the population segments.
	

The State and Federal governments need to appropriately allocate revenue to the high-risk members enrolled; the patient coded date (medical information submitted on physician claims for each patient) is an essential requirement. Specificity of diagnosis coding is substantiated by the medical record.

By demonstrating the level of complexity for the patient encounters, accurate coding helps to best reflect the cost of caring for members/patients.

Coding patient data that creates a baseline check for our initial HCC review has some cardinal rules.

- **Document existing conditions.** A review checks whether the condition is coded accurately, or the coded condition exists.
- **Diagnoses are episodic and do not roll over from one visit to another or one year to another.** A patient who has a missing limb needs to be recoded again in the next year. The system will not recognize the patient is still missing a limb.
- **The same condition** can be documented and coded multiple times to show relevance, accuracy, and that it is current.
- **Code together co-existing conditions** since these provide a holistic view of the patient.

The funding allocated for patients with HCC conditions in the current year can be adjusted (moved up or down) based on the changing clinical profile of the patient for the prospective year. HCC coding illuminates the path forward for regulators and payers who want to improve patient care while allocating appropriate funds **where they are needed**.

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CMS-based HCC Model

A CMS-based HCC model is used for the risk adjustment of the Medicare Advantage program. It applies to patients over 65 and disabled patients.

CMS-HCC is a prospective model that requires patients' diagnosis of a base year to forecast their healthcare costs for the upcoming year. The patients' data is captured by claim submission to Medicare. The risk score includes the parameters like their demographics, health conditions and institutional status.

Capturing Patient Complexity Example*

68-year-old female	0.323	68-year-old female	0.323
Originally disabled	0.250	Originally disabled	0.250
Diabetes (HCC 19)	0.105	Diabetic CKD (HCC 18)	0.302
CKD unspecified	0.000	CKD stage 3b	0.069
Multiple sclerosis (HCC 77)	0.423	Multiple sclerosis (HCC 77)	0.423
		Diabetic PVD (HCC 18 & 108)	0.288
		RT BKA (HCC 189)	0.519
		Payment condition count	0.042
Demographic and HCC RAF	**1.101**	**Demographic and HCC RAF**	**2.216**

*Illustrative purposes only, using CMS HCC Model V24

CMS is increasingly placing more emphasis on accurate documentation of HCC scores. If not acknowledged, there could be serious compliance risks due to over- or under-documentation without supporting evidence.

HCC risk adjustment is not a simple concept. The rules are also constantly changing; diagnosis codes are added and removed each year and knowledge can quickly become outdated. When physicians understand how risk-based contracts work, and the importance of HCC coding, they are more likely to invest the extra time needed to document each patient's health status properly and fully according to best practices.

Provider education initiatives should:

- Include an overview of the relationship of HCC and ICD-10-CM codes.
- Emphasize the importance of accurate documentation and coding and the impact of specificity to ensure the true complexity of every patient is reflected.
- Start with the most common conditions physicians are more likely to encounter.
- Keep providers and support staff up to date on rule changes on a regular basis.

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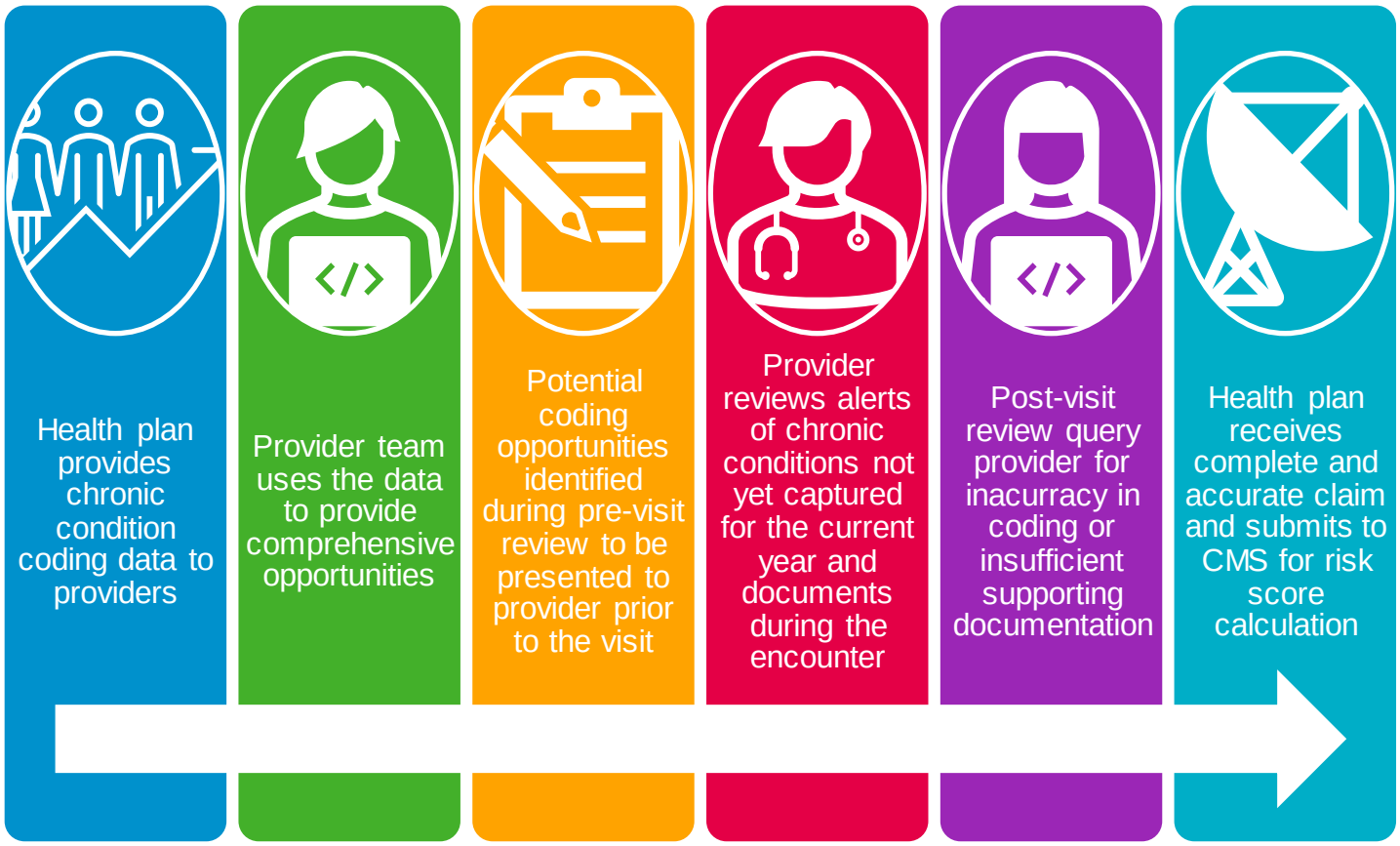
Pre-Visit and Post Visit Process for Accuracy



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Topics include:

- Atrial fibrillation
- Cancer
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Diabetes
- Major depression
- Mental Health
- Rheumatoid arthritis

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