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On the topic:
HCC Coding and Its Impact on your Revenue
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HCC Coding and Its Impact on Your Revenue

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What is HCC Coding?

• HCC or Risk Adjustment Coding is Hierarchical Condition Categories. It is a category of medical conditions that map to a corresponding group of ICD-10 codes in order to receive reimbursement from CMS.
  – these are usually chronic conditions used to create a risk adjustment methodology
• Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs.
• Increased accuracy benefits patients, providers, health plans, and the nation as a whole.
History

• In 1997, beneficiaries could choose between traditional and managed Medicare.

• Managed Medicare companies are given a fixed dollar amount per enrollee from CMS.

• Since 2007, the Medicare companies receive payments based upon the HCC diagnoses assigned to each enrollee, plus a demographic factor - the Risk Adjustment Factor.

What is RAF?

• **Risk Adjustment Factor** is a score that identifies patient health status. If chronic conditions are not documented and coded yearly, the accurate health status of the patients are not accurately reflected.

• This score assesses the acuity of illness based upon ICD-10 codes and demographics.

• HCC codes are payment multipliers (Average RAF is 1.0 Each)

• .01 increase in RAF results in 1% higher reimbursement to the Medicare Advantage company from CMS
Coding Strategy

- ICD-10 codes must be supported in the medical documentation. Official coding guidelines must be followed.
- Physicians should document and code conditions that co-exist at the time of the encounter, and require or affect patient care, treatment or management.
- History codes may be used if they impact the current care.

M.E.A.T.

- Remember the acronym M.E.A.T.
  - Monitor - order/reference labs/other tests
  - Evaluate - examination
  - Assess/Address – Acknowledging or Status
  - Treat – Prescriptions, surgical or therapeutic intervention, referral to specialist, any plan for management of a condition

- A progress note or encounter note only needs to have one of these documented to be coded. All diagnoses must occur as a result of a face-to-face encounter.
Documentation

• Documentation must show or support the diagnosis and **plan of care** for each diagnosis.
• Diagnoses must be re-established each year to ensure that next year’s payments will cover costs.
• Codes should be documented to the highest specificity and follow coding guidelines in each chapter.

Documentation Basics

• Every note should include:
  • Date of service
  • Patient name and date of birth on each page
  • Provider signature and credentials
  • Only industry standard abbreviations
  • Documentation of each medical condition being monitored, managed, evaluated, assessed, addressed, treated, or considered in the care of the patient
  • Be specific – only use signs/symptoms if diagnosis is not clear
Documentation Basics continued

• Pertinent Conditions:
  • Present but stable
  • Managed on therapy
  • Requires observation
  • Requires referral
  • Influences medical decision making
  • Chronic conditions should be documented even when they are stable (document that condition is stable)
  • Document severity or stage of the condition
  • Document associated conditions

• Active status – CMS considers a condition resolved if not evaluated and coded at least once per calendar year and the risk factor is lowered for the member

• Forever codes – conditions that do no go away (CHF, transplants, amputation, ostomy, cirrhosis, hepatitis, paraplegia, quadriplegia, diabetes)

• Remember to use terms like due to or secondary to describe relationships and manifestations
Why Is This Important?

- CMS and HHS require accurate reporting of members’ conditions, including diagnosis codes and secondary diagnoses, to the highest level of specificity.
- Audits are performed by the Medicare Advantage insurance companies to ensure that this is done. These audits can occur annually.

Examples of HCC Coding

- Hypertension Categories
  - Hypertensive Heart and Kidney Disease
  - Is it documented as due to or is there a causal relationship for the Heart?
  - Is it Diastolic or Systolic Heart Failure?
  - Is the stage of the Kidney disease documented?
  - Is there ESRD or Dialysis?
Examples continued

• Diabetes Categories
  – Is it Primary or Secondary – caused by an underlying condition or drug, juvenile type or adult onset?
  – Are there documented manifestations?
  – Do these manifestations state “due to” or “diabetic”?
  – Does the patient take routine insulin or oral medication and is it documented?

Examples continued

• Cerebrovascular Accident (CVA)
  – May be documented as acute or history of
  – Are there residual late effects or sequela
    • Once discharged, late effects or sequela are coded from the I69 series of codes
    • There is no time limit on late effects but documentation must support that it was caused by Cerebrovascular disease or accident
Other HCC Categories

- Respiratory Diseases
- Asthma
- COPD
- Skin Ulcer
- Major Depression
- Malnutrition
- Neoplasm

In Conclusion

- Familiarize yourself with coding guidelines to ensure that you are coding to the highest specificity
- Document all conditions following the M.E.A.T. guidelines at least once per year
  - The annual wellness exam is a good time to look at all pertinent conditions
  - Become familiar with your HCC categories to ensure that you are listing all conditions
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp