IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

What is HCC Coding? Understanding Today's Risk Adjustment Model

Risk Adjustment (RA) 101

A method uses a patient's demographics and diagnoses to determine a risk score, which is a relative measure of how costly that patient is anticipated to be.

Risk Adjustment calculations consider:

- Diseases that have significant impact on patient cost of care
- Demographic information such as age and sex

Predictive in nature:

- Information from current year to predict future year expenditures.

Why is Risk Adjustment Done?

To accurately reflect the health of our membership:

- Risk adjustment scores are higher for a patient with a greater disease burden, less for a healthier patient.
- The dx codes reported on your claims determine a patient's disease burden and risk score.
- Chronic conditions must be reported once per year.
- ***Each January 1st, the RA slate is wiped clean. All Medicare patients are considered completely healthy until dx codes are reported to claims.***

HCC Coding 101

CMS uses HCCs (Hierarchical Condition Categories) to reimburse Medicare Advantage plans based on the health of their members starting in 2004.

HCC relies on ICD-10 coding to assign risk scores to patients. Each HCC is mapped to an ICD-10 code and has a risk score associated with it. Along with demographic factors (such as age and gender), CMS use HCC coding to assign patients a risk adjustment factor (RAF) score. Using algorithms, CMS can use a patient's RAF score to predict costs.

How HCCs Work

Diseases and conditions are organized into body systems or similar disease processes. Some top HCC categories include:

- Diabetes

- Chronic Kidney Disease (CKD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Malignant neoplasms
- Some Acute conditions (MI, CVS, hip fx)
- Breast and prostate cancer
- Rheumatoid arthritis

Patients are often assigned to more than one category because the combination of demographic information and risk factors can cumulate to represent more than one kind of illness or potential for illness. The risk adjustment identifies patients in need of disease management and establishes the financial allotment provided by CMS towards the annual care of each patient.

Risk Adjustment Coding Example

No Conditions Coded	RAF	Some Conditions Coded	RAF	All Chronic Conditions Coded	RAF
76-year-old female	0.442	76-year-old female	0.442	76-year-old female	0.442
Medical Eligible	0.151	Medical Eligible	0.151	Medical Eligible	0.151
DM with Complications	X	DM w/o Complications	0.118	DM with Complications	0.368
Vascular Disease	X	Vascular Disease	X	Vascular Disease	0.299
CHF	X	CHF	X	CHF	0.368
Disease Interaction (DM + CHF)	X	Disease Interaction (DM + CHF)	X	Disease Interaction (DM + CHF)	0.182
Total RAF	0.593	**Total RAF**	0.711	**Total RAF**	1.810

* Health Plans submit their data to CMS via encounter data. CMS calculates a member's score. If a member is relatively healthy, they will have a score less than 1. Members with various chronic medical conditions can have a score greater than 1.

Why is HCC/Risk Score Important to Clinics?

If a member has chronic conditions that are not documented consistently, his/her HCC Score will decrease, and CMS will decrease the reimbursement to care for the member.

It is important to see your members on a regular basis. Always document all their chronic conditions as often as treated. If is not documented in the chart it didn't happen.

Annual Wellness Visit

- A typical visit last 40-60 minutes, at no cost to the patient, including preventive labs.
- The goal is to see every Medicare patient every year and for this service to be billed once per calendar year.

- The benefits refresh January 1st of every year, no need to wait 365 days between visits.
- Visits need to be performed by a PCP, NP, or PA

During an AWV:

- Document patients' current chronic conditions and ongoing treatment plans
- Conduct preventive screenings for conditions such as high BP, diabetes, depression, and heart disease.
- Detect any cognitive impairment they may have.
- Review medications
- Schedule preventive treatments: colonoscopy, blood work, mammogram, etc.
- Complete labs work as necessary.

Benefits of an AWV:

- Allows for accurate reporting/submission of patients' chronic conditions to Medicare in the current year.
- Maintain best practice of seeing your patients at least once a year.
- Allows opportunity to identify care gaps and create a plan of care for the year.
- Ensures acceptable medical records documentation in the case of a Risk Adjustment Data Validation (RADV) audit. Compliance with Star Measures is also required by CMS.

Just an FYI…

Physicians can accomplish the documentation standard by understanding **MEAT**. The provider must document all active chronic conditions as well as conditions that are relevant to the patient's current care. **MEAT** is an acronym used in HCC to ensure that the most accurate and complete information is being documented:

Monitor-signs and symptoms, disease process.

Evaluate-test results, meds, patient response to treatment.

Assess-ordering tests, patient education, review records, counseling patient and family members.

Treat-meds, therapies, procedures, modality.

Code to the highest specificity to accurately capture the disease severity burden. Some examples:

CKD	Obesity	Depression
Unspecified, Stage 1 or 2 = no HCC	Obesity = no HCC	Major depressive disorder, single episode, unspecified = no HCC
Stage 3 = HCC 138	Morbid obesity = HCC 22	Major depressive disorder, single episode, mild =HCC 59
Stage 4 = HCC 137	BMI > 40 = HCC 22	
Stage 5, ESRD = HCC 136		

For HCC to be successful, the provider must report all diagnoses that impact the patient's evaluation, care, and treatment including co-existing conditions, chronic conditions, and treatments rendered.