Introduction to HCC Coding

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Types of Coding

- **Evaluation and management (E&M) coding ***
  - E/M services represent a category of Current Procedural Terminology (CPT) codes used for billing purposes.
  - Most patient visits require an E/M code, and these are used to determine provider reimbursement.
  - There are different levels of E/M codes (99213, 99204, etc.) which are determined by the complexity (or length of time) of a patient visit and documentation requirements.
  - CPT codes are also used to bill for procedures.

- **HCC "complexity" coding**

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*Adapted from AAFP / Family Physician / Practice and Career / Getting Paid / Coding / Coding for E/M Services

What is HCC coding?

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- Hierarchical condition category (HCC) coding is a **risk-adjustment model** originally designed to estimate future health care costs for patients.

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Hierarchical condition category (HCC) coding

- HCC coding is based on patient complexity.
- Along with demographic factors (such as age and gender), insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score.
- HCC codes represent costly chronic health conditions, as well as some severe acute conditions.
- Of the approximately 70,000 ICD-10 codes, about 9,500 map to HCC categories.*

*Adapted from https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/an-introduction-to-hierarchical-condition-categories-hcc

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Why is HCC coding important?

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- In recent years, there has been a shift away from a “fee-for-service” model (where providers are paid for each service that they perform) to a “value-based” model (where healthcare teams are paid based on patient health outcomes).
- Therefore, it is crucial that the providers’ documentation accurately reflects the true illness burden of their patients (as this directly impacts reimbursement).

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How do HCCs impact reimbursement?

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* HCCs directly impact the amount of money received by healthcare organizations participating in “value-based” contracts.

* Patients with high HCCs are expected to require intensive medical treatment, and clinicians that enroll these high-risk patients are reimbursed at higher rates than those with enrollees who have low HCCs.

* Organizations who do not document HCC codes properly or to the highest specificity will not receive the additional reimbursement amount for applicable patients.

* The ability to document with greater precision can dramatically impact payment amounts.

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*Adapted from https://www.imohealth.com/ideas/article/hcc-101-what-you-need-to-know-about-hierarchical-condition-categories

Economic Formula

Total Members
Demographics
ICD-10 Codes

ER Visits
Readmissions
SNF LOS
Network Integrity
Unnecessary testing/care

Surplus/Deficit = (Budget – Expenses) + Quality

BP Control
DM Control
Cancer screening
Immunizations
Patient Satisfaction

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When should I include these HCC diagnoses?

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Remember to include the appropriate HCC diagnosis codes whenever you are:

A. Managing the specific problem during the visit
   - evaluating, ordering tests, prescribing medications, sending a referral, etc.

B. Assessing the stability of the problem at the visit (even if it is being managed by an outside specialist)

-OR-

C. The problem directly impacts your medical decision making
   - You want to prescribe steroids, but the patient is diabetic.
   - You want a contrast imaging study, but the patient has CKD.

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Example

- A 68-year-old female with DM2, polyneuropathy, and CHF presents for evaluation of shortness of breath. Her BMI is 38.2

Scenario 1	Scenario 2
Type 2 Diabetes w/o complications (E11.9)	Type 2 Diabetes with diabetic polyneuropathy (E11.42)
Obesity, unspecified (E66.0)	Morbid obesity (E66.01)
Dyspnea (R06.0)	Systolic CHF (I50.2)
Approx Budget = $4,200/year	**Approx Budget = $13,200/year**

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Example

- A 65-year-old male ex-smoker is seeing you in the office for a productive cough for several days. He has a history of COPD and atrial fibrillation and is on coumadin. His BMI is 38.2.

Scenario 1	Scenario 2
Chronic bronchitis, unspecified (J42)	COPD with exacerbation (J44.1)
Obesity, unspecified (E66)	Morbid obesity (E66.01)
	Chronic atrial fibrillation (I48.2)
Approx Budget = $6,200/year	**Approx Budget = $11,100/year**

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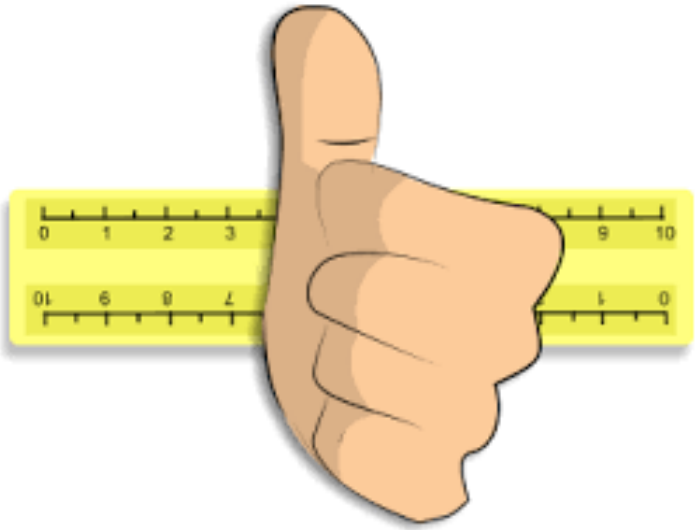
Rules of Thumb

- Code more specifically when possible
- Code for everything addressed and documented
  - **Include diseases that impacted decision making**
    - CKD impacting medication choices
    - DM impacting whether to prescribe steroids
- Code chronic conditions yearly*

*Although chronic conditions are ongoing, providers must document a patient's chronic condition and recapture the ICD-10 code annually to maintain the patient's HCC risk score. This includes amputations and ostomies.



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Most Frequently Missed RAF Codes

1. **Diabetes**, with or without complications, with or without insulin, etc.
2. **Major Depression** F32.9 single episode MUST be specified mild/moderate etc., F33 recurrent
3. **Morbid Obesity** – BMI>40 OR BMI >35 with HTN, DM, Hyperlipidemia, and other comorbidities
4. **Drug Dependence** (can list as IN REMISSION – any drug abuse) sedative/BZD: F13.20; psychoactive other F19.20; cannabis F12.20; stimulants F15.20; cocaine F14.20; Opioid de F11.20; opioid in remission F11.21
5. **Alcohol Dependence** (can list as IN REMISSION) F10.20; in remission F10.21
6. **Angina** I20.9
7. **CHF** I50.9/ I50.* for all specified CHF including DIASTOLIC
8. **COPD** J44.9
9. **Chronic respiratory failure** J96.12 (O2 dependent COPD/CO2 retainer) (Anyone on oxygen; ADDITIVE with COPD!!)
10. **Chronic Kidney Disease** (CKD) 3A (GFR 45-59) N18.31; 3B (GFR30-44) N18.32; 4 (GFR 15-29) N18.4, CKD 5 GFR <15/ESRD N18.5/N18.6
11. **Renal Dialysis** Z99.2 has a DIFFERENT HCC code than ESRD/CKD5; be sure to bill BOTH in a dialysis patient!
12. **Chronic DVT** I82. * (acute or chronic)
13. **Atrial Fibrillation** I48

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Most Frequently Missed RAF Codes

14. Peripheral Neuropathy (non-diabetic only) G62.0 - drug-induced (chemo fits here); G62.1 - alcoholic polyneuropathy; G63 - polyneuropathy in diseases classified elsewhere (amyloidosis, metabolic & endocrine disorders, neoplasm, nutritional deficiencies)
15. Ostomies Z93.*
16. Malnutrition OR cachexia E43, E46
17. Hepatic failure K72.90
18. Cirrhosis K74*
19. Epilepsy G40.* (any seizure ever, including febrile seizures)
20. Late Effect of Stroke dysphagia I69.391/I69.328 paralysis I69.36*
21. Paraplegia G82.2*
22. Quadriplegia G82.5*
23. Lower Limb amputation status Z89.* ANY TOES all count
24. Decubitus ulcer stage 3 L89.93/ stage 4 L89.94
25. Traumatic Brain injury S06.2X0S no loss of consciousness sequela; S06.2X9S with LOC
26. Transplant status Z94.* (except kidney)
27. Autoimmune disease needs to be specified, but think about it!

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