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HCC Coding Update – Obesity & Malnutrition



What is HCC coding?





Hierarchical condition category (HCC) coding

- HCC coding is based on patient complexity.
- HCC codes represent costly chronic health conditions, as well as some severe acute conditions.
- Along with demographic factors (such as age and gender), insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score.
- 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.*



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

When should I include these HCC diagnoses?





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.



Coding for Obesity & Malnutrition





United States Obesity Statistics*



The US obesity prevalence was 41.9% in March 2020. During the same time, the prevalence of severe obesity increased to 9.2%.

Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer. These are among the leading causes of preventable, premature death.

The World Health Organization acknowledges that the US has unprecedented rates of both obesity (greater than 1/3 of all adults) and food insecurity (about 1/8 of the population). [NIH.gov, December 2018]

Non-Hispanic Black adults (49.9%) had the highest ageadjusted prevalence of obesity, followed by Hispanic adults (45.6%), non-Hispanic White adults (41.4%) and non-Hispanic Asian adults (16.1%).



*Source: CDC.gov 12/8/2022

HCC Coding for Obesity

There is no risk adjustment value for overweight [E66.3] or obesity [E66.9].

There is risk adjustment value for morbid obesity [E66.01] and morbid obesity with hypoventilation [E66.2].

Morbid obesity is defined as a BMI>40, or a BMI>35 with comorbidity.*

*This can be any comorbid condition which is impacted by their weight (diabetes, hypertension, sleep apnea, hyperlipidemia, osteoarthritis).



United States Malnutrition Statistics



The World Health Organization acknowledges that the US has unprecedented rates of both obesity (greater than 1/3 of all adults) and food insecurity (about 1/8 of the population). [NIH.gov, December 2018] According to the USDA, more than 34 million people, including 9 million children, in the United States are food insecure.

According to the latest WHO data published in 2020 Malnutrition Deaths in United States reached 6,762, making malnutrition the 44th leading cause of death in our country (ahead of asthma, epilepsy, and fires).

> The percent of Black (25.6 percent) and Hispanic households with food-insecure children (24.3 percent) was nearly two times that of white households (13.2 percent) in 2016.



HCC Coding for Malnutrition

Consider using the following diagnoses:

- Malnutrition (mild, moderate, severe) *
 - Mild [E44.1] weight loss less than that listed for moderate malnutrition
 Moderate [E44.0]
 - Some muscle wasting, loss of subcutaneous fat
 - Unintentional weight loss of 5-10% in <6 months, or 10-20% in >6 months.
 - Low BMI (< 20 if < 70 years, or < 22 if > 70 years)
 - Severe [E43]
 - Obvious significant muscle wasting, loss of subcutaneous fat
 - Unintentional weight loss of >10% in <6 months, or >20% or > 6 months.
 - Low BMI (< 18.5 if < 70 years, or < 20 if > 70 years)
- Unspecified protein calorie malnutrition [E46]



Using the most specific diagnosis when coding for your visits can have a significant impact on reimbursement.





Example

• A 65-year-old male is seeing you in the office for evaluation of sleep apnea. He has a history of regular daily alcohol consumption. His BMI is 42. After evaluation, you feel that his morbid obesity and alcohol consumption are all playing a role in his sleep apnea.

Scenario 1	Scenario 2
Sleep apnea (G47.30)	Sleep apnea (G47.30)
	Alcohol dependence (F10.20)
Obesity, unspecified (E66.0)	Morbid obesity (E66.01)

Approx Budget = \$3,000/yearApprox Budget = \$8,500/year



Example

• A 68-year-old female with poorly controlled type 2 diabetes presents for evaluation of chronic left knee pain. Her BMI is 38.2 After evaluation, you feel that her morbid obesity is contributing to her chronic knee pain and her poorly controlled diabetes is impacting your decision making re: a steroid injection.

Scenario 1	Scenario 2
Left Knee Pain (M25.562)	Left Knee Pain (M25.562)
Type 2 Diabetes without complications (E11.9)	Type 2 Diabetes with unspecified complications (E11.8)
Obesity, unspecified (E66.0)	Morbid obesity (E66.01)

Approx Budget = \$4,100/year

Approx Budget \in \$8,400/year



Example

• A 70-year-old female ex-smoker with COPD presents for her regular follow-up visit. O2 sat on room air is 88%. Her BMI is 17.2. Patient reports a decreased appetite over the past few months.

Scenario 1	Scenario 2
COPD (J44.9)	COPD (J44.9)
	Chronic respiratory failure with hypoxia (J96.11)
	Protein calorie malnutrition (E46)

Approx Budget = \$7,000/year

Approx Budget <\$17,500/year



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.



