

Hierarchical Condition Category (HCC) Coding

Overview

Hierarchical Condition Category (HCC) Coding plays an important part in representing the health of a population and is used by CMS to adjust the risk score of each Medicare beneficiary. It aims to predict costs for Medicare beneficiaries based on disease and demographic risk factors. This is the only way that CMS knows how sick your patients are and gives you credit for the hard work you're doing.

Interpreting the Risk Adjustment Factor (RAF)¹

- RAF score identifies patient's health status
 - Low RAF score may indicate a healthier population
 - High RAF score may indicate members with increased health risks
- OR
- Low RAF score may falsely indicate a healthier population due to:
 - Incomplete and/or inaccurate ICD-10 CM coding
 - Diagnoses are under reported
 - Patients who were not seen annually
- High RAF score may be inflated due to:
 - Reported diagnoses not documented
 - Over coding (i.e. copying and pasting problem list into assessment and plan)

The Impact of Risk Adjustment on Savings

Scenario	Baseline Cost (in millions)	Actual Cost (in millions)	Risk Adjustment Factor (RAF)	RAF Adjusted Baseline Cost	Savings/Loss
<i>Calculation</i>	<i>a</i>	<i>b</i>	<i>c</i>	$d = a * c$	$d - b$
ACO 1	\$500	\$501	.95	\$475	(\$26,000,000)
ACO 2	\$500	\$501	1	\$500	(\$1,000,000)
ACO 3	\$500	\$501	1.05	\$525	\$24,000,000

Patient Example: The effects of coding accuracy

75-year-old patient with type 2 diabetes and a body mass index (BMI) of 40.0

ICD-10	Description	RAF
E08.9	Type 2 diabetes with no complications	0.106
Z68.37	BMI of 37.0	none
Total Risk		0.106

ICD-10	Description	RAF
E10.42	Type 2 diabetes with diabetic polyneuropathy	0.307
E66.01 & Z68.37	Morbid obesity with a BMI of 40.0	0.262
Total Risk		0.569



Guidelines for Proper Documentation

M.E.A.T. is at the heart of HCC coding and clinical documentation:

These four factors help providers to establish the presence of a diagnosis during an encounter and ensure proper documentation

For every condition, follow M.E.A.T to ensure proper documentation

If it was not documented, it does not exist

M

Monitoring: signs, symptoms, disease progression, disease regression

E

Evaluating: test results, medication effectiveness, response to treatment

A

Assessing: ordering tests, discussion, review records, counseling

T

Treatment: medications, therapies, other modalities

Additional Tips:

- Review problem lists during the patient's annual wellness visit and keep them to date and accurate
 - All chronic conditions need to be documented at least once annually
- Select the most specific ICD-10 and document it in the EHR
- Avoid using the term “history of” for chronic, but currently stable conditions

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Visit (AWV)**



**Hierarchical
Condition Category
(HCC)**



**Transitional Care
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**Reducing
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