Operationalizing Hierarchical Condition Categories (HCC Scoring)

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CPAs & BUSINESS ADVISORS

Objectives

- Define Hierarchical Condition Categories
- Determine why they are important to your organization
- Understand common errors that can affect HCC scores
- Discuss how you can operationalize processes to support accurate HCC scoring in your organization

Hierarchical Condition Categories

- The CMS-HCC model was first introduced to pay Medicare Advantage plans
- Risk-adjustment model which calculates expected resource use of a patient or patient population
- Utilized to communicate expected and current cost an resource utilization at a patient level

Source: CMS

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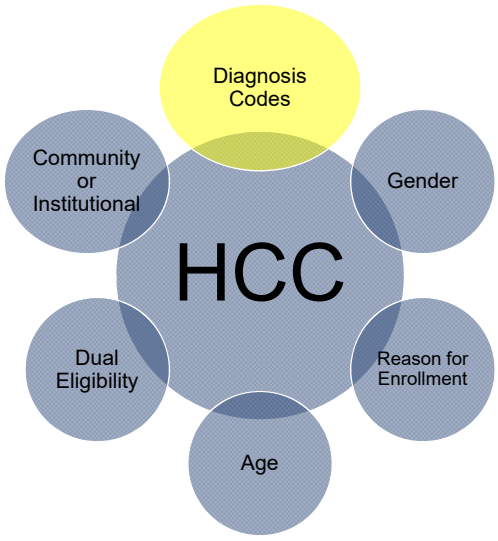
HCC Scoring



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HCC Scoring

Categories

- Over 8,500 ICD-10 Diagnosis codes are broken down into 79 categories
- Not all ICD-10 codes are mapped to a category. Only diagnosis codes that are usable in predicting costs are included.
- Categories are comprised of diagnoses that:
  - Are clinically related
  - Have similar cost/resource use expectations

Example of Categories

Category

- Description

HCC 17

- Diabetes with Acute Complications

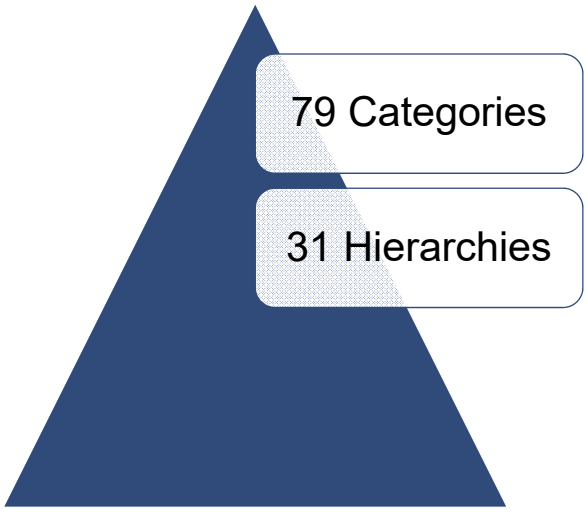
HCC 18

- Diabetes with Chronic Complications

HCC 19

- Diabetes without Complications

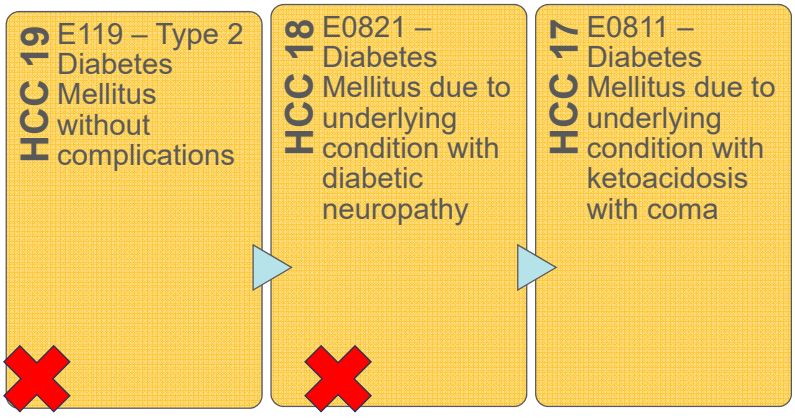
HCC Scoring



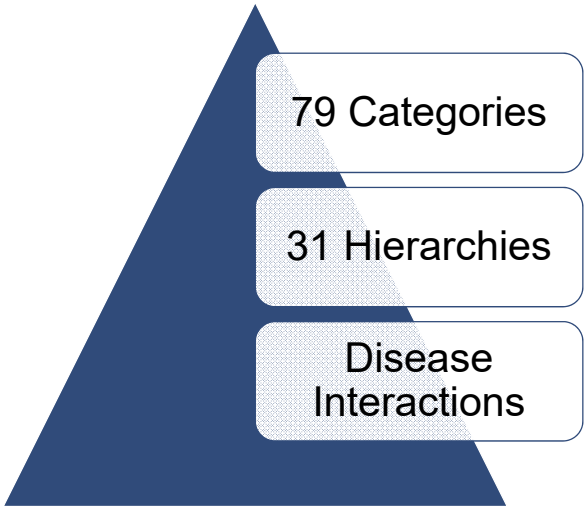
Hierarchies

- CMS developed 31 hierarchies of the 79 categories
- These hierarchies allow for risk calculation to occur from the most severe diagnosis when a lesser diagnosis is also submitted in the same year

Example of a Hierarchy



HCC Scoring



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Disease Interactions

- Disease interactions are used to represent the additional resources utilized for certain conditions when a patient endures them in combination with each other
- They also represent a higher cost utilization for some diseases when a patient is also disabled

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Disease/Disabled Interactions

+.27

I110 – Hypertensive Heart Disease w/ heart failure .323

N184 – Chronic Kidney Disease, Stage 4 .237

+.0608

Disabled

L89024 – Pressure Ulcer of Left elbow, Stage 4 2.163

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HCC Scoring

Acceptable Provider Settings for CMS HCCs – Inpatient & Outpatient Services

- Short Term Hospitals (general and specialty)
- Critical Access Hospitals
- Children's Hospitals
- Long-Term Hospitals
- Rehabilitation Hospitals
- Psychiatric Hospitals

Acceptable Provider Settings for CMS-HCCs – Outpatient Services Only

- Rural Health Clinic (Free-Standing and Provider-Based
- Federally Qualified Health Centers
- Community Mental Health Centers
- Religious Non-Medical Health Care Institutions

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HCC Scoring

Non-Covered Settings	Non-Covered Services
• Hospital Inpatient Swing Beds • Skilled Nursing Facilities • Intermediate Care Facilities • Respite Care • Free-standing Ambulatory Surgery Centers • Hospice • Home Health Care • Free-standing Renal Dialysis Facilities	• Ambulance • Lab • Radiology • DME – Prosthetics & Orthotics and Supplies

Approved Providers

- Family Practice
- Internal Medicine
- General Surgery
- Cardiology
- Neurology
- Pulmonology
- Nephrology
- Physical Medicine & Rehab
- Emergency Medicine
- Ophthalmology
- Psychiatry
- Oncology
- Hematology
- Pain Management
- Interventional Radiology
- Nuclear Medicine
- Certified Nurse Midwife
- Optometrist
- Pathology
- CRNA
- Audiology
- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Licensed Clinical Social Worker

The Clean Slate – January 1st

Source: Conversation.com

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Example of HCC Scoring

72 year old male, residing in Nursing Home, presents feeling short of breath. Complains of dyspnea, fatigue, and persistent coughing. Recently completed antibiotics for UTI. U/A done today is clear. Patient appears frail with mild malnutrition. Previously diagnosed COPD, stable on Flovent daily. Patient continues to smoke. After Radiologic exam, patient diagnosed with aspiration pneumonia and sepsis. Antibiotic prescribed twice daily for next seven days. Ensure twice daily on a continual basis.

Poor Coding

- 72 yo institutionalized male:1.323
- Pneumonia coded as J18.9: 0
- Total HCC score: 1.323
- **Total Cost: $12,152.14**

Better Coding

- 72 yo institutionalized male: 1.323
- Aspiration Pneumonia J69.0: .067
- Tobacco Use F17.210: 0
- Total HCC score: 1.39
- **Total Cost: $12,767.55**

Complete Coding

- 72 yo institutionalized male: 1.323
- Aspiration Pneumonia J69.0: .067
- COPD J449: .305
- Tobacco Use F17.210: 0
- Sepsis A41.9: .346
- Mild Malnutrition E44.1: .260
- Disease Interaction COPD*Aspiration Pneumonia: .254
- Disease Interaction Sepsis*Aspiration Pneumonia: .321
- Total HCC score: 2.876
- **Total Cost: $26,416.89**

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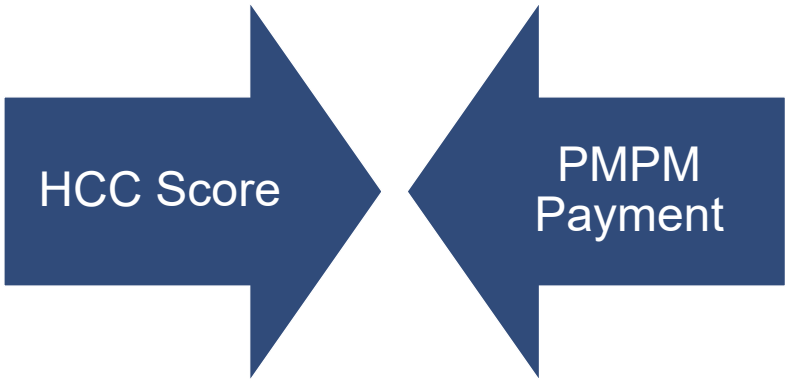
Programs that utilize HCC Scoring

Medicare Shared Savings Programs

- Determining Benchmarks
- Shared Savings/Loss Calculation

Medicare Advantage



CPC+

Table 3-1
Risk Tier Criteria and CMF Payments (per Beneficiary per Month)

Risk tier	Risk score criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

Source: CMS

MACRA

- Previous Models (Value Based Modifier)
- Cost Category
- New Modifiers/Groupers

New Required Modifiers and Codes

- Care Episode Groups
- Patient Condition Groups
- Patient Relationship Categories

www.healthinformatics.wikispaces.com

Source: CMS

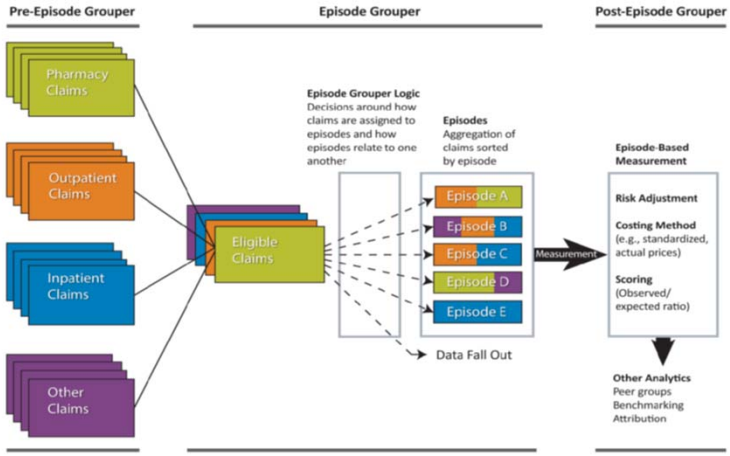
Patient Relationship Categories

- Patient Relationship codes will be required to be submitted on all claims where a clinician has provided items or services
- Utilized to attribute patients, in part or in whole, to clinicians and conduct an analysis of resource use based on care episode and attributed clinician

Source: CMS

Cost: Episode Grouping

Figure 2. Illustrating episode grouping



SOURCE: Evaluating Episode Groupers: A Report from the National Quality Form, 2014.

Care Episode Groups

- MACRA requires a *concurrent* approach that enables physicians to determine, at the time a service is rendered, the care episode or episodes to which the service should be assigned based on the goal of the service and its relationship to other services that the patient is receiving
- define the types of procedures or services furnished for particular clinical conditions or diagnoses
- Enable better measures of the kinds of services and costs physicians can control or influence than the total cost of care and episode spending measures currently in use in Medicare programs
- Used to determine resource use by physician groups
- CMS must consider the patient's clinical problems at the time items and services are furnished during an episode of care, such as clinical conditions or diagnoses, whether or not hospitalization occurs, and the principal procedures or services furnished

Source: CHQPR and CMS

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Episode Groups

- Objectives of their use
  - Describe or account for Medicare cost and utilization using categories that make sense to clinicians and others who are responsible for patient care and healthcare systems
  - Estimate average Medicare payments for episodes, risk-adjusted according to patient-level information and other factors as appropriate
  - Frame spending patterns in ways that highlight opportunities for improvement

Source: CMS

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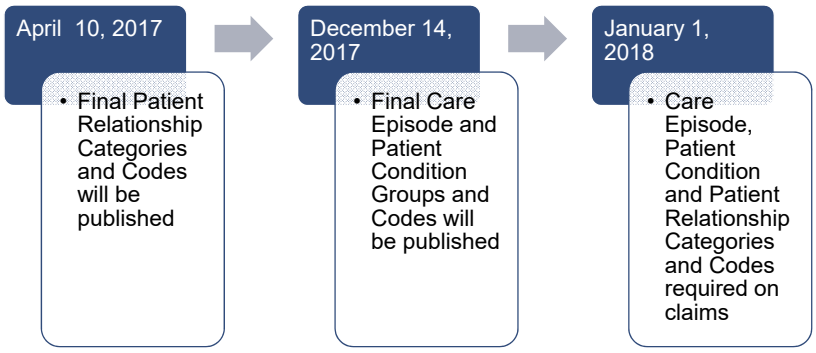
Patient Condition Groups

- CMS must consider the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period)

Source: CMS

Timeline



Source: CMS

Where does Risk Adjustment fit in?

Source: progressive-Charlestown.blogspot.com

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Operationalizing HCC Scoring

Education – Bringing Everyone Together

Source: infopress-gr.blogspot.com

Understand Common Errors

- Not documenting or coding to the highest specificity
- Chronic or coexisting conditions not documented or left out of clinical documentation
- Using history of when documenting/coding stable chronic conditions
- Lack of understanding related to diagnosis coding affecting E/M levels and number of diagnoses that can be included on a claim

Common Error Example

Unspecified DX	HCC Category	Specified DX	HCC Category
Major Depressive Disorder – F32.9	_____	Major Depressive Disorder (Mild, Moderate, Severe) – F33.0 – F33.2	Category 58

Common Error Example

Unspecified DX	HCC Category	Specified DX	HCC Category
Obesity – E66.9	____	BMI Guidelines beginning at 40 or greater or Morbid Obesity	Category 22

Common Error Example

Current Documentation	HCC	More Specific Documentation	HCC
Z8673 - History of CVA	---	I69354 - Previous CVA with residual left side weakness	103
R531 - Weakness	---		

Documentation Requirements

M.E.A.T.

Monitor signs, symptoms, disease progression

Evaluate – test results, response to treatment

Assess/Address – test, discussion, record review, counseling

Treat – medications, therapies, other modalities

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Source: flickr.com and www.clipshrine.com

M.E.A.T. and E/M Guidelines

Providers should/are required to document all conditions evaluated during the face to face visit

Should be a “causal relationship” statement for chronic conditions or manifestations

Each note should contain History of Present Illness (HPI), Exam, and Medical Decision Making (MDM) as per E/M guidelines

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Effect to E/M

- Common Misconceptions:
  - "I don't want patient to have extra expense"
  - "I don't have time to discuss all diagnosis"
  - "That isn't why patient made appointment"

  - Adding chronic conditions does NOT automatically increase the E/M code assignment

Effects to E/M

- Balancing act between not over coding BUT accurately coding
- Pulling information forward every single time in the Electronic Medical Record
- Watch for only coding a chronic diagnosis once in the calendar year
  - Claim could be denied
  - Claim could be "lost"

M.E.A.T. and Diagnoses

- Each diagnosis reported as “active” chronic condition must not only be documented but also have an assessment and a treatment plan
- Listing every diagnosis does not support an HCC Code
- Must not code from the Problem List
- May assign codes from the Past Medical History if pertinent

Per CMS, an acceptable problem list must show Evaluation and Treatment for each condition that relates to a diagnosis code

Source: CMS

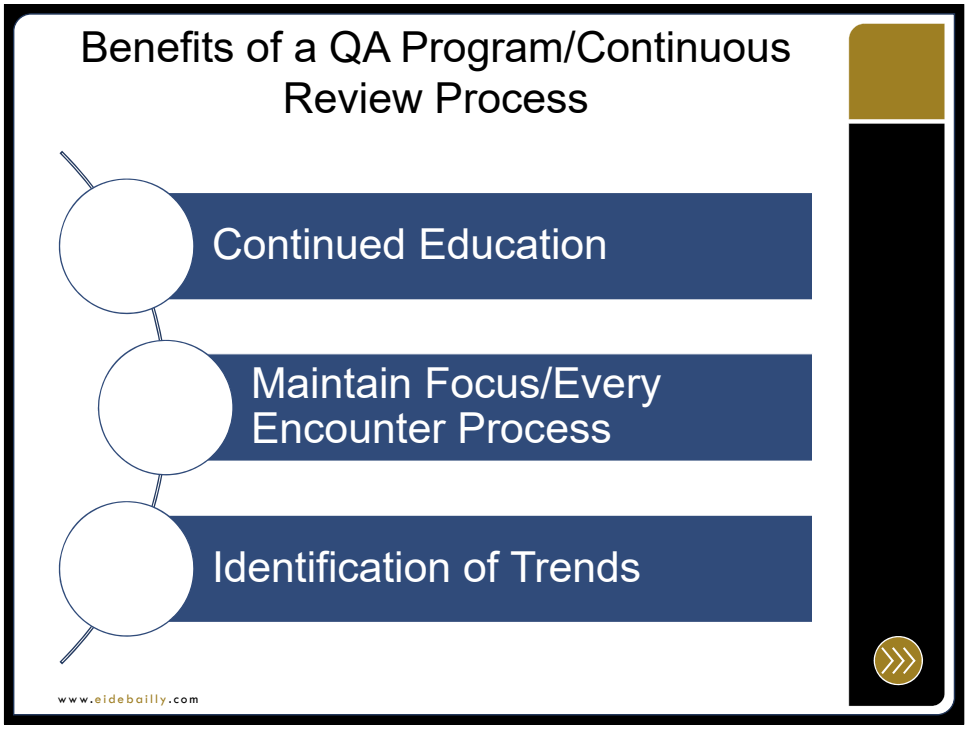
M.E.A.T. Examples

- Examples of supported documentation from Past Medical History
  - CHF-symptoms well controlled with Lasix. Continue current medications
  - Major Depression-Patient continues feeling down despite Zoloft 50 mg daily. Increase to 100 mg daily and monitor
  - Hypertension-Stable on medications

Documentation Requirements

- Document specified diagnoses – avoid unspecified diagnoses
- Document all components of a diagnosis
- Clarify conflicting and unspecified documentation
- Clearly document as an active or history diagnoses
- Spell out diagnoses – avoid symbols and non-specific verbiage
- Document sequelae of conditions

Additional Operationalizing Opportunities


Benefits of a QA Program/Continuous Review Process
Continued Education
Maintain Focus/Every Encounter Process
Identification of Trends
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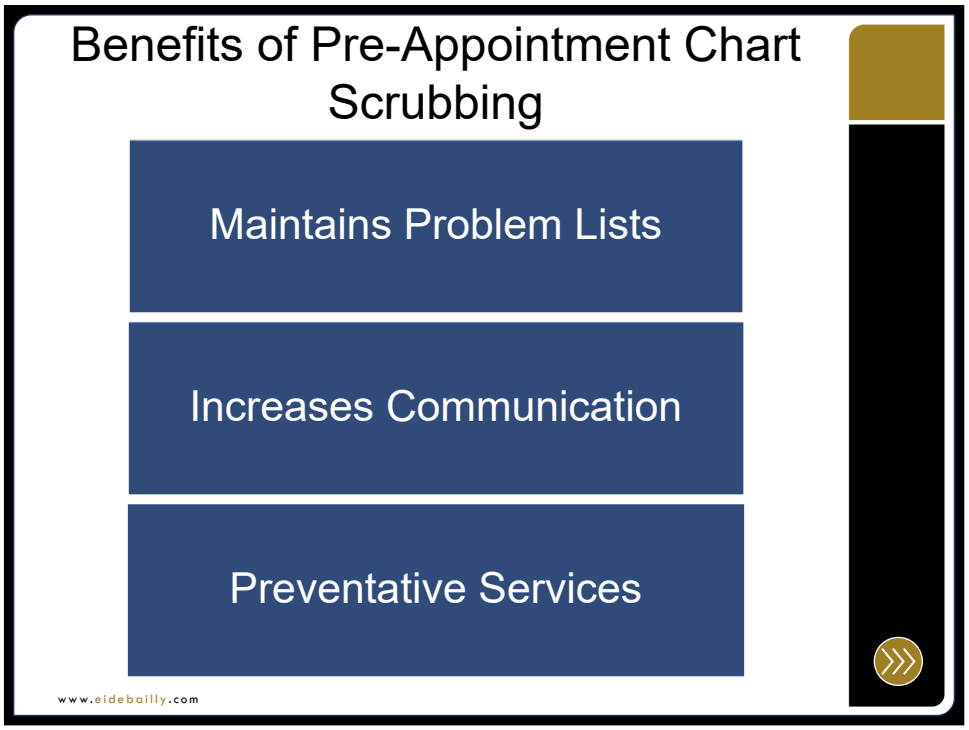
Benefits of Pre-Appointment Chart Scrubbing
Maintains Problem Lists
Increases Communication
Preventative Services
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Benefits of Additional Resources and Tools

Source: Opinion-forum.com

RADV Audits

RADV Audits

- Risk Adjustment Data Validation Audits
- CMS verifies that each diagnosis code submitted is supported by medical record documentation
- May be reviewed annually
- Must submit member medical records to validate diagnosis that were previously reported to CMS

Source: CMS

RADV Audits

Five Steps:

- Sample Documentation Selection
- Documentation Review
- Medical Record Review
- Payment Error Calculation
- Administrative Appeals Process

Two Different Types of RADV Audits:

- Comprehensive
- Condition Specific Audits

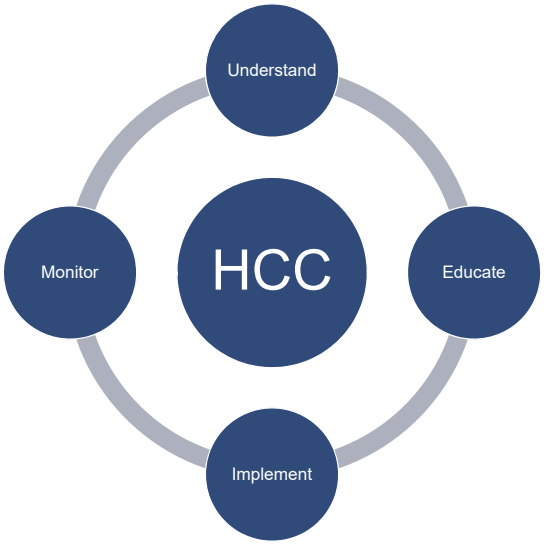
Source: CMS

RADV Audits

- CMS declared the HCC Error Rate is approximately 33%
- January 1st the slate is wiped clean
- Work you do THIS year will determine your funding for NEXT year
- Mapping diagnosis only needs to be reported once in calendar year. HOWEVER, you are able to submit up to five Date of Service (DOS) to support any one HCC during an audit

Source: CMS

Operationalizing HCC Scoring



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Thank You!

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