



CPAs & BUSINESS ADVISORS

**OPERATIONALIZING HIERARCHICAL CONDITION
CATEGORIES (HCC SCORING)**



OBJECTIVES

1 DEFINE HIERARCHICAL CONDITION CATEGORIES

We will cover how Hierarchical Condition Categories (HCC) are determined and the Risk Adjustment Factor (RAF) is calculated.

2 DETERMINE WHY THEY ARE IMPORTANT TO YOUR ORGANIZATION

We will discuss how Hierarchical Condition Categories impact the new payment methodologies.

3 UNDERSTAND COMMON ISSUES THAT CAN AFFECT HCC SCORES

Hierarchical Condition Categories are not owned by coding. We will discuss common issues that impact HCC scores.

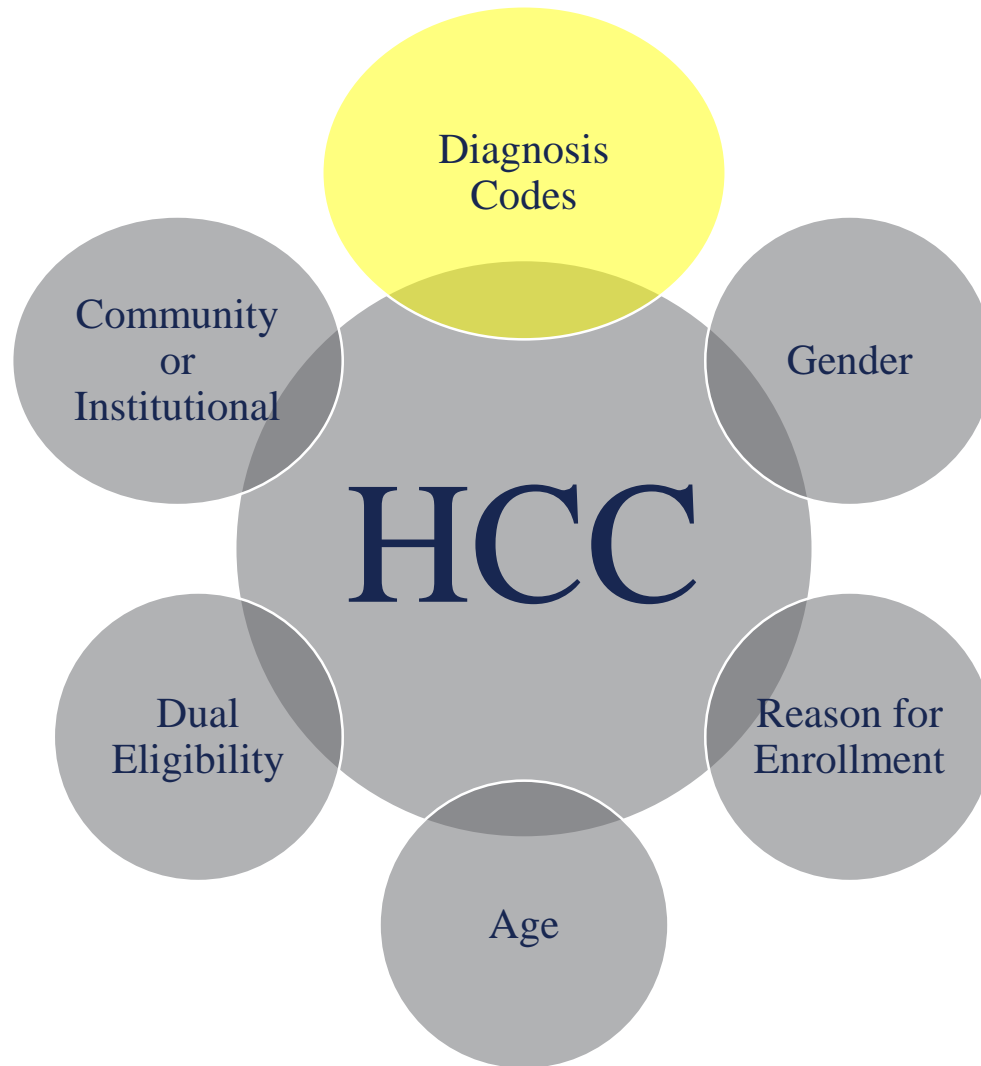
4 DISCUSS OPERATIONALIZING PROCESSES TO SUPPORT ACCURATE HCC SCORING

We will discuss ways to strengthen process to assure your organizations HCC scores reflect the care provided to patients.

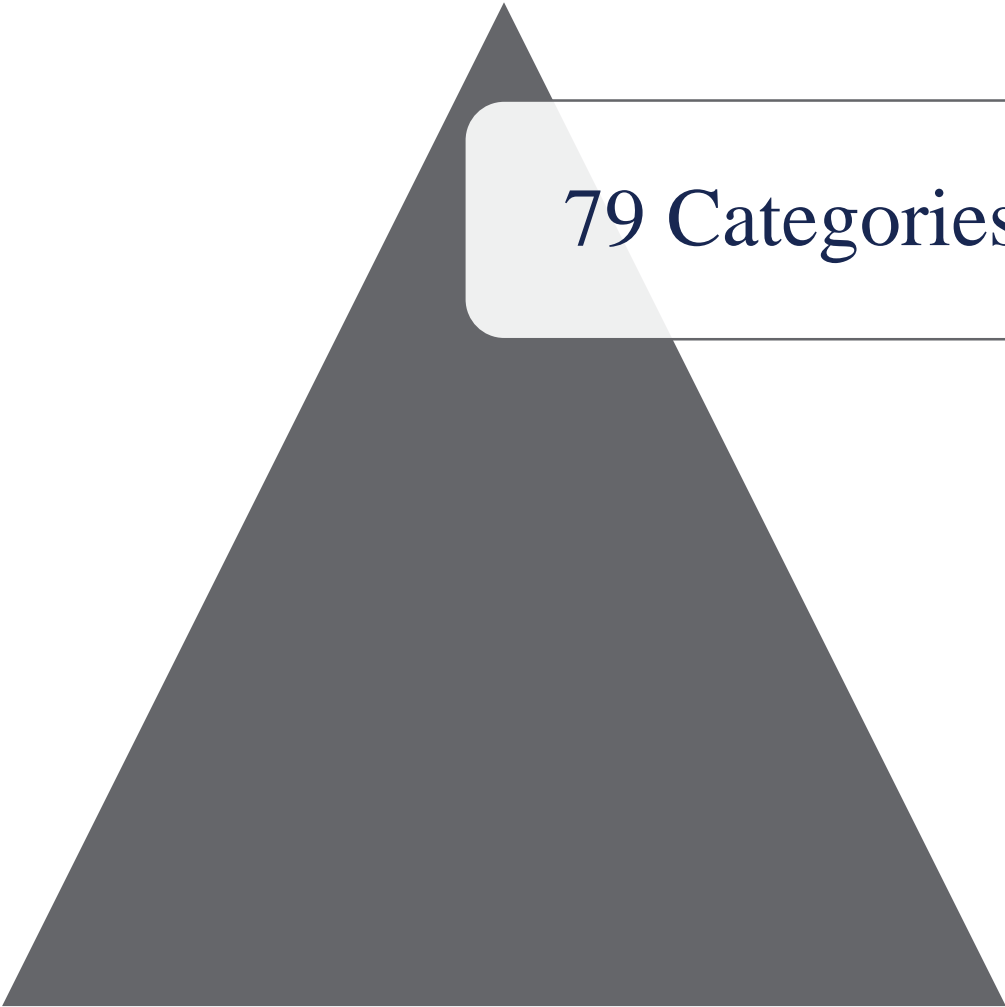
HIERARCHICAL CONDITION CATEGORIES

- 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 and resource utilization at a patient level

HCC SCORING



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



79 Categories

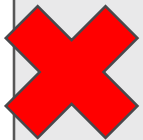
31 Hierarchies

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 19 E119 – Type 2
Diabetes Mellitus
without
complications

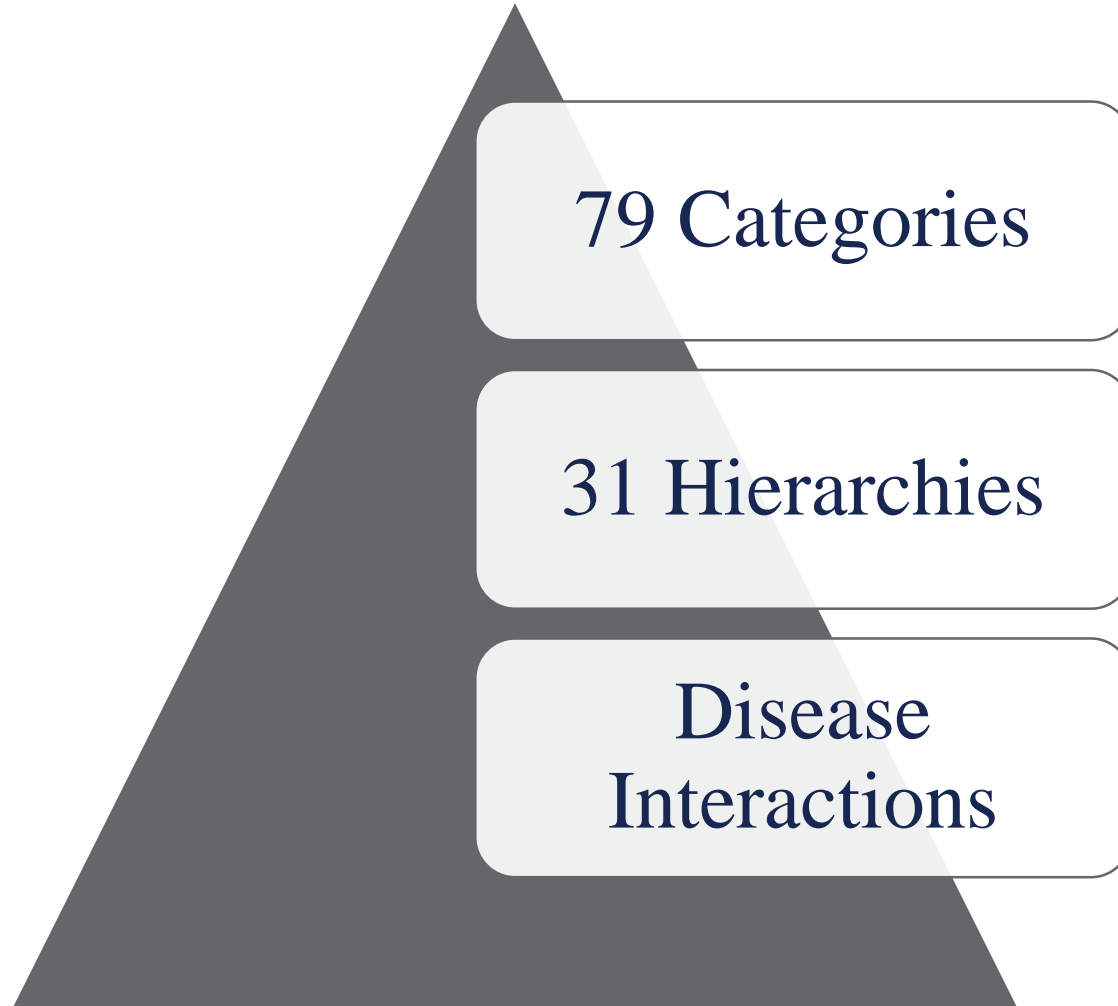


HCC 18 E0821 –
Diabetes Mellitus
due to underlying
condition with
diabetic
neuropathy



HCC 17 E0811 –
Diabetes Mellitus
due to underlying
condition with
ketoacidosis with
coma

HCC SCORING



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

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

HCC SCORING

Acceptable Provider Settings for CMS HCCs – Inpatient and 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

HCC SCORING

Non-Covered Settings

- 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

Non-Covered Services

- 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

Orthopedics
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



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**



PROGRAMS THAT UTILIZE HCC SCORING

MEDICARE SHARED SAVINGS PROGRAMS

Determining
Benchmarks

Shared Savings/Loss
Calculation

MEDICARE ADVANTAGE

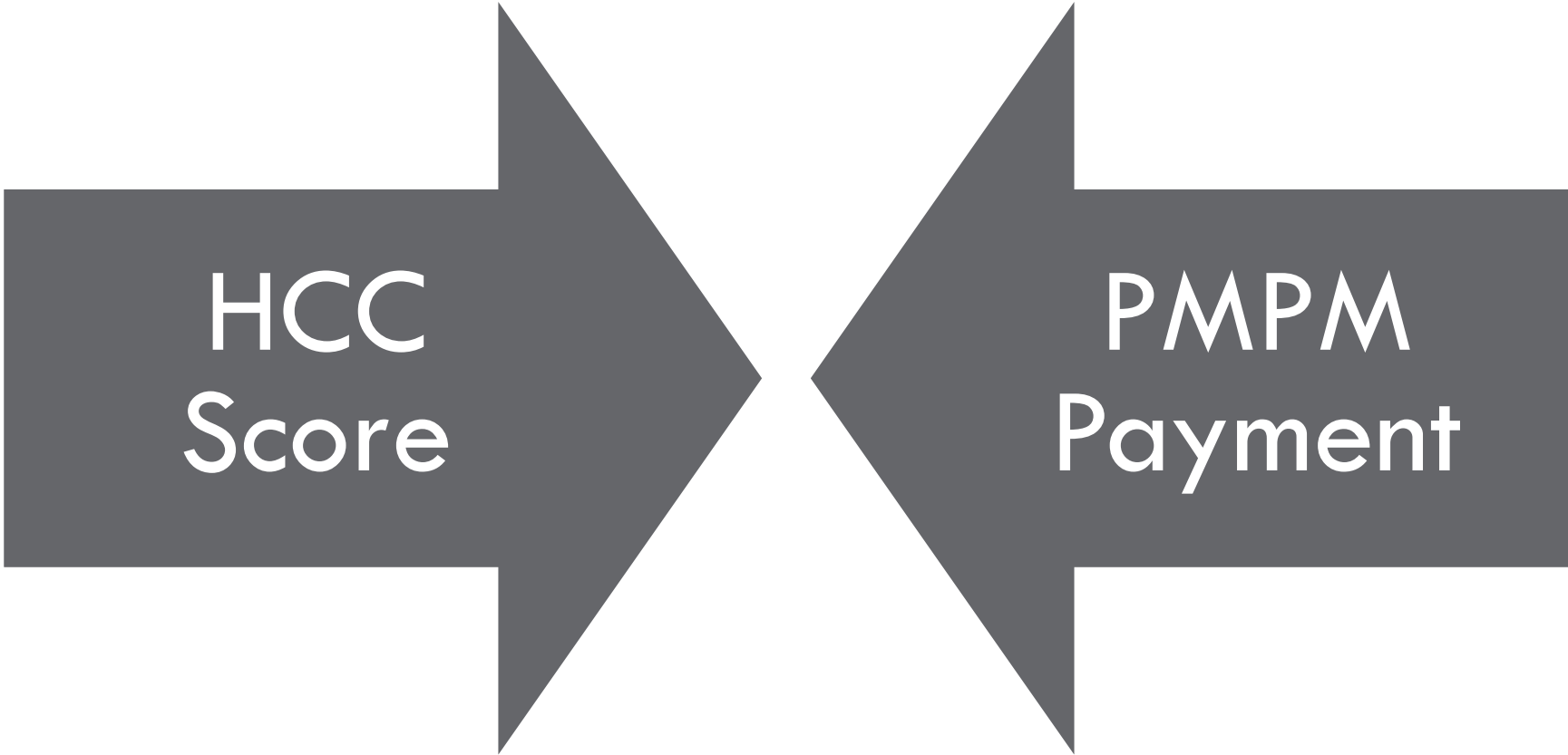
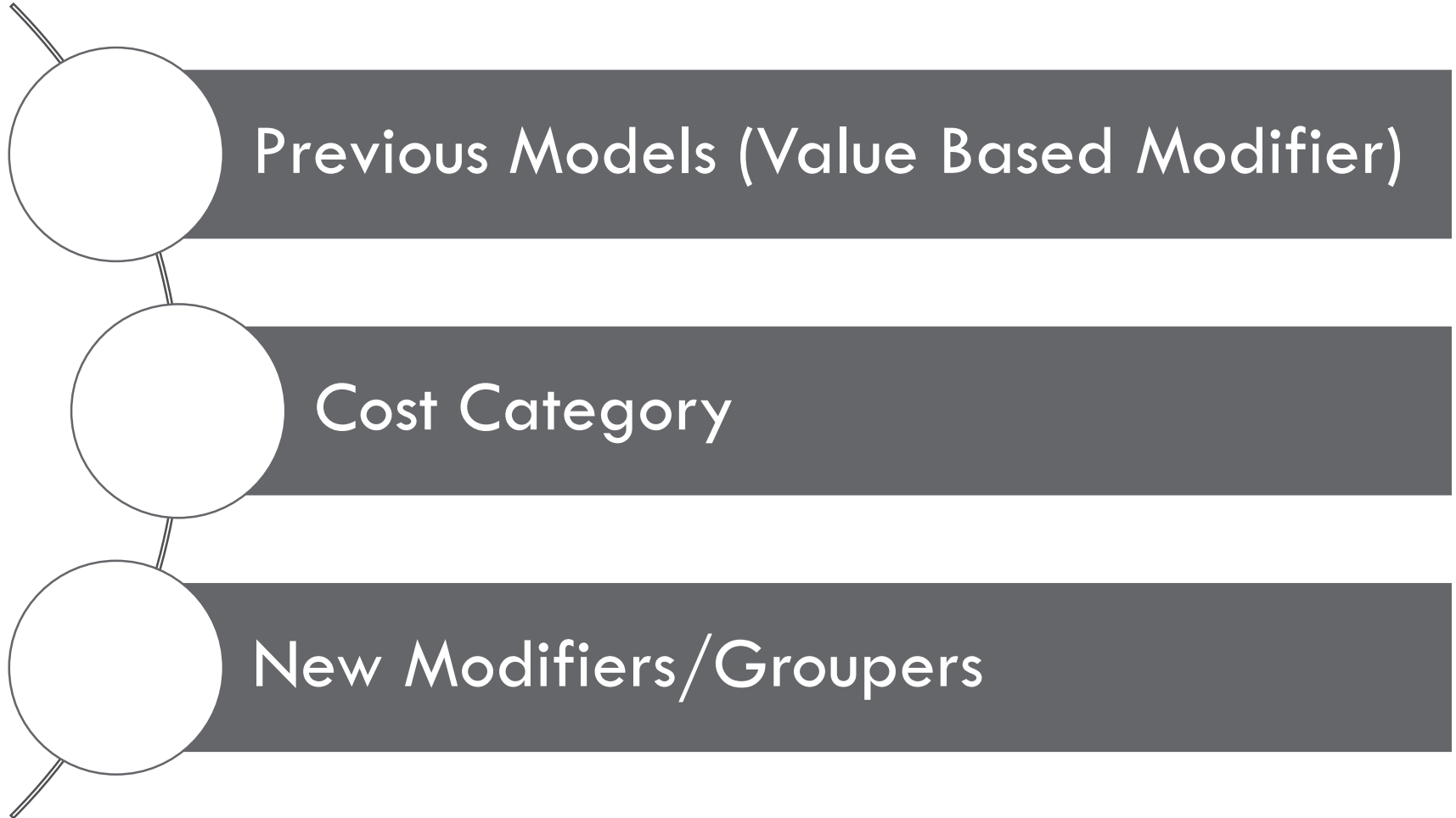


Table 3-1
Risk Tier Criteria and CMF Payments (per Beneficiary per Month)

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 <i>or</i> Dementia diagnosis	N/A	\$100

MACRA



WHERE DOES RISK ADJUSTMENT FIT IN?





OPERATIONALIZING HCC SCORING

OPERATIONALIZING HCC SCORING

- **Factors Affecting a Patient's Diagnostic Picture**
 - **Patient not seen by Primary Care Provider each year**
 - Many reasons attribute to this
 - Patient seen Infrequently for other Other Problems
 - Chronic conditions of a patient not monitored = not treated
 - Patient only presents with an acute problem in an acute setting such as urgent care or Emergency Room
 - Chronic conditions not addressed
- **How Can We Address Patients Who Seek Care Infrequently**
 - **IPPE – Initial Preventative Physical Exam**
 - **AWV – Annual Wellness Visit**
 - **CCM – Chronic Care Management**
 - **Annual Routine Physical**

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Diagnosis Driven
 - HCC built on Diagnoses not CPT
- Fee for service continues for individual claim
 - Potential for Revenue Leakage if focus is only on individual claim payment
- For HCCs most documentation comes from outpatient office visits rather than inpatient encounters
 - Chronic conditions addressed in office setting

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Number of Diagnoses reported for encounter
 - Claim will be paid based on CPT code if medical necessity met with minimal diagnoses coded
 - AWWV and IPPE – will be reimbursed with as little as one diagnosis code
- Complete coding important to assure accurate HCC capture
 - Impact on Productivity
 - Assure all codes are submitted

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Symptoms vs Specific Diagnoses
 - HCC model typically excludes symptoms
 - Symptoms are typically acceptable to support the E/M reported
 - Example:
 - Hypoxia – no HCC
 - Respiratory Failure - HCC

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Unspecified vs Specified Diagnoses
 - HCC model may excludes unspecified codes
 - Chronic Kidney Disease
 - Stage 4, stage 5 and ESRD are HCC
 - Stage 3 in proposed rule for assignment of HCC
 - Unspecified CKD – no HCC

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Unspecified vs Specified Diagnoses
 - Additional Specificity Changes the HCC score
 - Diabetes Mellitus
 - Different HCCs for with acute complications (17), chronic complications (18), and without complications (19)

OPERATIONALIZING HCC SCORING

NEW WAY OF THINKING

- Status codes are Important
 - Status Post Amputation
 - Below knee
 - Foot
 - Toe
 - Presence of an opening such as a colostomy/gastrostomy
- Dialysis Status
 - HCC score higher than ESRD

OPERATIONALIZING HCC SCORING

Hospital environment often has more resources

- Coding
- Documentation Improvement Activities
- Physician Queries

Increased importance in physician office setting with need for resources

- Coding
- Documentation Improvement Activities
- Physician Queries

OPERATIONALIZING HCC SCORING

PROBLEM LISTS

Useful Problem List	Where Problem Lists Fail
Problem oriented, patient centered focus	Laundry List of all diagnoses and procedures
Specific diagnoses	Symptoms and unspecified conditions
Defined what goes on the list	Users decide what and what not to include
Roles are defined <ul style="list-style-type: none">• Who can contribute to problem list• Who is responsible for problem list management	Everyone responsible and nobody responsible
Single entry of conditions	Duplicate entries
Process for maintaining list is integrated with clinician workflow	Separate process for updating the problem list



An accurate problem list helps providers identify ongoing chronic conditions and can play a significant role in improving patient care.

OPERATIONALIZING HCC SCORING

- **Pre-Appointment Chart Scrubbing**
 - **Highlight for provider**
 - Chronic conditions
 - Medications
 - Current treatments
 - Utilize Problem List as a tool
 - **Utilize team**
 - CDI
 - Case Management
 - Nursing
 - **Utilize medical records from outside provider for patient follow up**
 - **Utilize EMR tools to assist**
 - BMI
 - Amputations
 - Artificial openings

ADDITIONAL BENEFITS OF PRE-APPOINTMENT CHART SCRUBBING

Maintains Problem Lists

Increases
Communication

Preventative Services

OPERATIONALIZING HCC SCORING

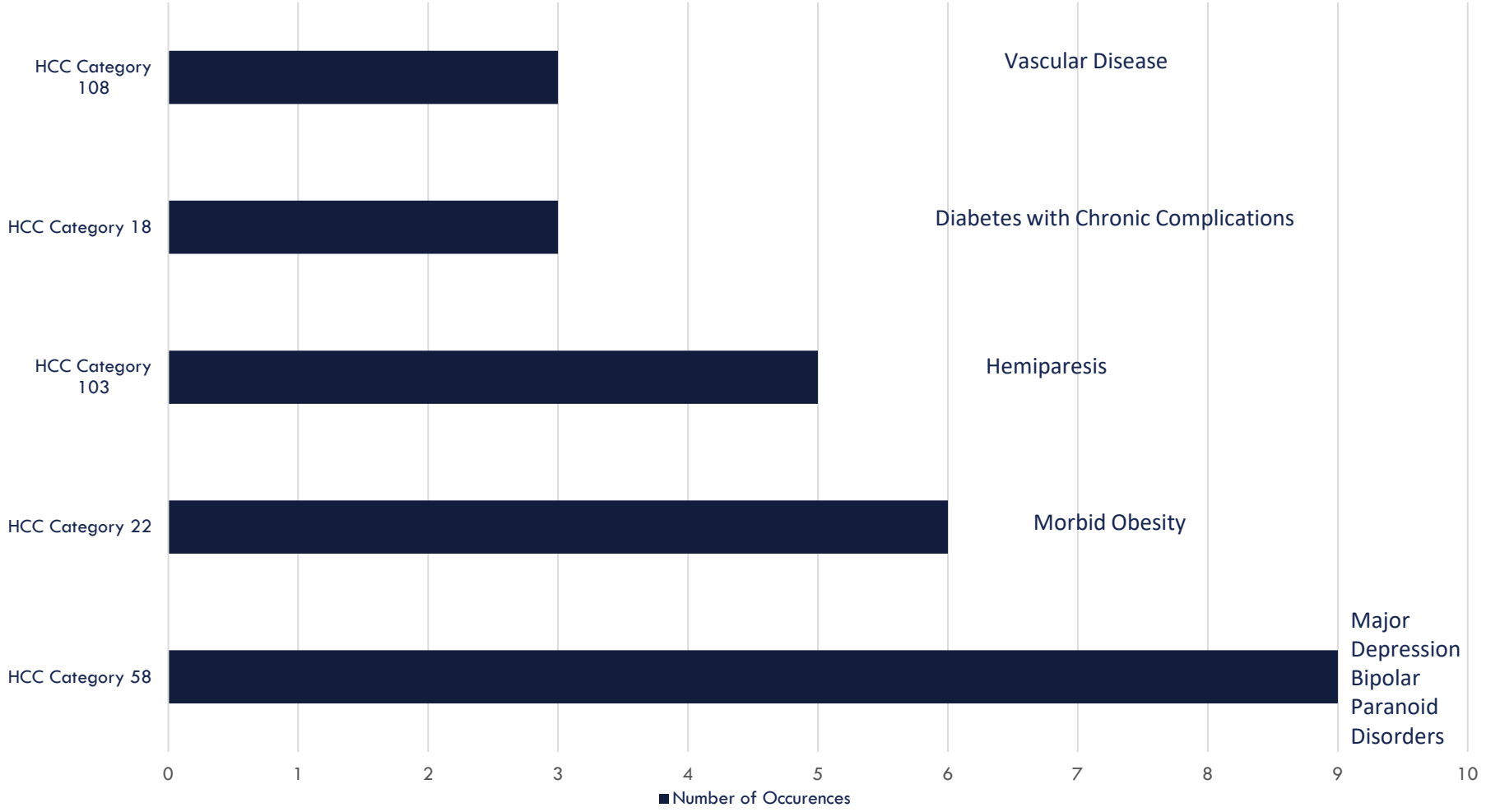
- **Utilize EMR Tools**
 - EMR identifies diagnoses on problem list which are HCC
 - Caution – need to document more than just the diagnosis to support
 - Identifies potential diagnoses not reported in calendar year
 - Alerts:
 - BMI
 - Amputations
 - Artificial Openings

OPERATIONALIZING HCC SCORING

- **QA Reviews**
 - Take a snapshot of patients
 - Identify top HCC categories commonly missed documented
 - Provide education on diagnoses within each category
- **Provide Education**
 - Providers
 - Coders
 - Case Management
 - CDI
 - Nursing

OPERATIONALIZING HCC SCORING – QA REVIEWS

Number of Occurrences of Missing Documentation



COMMON DOCUMENTATION OPPORTUNITIES

Unspecified DX	HCC Category	Specified DX	HCC Category
Major Depressive Disorder – F32.9	_____	Major Depressive Disorder (Mild, Moderate, Severe) – (Single or Recurrent) F32.0 – F32.5 F33.0 – F33.9	Category 58

COMMON DOCUMENTATION OPPORTUNITIES

Unspecified DX	HCC Category	Specified DX	HCC Category
Obesity – E66.9	_____	BMI (Body Mass Index) beginning at 40 or greater or Morbid Obesity	Category 22

COMMON DOCUMENTATION OPPORTUNITIES

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

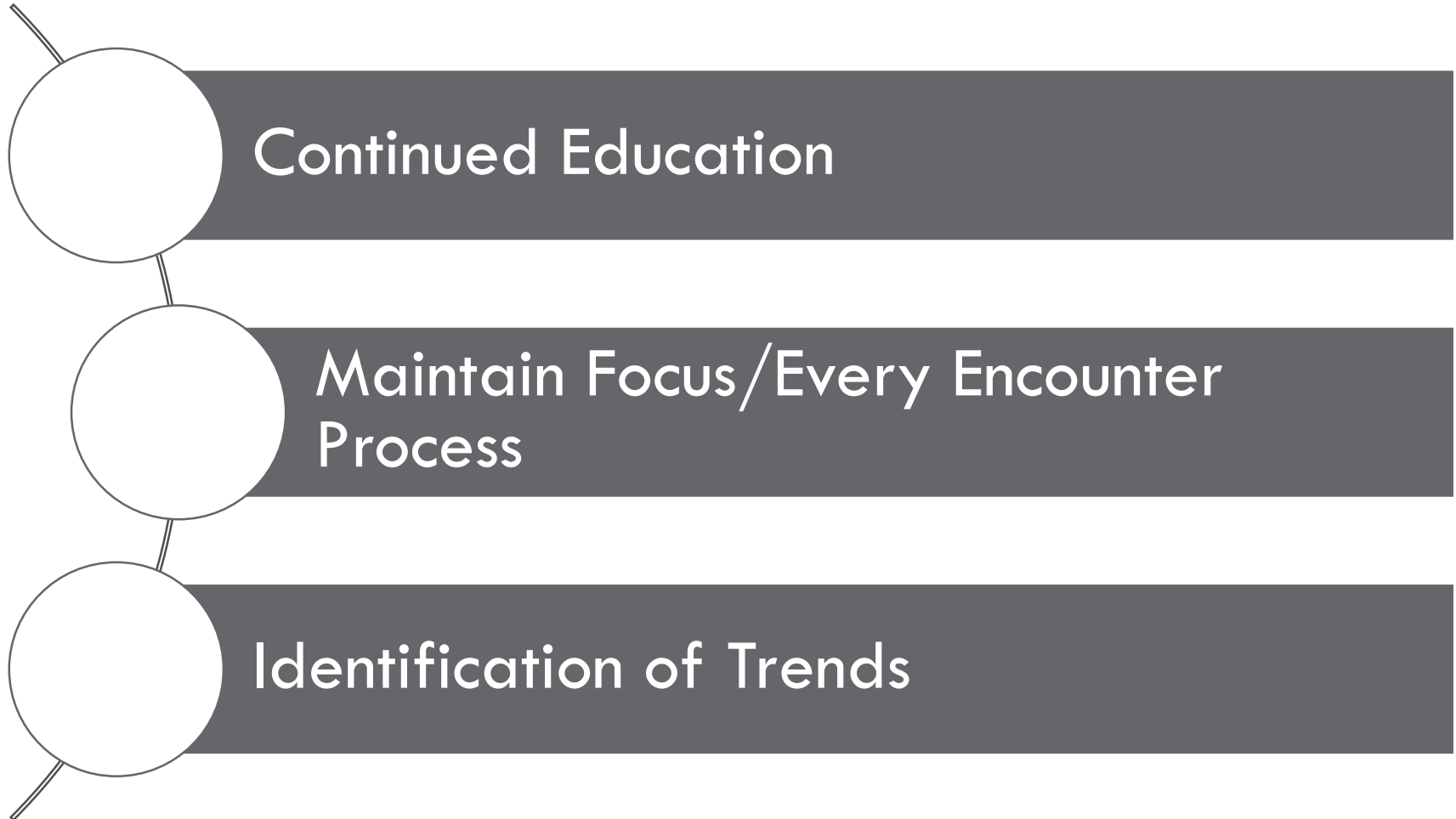
COMMON DOCUMENTATION OPPORTUNITIES

Current Documentation	HCC	More Specific Documentation	HCC
E119 – Diabetes	19	E1142 – Diabetes with polyneuropathy E1121 – Diabetes with nephropathy E11319 – Diabetes with retinopathy	18

COMMON DOCUMENTATION OPPORTUNITIES

Current Documentation	HCC	More Specific Documentation	HCC
M79604 - Pain in Right Leg	---	I739 – Peripheral Vascular Disease	103

BENEFITS OF A QA PROGRAM/CONTINUOUS REVIEW PROCESS



BRINGING EVERYONE TOGETHER





DOCUMENTATION REQUIREMENTS

M.E.A.T.

M

- Monitor signs, symptoms, disease progression

E

- Evaluate – test results, response to treatment

A

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

T

- Treat – medications, therapies, other modalities

DOCUMENTATION AND CODING

Do's	Don't
Specified Diagnosis/Code <ul style="list-style-type: none">Aspiration Pneumonia	Unspecified Diagnosis/Code <ul style="list-style-type: none">Pneumonia
List Diagnoses with evaluation and treatment	Rely on Problem List
Individualize documentation	Clone documentation
Include chronic conditions/diseases which impact treatment and decision making	Leave off chronic conditions/diseases
If diagnosis is active, list active diagnosis with treatment "COPD on home nebulizer"	List diagnoses as all "history of" "History of COPD"
Code claim completely	Code to get the claim paid



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

RADV AUDITS

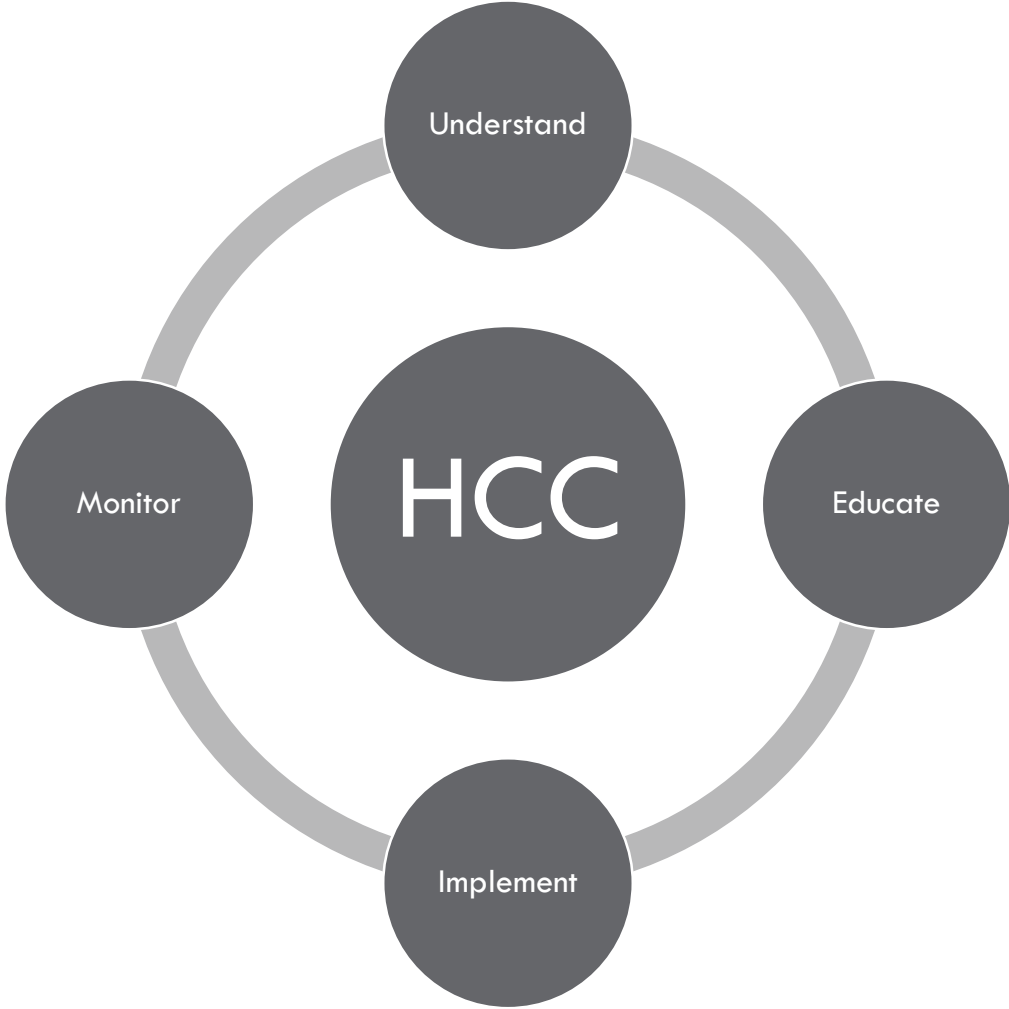
CMS declared the HCC Error Rate is approximately 33%.

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.

Summary

OPERATIONALIZING HCC SCORING



QUESTIONS?

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THANK YOU

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