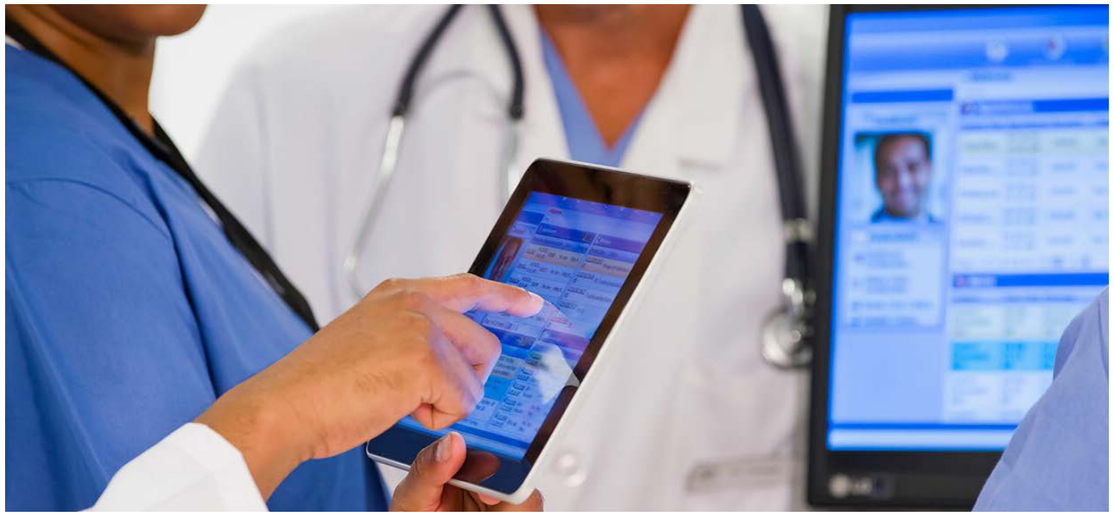
Optimizing HCC Coding
for Accurate Reimbursement

Hierarchical Condition Category (HCC) codes are an integral aspect of healthcare's ongoing transition from fee-for-service to a value-based care model of reimbursement—a transition that requires providers to better manage patient costs based on a clear, concise, and comprehensive picture of patients' health and medical conditions.



Used by the Centers for Medicare and Medicaid Services (CMS) and commercial payors to forecast medical costs for patients with more complex healthcare needs, the HCC risk adjustment model measures relative risk due to health status to determine reimbursement levels. The more complex the patient's medical needs, the higher the provider's payment.

HCCs are now the preferred method of risk adjustment for the Medicare population which, according to figures from CMS, includes nearly 60 million people on both Part A and Part B, approximately 30.2 million of whom are enrolled in a Medicare Advantage (MA) plan. Thus, doing it correctly is crucial to Medicare providers and payors who wish to be appropriately reimbursed for the care provided to patients and beneficiaries.

The Critical Need for Accuracy

HCC is a highly complex model under which there are approximately 10,000 diagnosis codes that map to HCC codes and 189 different HCC categories with 87 CMS-HCCs, each representing diagnoses with similar clinical complexity and expected annual care costs. Accuracy is crucial, as any error can significantly impact reimbursements and, subsequently, the overall bottom line.

Under HCC, reimbursement is determined by mapping a patient's diagnoses to these codes to create a Risk Adjustment Factor (RAF) score, which represents the estimated cost of caring for that individual based on their disease burden and demographic information. The RAF score is then multiplied by a base rate to set the provider's per-member-per-month (PMPM) reimbursement. Typically, healthier patients will have a below average RAF, while sicker patients will be above average.

Each year, CMS publishes a list of diagnosis codes and the corresponding HCC category they adjust to within the model. Hierarchies are listed among related condition categories, which set values based on the severity of illnesses, with more severe diagnoses carrying the overall risk scores for families of conditions. Failing to properly document HCC codes—or failing to do so at the highest appropriate specificity—results in lower reimbursement rates. For example, HCC 19, diabetes with no complications, might pay an $894.40 premium bonus compared to a bonus of $1,273.60 for diabetes with ESRD, which requires two HCC codes mapping to 18 and 136.

Conversely, properly documenting HCCs at the highest appropriate specificity can boost reimbursements.

For example, if CMS has set a $1,000 PMPM for a patient with an RAF of 2.234 who has diabetes with complications:

- Reimbursement would be just $673 per month if the condition is not coded.
- If properly coded as E11.9, type 2 diabetes mellitus without complications, under HCC 19, diabetes without complications, the RAF increases to 2.366, resulting in reimbursement of $1,062 per month.
- If properly coded as E11.41, type 2 diabetes mellitus with diabetic mononeuropathy, under HCC 18, diabetes with chronic complications, the RAF increases to 2.513 for a reimbursement of $1,312.5.

HCC coding is important under value-based care models and for population health management. Failing to capture a comprehensive and accurate picture of the health and risks of a patient population can lead not only to reduced reimbursements but also to inaccurate or ineffective decision making regarding interventions and investments. For example, risk scores that inaccurately reflect a population's rate of diabetes or congestive heart failure could result in a provider organization investing money and resources into something other than a cardiac care or diabetes center, which could ultimately result in poor outcomes and money lost.

HCC Coding Challenges

Its interlocking steps make accurate documentation and coding for HCC as complex as it is critical. Hierarchies ensure an individual is coded for the most severe manifestation among related diseases. Diagnosis codes roll up to diagnostic categories, which are included in condition categories, which then become HCCs. Each mapped diagnosis must be supported with documentation and evidence to ensure timely, accurate, and complete coding and billing.

Maximizing the use of HCC tables to capture diagnosis codes, complication/comorbid conditions (42% of HCCs), and major complication/comorbid conditions (16% of HCCs) is important for accuracy, as is optimizing Medicare Severity Diagnosis Related Groups (MS-DRGs) assignments that confirm the severity of illness and risk of mortality. As such, complete and accurate clinical documentation is the foundation for proper HCC assignment.

The challenge is that the HCC documentation and coding process is fraught with challenges, which typically fall into three categories:

1. Incomplete medical records, which can lead to undercoding, resulting in lower reimbursements, inaccurate RAF scores, downgrades to lower hierarchical category levels, and bad investment decisions to support the patient population. It is a challenge that can be exacerbated by coders working in a manual environment who may not recognize they are working with incomplete records.
2. Limited resources, in particular coding specialists with the skills and experience necessary to properly evaluate a patient's chart and extrapolate the information needed to document the appropriate HCC category.
3. Complex and rapidly evolving regulations, which can be difficult to stay on top of (particularly in a manual environment), leaving coders to work from outdated HCC code sets and guidebooks.

Additionally, many organizations struggle to engage physicians in the query process, which hinders efforts to improve documentation that relates to risk-adjusted coding. Further, physicians embrace technology at varying rates, so it is often necessary to

employ multiple communication methods to succeed at risk-adjusted and HCC coding.

Optimizing Reimbursement

To optimize HCC coding for accurate reimbursement, healthcare providers should focus on several key areas, starting with adherence to the MEAT criteria (monitor, evaluate, assess/address, and treat) to support proper documentation. Coders use the MEAT formula to help them correctly identify and assign HCC chronic condition diagnoses, which payors also use to account for the overall health and medical cost expectations of each patient enrolled in a health plan. This is vital, as value-based payment models that require providers to carry greater financial risk are becoming the norm.

Another key focal point is the patient population—both individual patients and the global population. Focus on those areas that have the greatest impact on risk adjustment, as well as high value and volume encounters. Where appropriate, implement outpatient clinical documentation improvement (OP CDI) initiatives to close documentation gaps, shore up weaknesses, and improve evidence capture.

There are also several technology tools that can facilitate needed improvements in HCC coding and documentation, including:

- Computer-assisted coding (CAC) solutions that update automatically.
- Computer-assisted professional coding (CAPC) tools that leverage natural language processing (NLP), natural language understanding (NLU), and machine learning (ML) to automatically annotate documentation and autosuggest ICD-10 with HCC mappings for improved diagnosis capture, as well as identify diagnosis without supporting evidence and estranged evidence without a diagnosis.
- HCC ROI calculators or RAF aggregation tools that optimize HCC coding and accurately capture all relevant diagnoses.
- Dashboards that provide an accurate reflection of a provider's scores for real-time management.

Health plan relationships should also be part of any improvement strategy. In particular, request regular updates on their diagnosis codes, which will allow providers to sync with their payors and identify what is missing or no longer allowed.

Additionally, ensure physician engagement—a tricky prospect with risk-adjusted coding—by developing a program that balances the use of auto-generated queries and NLP-based functionality with CDI delivered in meaningful ways. For example, some providers prefer a checklist in the medical record, while others need more direct prospective OP CDI reviews to bring discrepancies to their attention.

Finally, make judicious use of internal audits. Prospective audits can help improve how physicians document care and how coders code health conditions, translating into improved financial performance. Retrospective audits can bridge documentation gaps and identify where additional provider and coder education is needed. For example, if providers are missing documentation of supportive evidence for diabetes and cancers, exclusive education programs can be developed to address the gap.

Conclusion

Accurate, compliant HCC coding is critical to the financial well-being of payors and providers, and to the health of their patient populations. The challenges inherent in the HCC process can be overcome with properly designed and implemented strategies that ensure appropriate documentation to support accurate coding at the highest specificity—leading to significantly improved bottom lines and patient outcomes.

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