Coding for Risk Adjustment with HCC's for Coders

Definition: Risk adjustment was developed to predict future costs for groups of beneficiaries or subscribers. Now, it is used to normalize cost, quality, and outcome for different groups of patients. Accurately assigning diagnosis codes to a patient record we communicate to the payers the correct acuity of the patient being treated.

HCC: Hierarchical Conditions Categories(HCCs) were developed by Medicare to pay Medicare Advantage Organizations a monthly fee, based on the disease burden of their patients. HCCs are now used by some ACO's and private payers as one metric in determining future payments.

ICD-10-CM guidelines: When assigning diagnosis code in physician practices use Section I, Conventions, official coding guidelines and the chapter specific guidelines and Section IV, Diagnostic coding, and Reporting Guidelines for Outpatient Services from the official guidelines. Sections II and III relate to NON-Outpatient settings.

Difference between Traditional coding and RA coding: Traditional coding focus is on the Chief complaint (CC) and capturing the reason for the visit and the treatment of the Chief Complaint. "Risk Adjustment coding, however, puts equal emphasis on the Chief Complaint and chronic conditions of a patient, because the chronic conditions affect the patient's overall health status, resource requirements, and decision making regarding the Chief Complaint." ." *(Risk Adjustment Documentation and Coding, by the AMA; Chpt 3 Clinical Documentation and Coding for RA page 61)*

> **Note:** " Coders should check the coding performed by physicians and correct it as necessary. Codes are not documentation, so coders do not need to be concerned they are altering documentation when they disregard a code selected by a physician. Correct coding and billing are joint efforts between physicians and coders, wherein the physicians' primary focus is on the patient and the documentation that follows from an encounter, while the coder's focus is on the abstraction after the encounter. " . *(Risk Adjustment Documentation and Coding, by the AMA; Chpt 3 Clinical Documentation and Coding for RA page 85)*

HCC Coding highlights

1. **"The assignment of a diagnosis codes** is based on the provider's diagnostic statement that the condition exists. **The provider's statement that the patient has a particular condition is sufficient.** Code assignment is not based on clinical criteria used by the provider to establish the diagnosis" (*ICD-10-CM Official Guidelines, Section A-19, p. 12)*

2. "**Code all documented conditions that coexist at the time of the treatment** that require or affect patient care treatment or management. (*ICD-10-CM Official Guidelines, Section IV J, P. 120)*
    a. *Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment.*
    b. *Do not code conditions which no longer exist.*
3. **When is a Problem Address?:** A problem is addressed or managed when it **is evaluated or treated at the encounter** by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. **Notation in the patient's medical record that another professional is managing the problem <u>without additional assessment</u> or care coordination documented does not qualify as being "addressed" or managed by the physician or other qualified health care professional reporting the service.** Referral without evaluation (by history, exam, or diagnostic study[ies] or consideration of treatment does not qualify as being address or managed by the physician or other qualified health care professional reporting the service." *(Current Procedural Terminology, 2021 Professional Ed., American Medical Association, p. 12)*
4. **CMS tells us** what parts of the visit note we CAN and which parts of the visit note we CANNOT Risk code from:

CAN Code from	CANNOT Code from
• HPI – History of Present Illness • ROS – Review of systems • Assessment • Plan	• Problem List • List of current problems (not addressed at visit) • Medication List • Conditions in past medical history that are not managed on the date of visit.

5. **Supporting documentation should describe** the condition, complications, and clinical significance. CMS says, "In all cases, the documentation must support the code selected and substantiate the proper coding guidelines were followed." *(2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide, Section 6-6)*
    a. ***At a minimum you should see documentation of "Condition/diagnosis – Status – Plan" before you code it.***
6. **When certain conditions occur together**, the risk score increases, be sure to watch for document that links these conditions. Such as to name a few:
    a. Immune disorders and cancer
    b. CHF and diabetes
    c. CHF and COPD
    d. CHF and renal disorders
    e. CHF and specified heart disorders
    f. COPD and chronic renal failure
    g. Substance uses disorders and psychiatric conditions
    h. Diabetes and CKD
7. **Remember:**
    a. Report chronic conditions **Annually**; Slate is wiped clean every January.
    b. For chronic conditions with a manifestation or complication, report with the appropriate combination code if that is appropriate; **AVOID** unspecified codes for chronic conditions.
    c. Add status codes when applicable. **(See the list below)**
    d. We want all codes to be specific but focus on conditions in problem list that are chronic, long standing, and have codes that describe manifestations and complications, or are defined by severity or stage an:
        i. Site, Location, or laterality
        ii. Substance use/exposure
    e. Add additional diagnoses to describe "with" conditions. (Ex. " Diabetes With CKD" E11.22, N18.4)
    f. Code to the highest level of specificity and ensure the diagnoses are properly sequenced on the claims.
8. **Don't forget these important codes:**
    a. Transplant status
    b. Ostomy Status
    c. Amputation Status
    d. Diabetes with Complications
    e. Dialysis Status
    f. History of Cerebral infarction vs. Cerebral Infarction
    g. Old Myocardial Infarction vs. Acute Myocardial Infarction
    h. Major Depressive disorder
    i. Watch for the correct coding for Hypertension, Chronic Kidney Disease and Heart Disease. These are often miscoded.
    j. Be sure code Diabetes with complications appropriately

The Right Resources

"*ICD-10-CM Guidelines* are essential to proper code abstraction, but they are not embedded in the codes set or most EHR's. It is the responsibility of anyone assigning diagnostic codes to ensure the *ICD-10-CM Guidelines* are being followed, and that code selections aligns with the advice of *AHA's Coding Clinic*. *AHA's Coding Clinic* is a quarterly publication that provides advice in addition to those found in the *ICD-10-CM Guidelines.* In addition, AHA's offers a free service of providing official ICD-10-CM coding advice through their website at https://www.codingclinicadvisor.com/, which may be used in defining and defending coding policies and procedures. CMS expects *AHA's Coding Clinic* advice to be followed when there is a void in current or recently amended conventions outlined in the ICD-10-CM Alphabetic Index, Tabular List, and *ICD-10-CM Guidelines*. When there are conflicts between ICD-10-CM conventions and guidelines and AHA's Coding Clinic, the flowing hierarchy should be followed:

1. Conventions supersede Guidelines and Coding Clinic.
2. Guidelines supersede Coding Clinic
3. Coding Clinic fills the void if the answers are not available in the Guidelines or coding conventions.

Failure to follow these rules can affect the accuracy of RA and have repercussion in an audit.") *Risk Adjustment Documentation & Coding 2nd Edition, American Medical Association, Chapter 3 page 95*