HCCs: Meeting Compliance Demands

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Identify what HCCs are used for
  – State the differences between inpatient and outpatient coding and documentation requirements
  – Explain diagnostic validation standards for compliant assignment of codes for outpatient claims
  – Identify HCC focus areas for the highest return on investment
Agenda

• Payment models for providers and health plans
• Hierarchical Condition Categories (HCC)
• Outpatient documentation and coding guidelines
• Outpatient clinical diagnostic validation standards and criteria
• Key HCC diagnosis and case study examples
Payment Models

1. Fee for service:
   - Inpatient DRG
   - APCs for hospital ambulatory care
   - CPT codes for physician services

2. Value-based: Fee for service with incentives and/or penalties based on certain quality and cost measures
   - CMS pay-for-performance programs
   - APM: Medicare Shared Savings Program, bundled payments

3. Risk: Full capitation – Capped annual payment to cover all healthcare expenses for a patient
What Are HCCs?

• Hierarchical Condition Category (HCC)
  – Diagnostic risk adjustment model
  – Groups of related diagnoses with similar long-term costs
  – Assigned a coefficient (weight)
  – Primarily chronic conditions

• CMS-HCC: Medicare Advantage
  – 79 HCCs
  – 9,500+ codes

• HHS-HCC: Commercial/non-elderly populations
  – 179 HCCs
  – 7,700+ codes
CMS Payment Medicare Advantage (Part C) Plans: CMS-HCCs

• Each Medicare Advantage member is assigned a Risk Adjustment Factor (RAF) based on
  – Demographic factors (age, disability, Medicaid eligibility)
  – Diagnostic data (inpatient and outpatient)

• Medicare pays the insurer/health plan for each patient based on each individual’s calculated risk score
Why Are CMS-HCCs So Important?

- **Directly** impact payment to health plans
  - HCC diagnoses directly affect the capitated payment a health plan receives for each of its Medicare Advantage members

- **Indirectly** impact payment to providers
  - HCC diagnoses are used to risk-adjust certain quality and cost measures (inpatient and outpatient)
# CMS Payment to Health Plans: CMS-HCCs

<table>
<thead>
<tr>
<th>Description</th>
<th>HCC</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 year old male</td>
<td>Demographics</td>
<td>0.437</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>Demographics</td>
<td>0.177</td>
</tr>
<tr>
<td>Diabetic nephropathy (E0821)</td>
<td>18</td>
<td>0.368</td>
</tr>
<tr>
<td>Pneumonia (J189)</td>
<td>--</td>
<td>0.0</td>
</tr>
<tr>
<td>Pulmonary hypertension (I272)</td>
<td>85</td>
<td>0.368</td>
</tr>
<tr>
<td>Acute respiratory failure (J9600)</td>
<td>84</td>
<td>0.329</td>
</tr>
<tr>
<td>Total RAF</td>
<td></td>
<td>1.679</td>
</tr>
<tr>
<td>Annual payment</td>
<td></td>
<td>$15,111</td>
</tr>
</tbody>
</table>

Assumes per capita base rate payment of $9,000
Payment to Providers

• Medicare Advantage patient
  – Health plans pay providers (hospitals and physicians) based on fee-for-service
  • Very few providers are paid by capitation
  • Payment adjustments if value-based contract with health plan

• Traditional Medicare patient
  – Medicare pays providers based on fee-for-service
  • Payment adjustments based on quality and cost measures
## CMS P4P Measures Risk-Adjusted With HCCs

<table>
<thead>
<tr>
<th>Program</th>
<th># of Risk-Adjusted Measures</th>
<th>Incentive / Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-Based Purchasing</td>
<td>6 of 21</td>
<td>+2% to -2%</td>
</tr>
<tr>
<td>Readmissions Reduction</td>
<td>7 of 7</td>
<td>Up to -3%</td>
</tr>
<tr>
<td>HAC Reduction</td>
<td>1 of 7</td>
<td>-1%</td>
</tr>
<tr>
<td>Value Modifier</td>
<td>~ 50%</td>
<td>+32 to -2%</td>
</tr>
<tr>
<td>Medicare Incentive Payment System (MIPS)</td>
<td>Cost of care measure + a few others</td>
<td>+4% to -4%</td>
</tr>
</tbody>
</table>
Focus on CMS-HCC Diagnoses

- Each program currently uses different versions of the condition categories for risk adjustment
  - Each measure includes its own set of HCCs for risk adjustment
  - Risk adjustment coefficients, scoring methodologies, and performance periods vary by measure
- Just focusing on CMS-HCCs in general should capture at least 90% of the risk adjustment for all these programs
  - Inpatient and outpatient
Outpatient Guidelines and Compliance
CDI in the Outpatient Setting

2016 ACDIS Outpatient CDI White Paper:

1. Emergency department
2. Observation services
3. Ambulatory clinics: Primary care, infusion, diagnostic, ambulatory surgery
4. Evaluation and management (E/M) services
5. CMS-HCCs
## Inpatient vs. Physician Practice

### Inpatient
- Long visit
- Payment based on diagnosis / DRG
- Inpatient coding guidelines
  - Uncertain diagnoses can be coded
- Documentation requirements
  - Meet secondary diagnosis guideline

### Physician Practice
- Short visit
- Payment based on E/M level, not diagnosis
- Outpatient coding guidelines
  - Uncertain diagnoses cannot be coded
- Documentation requirements
  - Must be relevant to encounter and addressed during the visit
Official Coding Guidelines

- **Inpatient**
  OCG Section III – Definition of additional diagnosis: clinical evaluation, treatment, diagnostic procedures, increased nursing care/monitoring, or extended LOS.

- **Outpatient**
  OCG Section IV – Documented condition must be directly “relevant” to or “affect” the specific encounter. The term “addressed” best describes this requirement.
Official Coding Guidelines: Outpatient

• Section II Principal Diagnosis and Section III Other (Secondary) Diagnoses do not apply to outpatient
  – For inpatient only
  – Section I Conventions / General and Chapter-Specific Guidelines apply to both outpatient and inpatient

• IV.I: “Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).”

• IV.J: “Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.”
Clinical Validation: MEAT

• Widely used and generally accepted industry standard “MEAT”
  – Monitoring – Signs, symptoms, disease progression, disease regression
  – Evaluating – Test results, medication effectiveness, response to treatment
  – Assessing/addressing – Ordering tests, discussion, review record, counseling
  – Treating – Referral, medications, planned surgery, therapies, other modalities
Clinical Validation: MEAT

- Misinterpretation and misapplication of MEAT are common and have resulted in compliance audits and regulatory penalties

- Examples:
  - Physician states in the record a condition is being “monitored” without actually performing any specific monitoring activities
  - Diagnosis associated with a medication without managing it in some way assumes “treatment”

- Something more specific and consistent than MEAT is needed that identifies what sort of information is needed and where in the medical record it needs to be documented
Clinical Validation – Relevance: HEETD

• **Addressed/addressing:** Best term to conceptualize and operationalize the OCG Section IV requirements that the patient “receives treatment and care for the condition(s)” and that the condition(s) “require or affect patient care treatment or management” at the time of the visit

• Addressing is the reason MEAT is needed, not one of the criteria (“A”) for relevance of the condition to the visit
Clinical Validation – Relevance: HEETD

1. **History**: Specifically asking about the condition and any relevant signs or symptoms

2. **Examination**: Documentation of the presence or absence of specific findings related to the condition, not just a general statement about body area or organ system examined

3. **Evaluation**:
   - Diagnostic studies (ordering, reviewing or interpreting) – lab, imaging, EKG, EEG, PFTs, other studies pertinent to the condition
   - Review and summary of other records
   - Referral for evaluation of the condition
Clinical Validation – Relevance: HEETD

4. **Treatment** includes:

- Medication: Administration during visit, initiation of new medication, adjustment of current medication or consideration of it, or a decision that current medications and doses are sufficient and will be continued – not just refilling an existing prescription
- Equipment (DME) and supplies: Provided, ordered, or modified
- Referral for treatment of a condition
- Performing a procedure
Clinical Validation – Relevance: HEETD

5. **Discussion:** Documentation of the nature of conversations or counseling about the condition with patient, family, caregivers, other providers, not just documentation of “discussed”
Key HCC Diagnoses

- Abdominal Aortic Aneurysm, Aortic Atherosclerosis
- Alcohol / Drug Abuse, Dependence
- Amputation Status
- Cardiac Dysrhythmia
- Cardiomyopathy
- Chronic Kidney Disease
- Chronic Respiratory Failure
- COPD
- Depression
- Diabetic Complications
- Heart Failure
- Morbid Obesity / BMI
- Paralysis (Plegia / Paresis)
- Malnutrition
- Neoplasms
- Pulmonary Hypertension & Heart Disease
- Skin Ulcers
Abdominal Aortic Aneurysm (AAA)

HCC 108  Vascular Disease  0.299

Diagnosis: Dilatation of the aorta technically > 3.0 cm. Includes abdominal aortic aneurysm (most common) and thoracic (ascending, arch, descending) aorta.

Often an incidental finding on chest x-ray, lumbar spine x-ray and would not be coded unless significance documented and subsequently addressed.
Abdominal Aortic Aneurysm (AAA)

1. History:
   - Any unusual symptoms of chest, abdominal, back, flank or lower extremity pain, or suggestive of thromboembolism attributable to aneurysm
   - Symptoms associated with exacerbation of underlying vasculitis or infection

2. Exam:
   - Aortic pulsation (impulse) on abdominal exam or abdominal bruits
   - Initial assessment of body areas for findings of a causative vasculitis or infection
Abdominal Aortic Aneurysm (AAA)

HCC 108  Vascular Disease  0.299

3. Evaluation:
   – Ultrasound of aorta, CXR, or lateral lumbar x-ray specifically for calcification or enlargement
   – Aortography
   – Vascular surgery referral
   – Initial testing for a causative vasculitis or infection
Abdominal Aortic Aneurysm (AAA)

HCC 108  Vascular Disease  0.299

4. **Treatment:**
   - Surveillance with ultrasound: recommended every 6 mo. to 3 years depending on size
   - Aneurysm / Ectasia –
     - Initiation of medical treatment (e.g. antiplatelet agents including ASA, statin therapy) are not recommended as specific treatment and do not represent treatment for aortic aneurysm
     - Initiation or adjustment of medications for causative vasculitis or infection
   - Blood pressure control is important for aneurysm but not specifically for it
5. Discussion:
   - Implications like risks, consequences, outcomes, mortality, complications, and important symptoms
   - Medications and side effects
   - Evaluation and/or results
   - Other treatment or management and the associated risks/benefits, side effects, or complications including procedures
Diabetic Hyperlipidemia

HCC 18  Diabetes with Chronic Complications  0.368

Hypertriglyceridemia with low HDL cholesterol
• LDL cholesterol is not particularly elevated
• Pancreatitis is a well-recognized consequence of uncontrolled hypertriglyceridemia

Indicators:
• Triglyceride (TG) level (fasting) > 200 mg/dl
• Severe > 500 mg/dl – sometimes reaching several thousand with “lipemic (cloudy) serum”
• HDL cholesterol < 40 mg/dl
Diabetic Hyperlipidemia

1. Evaluation: Lipid profile

2. Treatment:
   - Low fat, diabetic diet; avoid alcohol
   - Fibrates: Gemfibrozil (Lopid) and fenofibrate (multiple brand names) – also increase HDL
   - Niacin (vitamin B3) in high doses ≥ 1,500 mg/dl – also increase HDL and decrease LDL
Diabetic Hyperlipidemia

HCC 18  Diabetes with Chronic Complications  0.368

2. **Treatment (continued):**
   - Omega-3 fatty acids (fish oils) in high doses ≥ 4 gm/d
   - Statin drugs (e.g. Lipitor)
     - Primarily for hypercholesterolemia (elevated LDL)
     - High doses for modest elevation of TG
     - Not recommended for severe hypertriglyceridemia (> 1,000 mg/dl)

3. **Discussion:** Implications, complications like pancreatitis, lifestyle modifications including low carb diet, strict blood sugar control, medications and side effects
In Summary ...

• HCC diagnoses directly affect capitated payments to a health plan for its Medicare Advantage members
• For providers, HCC diagnoses are used to risk-adjust quality and cost measures that can affect payment
• Outpatient coding and documentation requirements differ from the inpatient setting
• Diagnoses submitted on outpatient claims must be clinically valid and be specifically “addressed” (HEETD) during the visit
Source Citations

• ICD-10-CM Official Guidelines for Coding and Reporting: FY 2018

Thank you. Questions?

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