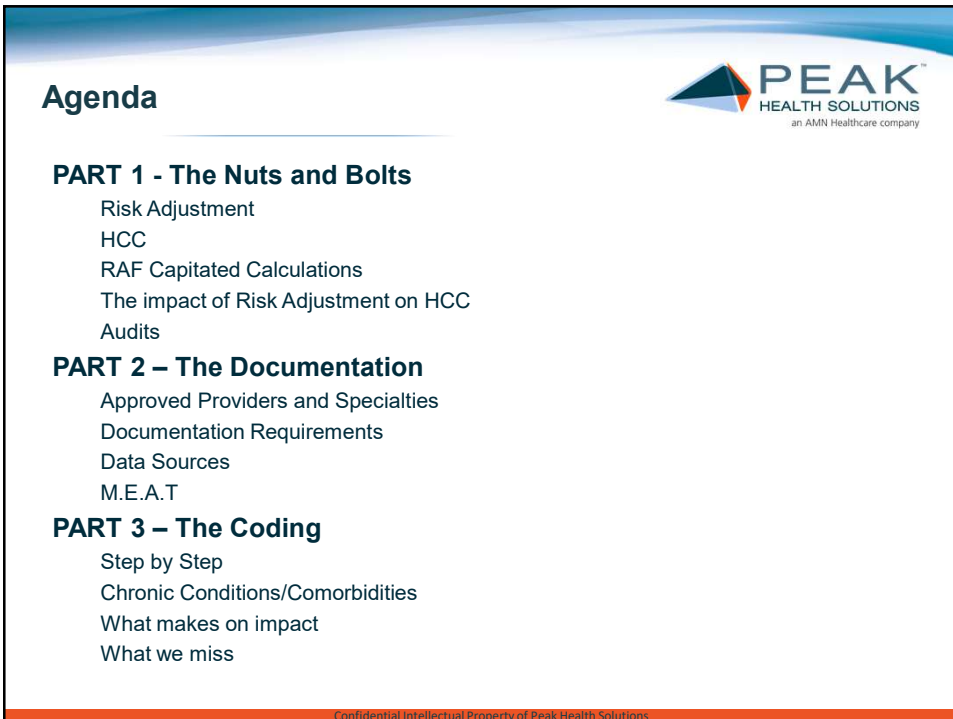
  
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**The ABC's of HCC's –  
HCC Reimbursement  
Methodology Fundamentals**

*Melissa McLeod-Seyfert*  
CDIP, CCDS, CCS, CPC, CPC-I,  
CRC, Ahima ICD-10-CM/PCS  
Trainer  
*Senior Director of Consulting*

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**Agenda**

**PART 1 - The Nuts and Bolts**

- Risk Adjustment
- HCC
- RAF Capitated Calculations
- The impact of Risk Adjustment on HCC
- Audits

**PART 2 – The Documentation**

- Approved Providers and Specialties
- Documentation Requirements
- Data Sources
- M.E.A.T

**PART 3 – The Coding**

- Step by Step
- Chronic Conditions/Comorbidities
- What makes on impact
- What we miss

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## PART 1 – The Nuts and Bolts




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<https://www.indiamart.com/proddetail/ms-nuts-bolts-4328565697.html>

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## Risk Adjustment


- Modern methodology that accounts for known and discovered health data elements
- Levels comparisons of wellness among patients
- Use diagnosis codes to determine potential patient-level risks
  - Age
  - Gender
  - Socioeconomic status
  - Disability status
  - Insurance status
  - Claims data elements such as procedure codes, place of service codes, etc.
  - Special patient-specific conditions

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## Risk Adjustment



- Risk adjustment models level the playing field when evaluating all patients being treated within a plan or group
- Explain current trends in healthcare spending
- Assist in the forecasting of future needs of those patients
- Identify where resources will be necessary to deliver care efficiently
- Adjust health plan revenue to better reflect the projected costs of the patient population and to compensate plans that enroll high-cost patients




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## Risk Adjustment Models



Diagnosis-based program risk adjustment examples:

- Health and Human Services Hierarchical Condition Category (HHS HCC)—Commercial, Individual, and Small Group
- Medicaid Chronic Illness and Disability Payment Systems (CDPS)
- **Medicare Hierarchical Condition Category, Part C (Medicare HCC)**

Prescription-based program risk adjustment examples:

- MedicaidRx (UCSD)
- RxGroups (DxCG)
- Medicare Hierarchical Condition Category, Part D (RxHCC)
- Health and Human Services Hierarchical Condition Category, Part D (HHS HCC)

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## Medicare Hierarchical Condition Category, Part C (Medicare HCC)



- Used by Medicare Advantage plans (Medicare HMOs)
- Filters ICD-10-CM codes into Diagnosis Groups (DxGs), and then into Condition Categories (CCs).
- Hierarchies or “families” of conditions are placed to gain an HCC numeric code, which translates to a risk adjustment factor (RAF) value
- Medicare-adopted risk adjustment HCC model assigns a value to each diagnosis code that is included in the model
- Not all ICD-10-CM codes carry value in risk adjustment models.
- Diagnoses that are costly to manage from a medical management or prescription drug treatment perspective are more likely to be found in risk adjustment models

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## Medicare Hierarchical Condition Category, Part C (Medicare HCC)




- CMS announced a new CMS-HCC Model for payment year 2014 (V22)
- For payment year 2014 (Dates of Service in 2013), risk scores from the 2013 CMS-HCC model (V12) were weighted at 25 percent (1/4), and the risk scores from the 2014 CMS-HCC model (V22) were weighted at 75 percent (3/4), a blending of models
- For payment year 2015 (Dates of Service in 2014), risk scores from the 2013 CMS-HCC model (V12) were weighted at 67 percent (2/3), and risk scores from the 2014 CMS-HCC model (V22) were weighted at 33 percent (1/3), a blending of models
- Blended methodology was chosen to ensure ease of transition from one model to the next
- Payment year 2018 (DOS 2017) is based on the 2017 CMS HCC Model

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## Disease Interactions



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Disease Interactions – Description Labels	Community, NonDual, Aged
Immune Disorders* Cancer Group	0.893
Congestive Heart Failure* Diabetes Group	0.154
Congestive Heart Failure* Chronic Obstructive Pulmonary Disease Group	0.190
Congestive Heart Failure* Renal Group	0.270
Cardiorespiratory Failure Group* Chronic Obstructive Pulmonary Disease Group	0.336
Congestive Heart Failure* Specified Heart Arrhythmias	0.105

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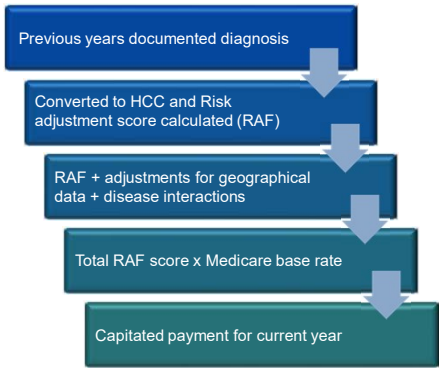
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## Medicare Capitated Payment



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All condition precisely documented	
84 yr. old Female – Full Benefit (FB) dual aged	0.739
COPD ICD-10-CM Code J44.9 (HCC 111)	0.422
Type II Diabetes w/ Diabetic CKD ICD-10-CM Code E11.22 (HCC 18)	0.346
CKD Stage 5 ICD-10-CM Code N18.5 (HCC136)	0.244
Chronic Diastolic CHF ICD-10-CM Code I150.32 (HCC85)	0.355
Disease Interaction (Diabetes and CHF)	0.205
Disease Interaction (CHF and Renal Failure)	0.271
Disease Interaction (CHF and COPD)	0.240
<b>Total Raw RAF: (Demographics and HCC)</b>	<b>2.582</b>
PMPM Payment	\$2,066
<b>Annual Payment</b>	<b>\$24,787</b>

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## CMS Stars Ratings



Affordable Care Act set a requirement that CMS make quality bonus payments (QBPs) to Medicare Advantage health plans based on the plan's quality rating

The star ratings, ranked plans on a scale from one to five stars, in half-star increments defined in the following manner:


- 5 Stars = Excellent Performance
- 4 Stars = Above Average Performance
- 3 Stars = Average Performance
- 2 Stars = Below Average Performance
- 1 Star = Poor Performance



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## CMS Stars Ratings




Part C Plan (Medicare Advantage HMO Plans) 5 Domains (2016)	
<b>Domain 1</b>	Staying Health – Screenings, Test, and Vaccines (7 measures)
<b>Domain 2</b>	Managing Chronic (Long Term) Conditions (12 measures)
<b>Domain 3</b>	Member Experience with Health Plan (6 Measures)
<b>Domain 4</b>	Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance (4 measures)
<b>Domain 5</b>	Health Plan Customer Service (3 measures)

Patients with Medicare who are enrolled in a poorly performing plan will be able to switch to an available five-star plan at any time during the year.

As such, there is increasing pressure for providers to document clearly all quality of care efforts.

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## MACRA Features

- MACRA began in 2015 and will continue beyond 2021
- MACRA's QQP streamlines multiple quality reporting programs to reward healthcare providers for giving better care
- MACRA's QPP includes Merit-based Incentive Payment Systems (MIPS), which combined [prior payment programs into four new performance categories on which provider quality is measured
- MIPS categories will be measured starting in 2017 and the data will impact provider reimbursement in 2019

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## Risk Adjustment and HCC

CMS publishes the list of diagnosis codes that risk adjust, and the HCC that it adjusts to in the model. The information can be found at: [www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html](http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

### CMS (Medicare Advantage) HCC Category Examples


2016/17 Hierarchal Categories in the HCC Model			
Infection	Blood	Cerebrovascular Disease	Complications
Neoplasm	Substance Abuse	Vascular	Transplant
Diabetes	Psychiatric	Lung	Openings
Metabolic	Spinal	Eye	Amputation
Liver	Neurological	Kidney	Disease interactions
Gastrointestinal	Arrest	Skin	Disability Status
Musculoskeletal	Heart	Injury	

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## Risk Adjustment and HCC



- Families or hierarchies set a value based on severity of illness, with **more severe diagnoses carrying the overall risk score for that family**
- Diagnoses within families or hierarchies are inclusive of one another, while any additional diagnoses from other hierarchies or stand-alone diagnoses are additive and increase each patient's overall risk score.

Diagnosis Code	Description	CMS-HCC Model Category V22
C155	Malignant neoplasm of lower third of esophagus	9
C7800	Secondary malignant neoplasm of unspecified lung	8


  

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column...	...Then drop the Disease Group(s) Listed in this column
	Hierarchical Condition Category (HCC) LABEL	
8	Metastatic Cancer and Acute Leukemia	9, 10, 11, 12
9	Lung and Other Severe Cancers	10, 11, 12

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## Deeper Dive – HCC's



The HCC model is made up of 9,000 ICD-10 codes that typically represent costly, **chronic** diseases such as:

- Diabetes
- Chronic kidney disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Malignant neoplasms
- Some acute conditions (MI, CVA, hip fx)


Not every diagnosis will “risk adjust,” or map to an HCC

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## Deeper Dive – HCC’s



- Failing to report a documented diagnosis will skew the patient profile
- This leads to incomplete reporting and possibly underpayment and limited resources toward that patient’s care, leaving health plans with a lack of appropriate funding and planning when it becomes necessary to treat those diagnoses later.


### HCC Financial Differences in Coding Specificity

No Conditions Coded (Demographic Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76-year-old female	.468	76-year-old female	.468	76-year-old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease without complication	.41
CHF not coded		CHF not coded		CHF not coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1,973
PMPM Payment for Care	\$452	PMPM Payment for Care	\$743	PMPM Payment for Care	\$1,381
Yearly Reserve for Care	\$5,418	Yearly Reserve for Care	\$8,921	Yearly Reserve for Care	\$16,573

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## Deeper Dive – Disease Interactions



- Identify conditions that are not only chronic to manage, but also that may be especially complex when paired with another comorbidity/condition.
- In such instances, additional risk factors are often added


1. **Disease:** Disease combinations can increase an individual’s medical costs. Combinations may be two or three diseases in an interaction.  
Calculated by Medicare based on documentation
2. **Disabled:** This is a combination of certain diseases and the disabled status of an enrollee.  
Calculated by Medicare based on documentation

- An interaction is the combination of multiple diagnoses or a diagnosis with disabled status that results in an additional relative factor added to the risk score calculation.


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## New Beneficiary Calculations



- CMS assigns a new enrollee factor to any beneficiary who does not have 12 months of diagnoses to support a risk score
- A new enrollee will become a full risk beneficiary after having 12 months of Medicare Part B entitlement in a data collection year
- A new enrollee factor will also be assigned to any beneficiary whose risk score is not available




<https://www.kevinmd.com>

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## Annual Risk Adjustment Audits





- CMS performs annual audits of the risk adjustment data submitted by, or on behalf of, health plans
- CMS determines which health plans will be audited, along with which patients are included in the audit
- Health plans are required to obtain all relevant medical records for the patients selected
- Initial review of these medical records is performed to determine which contain documentation required to substantiate the HCCs that have been captured in the CMS system for these patients.
- Additional analysis is performed to determine the medical records that should be submitted to CMS that support the HCC values sampled, for additional review and analysis
- **An error rate is determined, which is applied to the premiums for the entire patient population for that health plan.**

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**Annual Risk Adjustment Audits**


An error rate is determined, which is applied to the premiums for the entire patient population for that health plan.

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**Annual Risk Adjustment Audits**




- CMS Risk Adjustment Data Validation (RADV), CMS identifies a random stratified sample of patients to audit.
- The sample is 1/3 of patients with a high-risk factor, 1/3 of patients with a medium risk factor, and 1/3 of patients with a low risk factor.
- Only Part C HCCs are audited in a RADV.
- Supplemental diagnoses (those that were not originally submitted via claims) may be approved if they are documented as current diagnoses in the record.
- The submission of all diagnoses (with HCCs) are cumulative; **therefore, there may be a negative or positive financial outcome in such an audit.**

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## Annual Risk Adjustment Audits



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There are two main types of CMS RADV audit:

1. **National RADV audit**
  - Selection of patients using a “stratified sample” methodology, where a percentage of patients are selected randomly from high risk, medium risk, and low risk, based on HCC risk scores.
  - Selection of MA plan and/or contracts is random
2. **Targeted RADV audit**
  - Targeted contract of those who have had problematic past audit findings.
  - Plans with higher risk scores when compared to traditional FFS (Fee-For Service Medicare).

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## CMS RADV audit snippets



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- CMS RADV is typically two to three years after payment;
- CMS RADV involves choosing health plans by random sampling or targeting efforts
- CMS RADV typically involves approximately 30 health plans
- CMS RADV uses a stratified sample of three strata (high risk, medium risk, and low risk);
- CMS RADV allows any face-to-face encounter for audit support
- CMS RADV allows for up to five best records to support an HCC


**Financial impacts**

- The initial submission of specific diagnosis codes which relay certain HCC values
- Funding may need to be returned if HCC-valued diagnosis codes are unsupported.

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## HHS HRADV Audit




- Qualified health plans participating in the Health Exchange (HIX) under the ACA had to set up Edge servers for sharing data with the CMS.
- HRADV is conducted annually on the data submitted to the Edge server. It differs from the CMS RADV, in that health plans are not “selected.” The audit is an annual requirement.
- Sampling typically takes place from April-June of a calendar year
- The sample audited is 200 enrollees per issuer, per state where plans are eligible.
  - Of the 200 selected, 80 percent (4/5 or 2/3) will have one or more HCC's, while 20 percent (1/5 or 1/3) will have no suspected HCC's.

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## Nuts and Bolts of Audit



**Success** = accurate chart notes to support every chronic condition you report

**Average error rate nationally is 20–30%**


# OUCH!

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## Top Tips for HCC




- HCCs are categories of medical conditions which correlate to a corresponding group of ICD-10 diagnosis codes
- The HCC categories are based on demographic and diagnosis codes
- HCCs measure or report a patient's health or sickness
- There is a given weighted assignment for each HCC
- Patients can have more than one HCC category assignment
- Not all diagnosis map to an HCC
- Procedures are not included in HCC classifications
- HCCs are used to group clinically similar type patients, forecast future healthcare expenses of the group and compare quality of care


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## PART 1 – The Documentation




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<https://work.chron.com/importance-medical-documentation-6966.html>


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## Risk Adjustment and HCC



- CMS requires documentation in the person's medical record by a qualified health care provider to support the submitted diagnosis.
- Support the presence of the condition and indicate the provider's assessment and/or plan for management of the condition.
- Must occur at least **once each calendar year**




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<https://www.shrednations.com/articles/do-i-need-a-medical-record-destruction-log/>

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## Approved Providers for HCC Documentation




- Medical doctor (MD)
- Doctor of osteopathy (DO)
- Nurse practitioner (NP)
- Physician assistant (PA)
- Certified registered nurse anesthetist (CRNA)
- Licensed clinical social worker (LCSW)
- Occupational therapist (OT)
- Physical therapist (PT)
- Certified nurse midwife (CNM)
- Clinical nurse specialist, CRNA, or NP

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## Approved Providers for HCC Documentation




- Any provider may validate any diagnosis, as diagnoses are not dependent upon the specialty
- If an approved provider validates any diagnosis as current, it will be accepted
- Not about the provider treating or attending to the diagnosis, but rather validating the diagnosis as a part of his or her medical decision-making

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## The Documentation – Data Sources



The following data sources are acceptable for risk adjustment:

- Hospital Inpatient
- Hospital Outpatient
- Physician Services

Documentation is the key to proper diagnosis code selection. Diagnosis coding guidelines state that providers should document all diagnoses that are a part of the medical decision making (MDM) for each visit.

Covered Facilities	Non-Covered Facilities
<ul style="list-style-type: none"> <li>• Short-term (general and specialty) Hospitals</li> <li>• Medical Assistance Facilities/Critical Access Hospitals</li> <li>• Community Mental Health Centers</li> <li>• Federally Qualified Health Centers</li> <li>• Religious Non-Medical Healthcare Institutions</li> <li>• Children's Hospitals</li> <li>• Long-term Hospitals</li> <li>• Rehabilitation Hospitals</li> <li>• Psychiatric Hospitals</li> <li>• Rural Health Clinic (Free-standing and Provider-Based)</li> </ul>	<ul style="list-style-type: none"> <li>• Free-standing Ambulatory Surgical Centers (ASCs)</li> <li>• Home Healthcare</li> <li>• Free-standing Renal Dialysis Facilities</li> </ul> <p>Non-Covered Services:</p> <ul style="list-style-type: none"> <li>○ Laboratory Services (except pathology)</li> <li>○ Ambulance</li> <li>○ Durable Medical Equipment (DME)</li> <li>○ Prosthetics</li> <li>○ Orthotics</li> <li>○ Supplies</li> <li>○ Radiology Services (except for diagnostic mammograms, and interventional cardiology)</li> </ul>


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## The Documentation - Signatures




- Providers signatures and credentials are of the utmost importance in all documentation efforts
- A signature is an expected element for payment under the U.S. Code of Federal Regulations
- Signature or credential may be added for Medicare purposes within a year of the DOS;
- A signature or credential missing from a DOS does not negate the factual diagnoses identified
- **If the record were to be used in an audit (such as a RADV or HRADV) that an attestation for signature or credential would be necessary**
- Attestations are commonly accepted for RADV or other audit purposes when clarifying signatures and or credential issues.
- **Attestations cannot, however be used to validate diagnoses**

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## The Documentation - Signatures



Acceptable and Unacceptable Signatures for Risk Adjustment

Unacceptable Signature/ Authentication	Acceptable Signature/ Authentication
"Signed but not read"	Handwritten signature or initials or treating provider
"Dictated but not signed/read", etc.	Electronic signature/authentication (e.g. "authenticated by," "completed by," "finalized by," "validated by," "attested by," "sealed by," etc.
Signed by someone other than the treating provider (nurse, transcriptionist, etc.) on providers behalf	
Signature stamps were phased out effective 12/31/2008. (Note that some EMR systems affix a JPEG that may look like a signature stamp and these are approved)	


There must also be appropriate credentials (MD, DO, PA, NP, LCSW, OT, PT, etc.) for each DOS

**"Dr." is not an acceptable credential for signatures**

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**The Documentation – Outpatient no go’s** 


Wording That May and May Not Be Used for Diagnosis Capture

Cannot Use in Outpatient Records:	May Use in Outpatient Records:
Suggestive of/Symptoms of/Likely	Early/Underlying
Consistent With/Compatible With	Evidence of
Suspicious for/Pending	Element of
Probable/Suspect/Tendency/Possible	Component of
Presumed/Sign(s) of/Suspect	Significant
Pre-_____/or_____/vs. _____	Compensated
Rule-Out/Perhaps/Questionable	Results show _____

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**MEAT the chronic condition** 

- Monitor**  
Signs, symptoms, disease progression, disease regression
- Evaluate**  
Text results, medication effectiveness, response to treatment
- Assess/Address**  
Ordering tests, discussion, review records, counseling
- Treatment**  
Medications, therapies, other modalities

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### MEAT the chronic condition


- Stable
- Improving
- Worsening
- Referred to Providers
- Diagnosis linked to medication
- Controlled
- Uncontrolled
- Likely elevated
- At goal
- No change
- No associated orders are given
- No improvement
- Not changed from previous visit

- Mild
- Asymptomatic
- Compensated
- Severe
- Persistent
- Permanent
- No signs & symptoms
- New onset
- Referred for surgery
- Unchanged
- Well regulated
- Progression

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### MEAT the chronic condition

HCC	DESCRIPTION	RAF
HCC17	Diabetes with acute complications	0.474
HCC18	Diabetes with chronic complications	0.474
HCC19	Diabetes without complications	0.182

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**The Documentation – Outpatient no go’s** 

Many providers, especially in pathology, use the phrase “consistent with” when describing a diagnosis or condition

**NO GO**

Use of up and down arrows for diagnosis coding purposes (for example, ↑cholesterol, thyroid) is not appropriate.

**NO GO**


Reporting the diagnosis code alone is not appropriate documentation

**NO GO**

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**Specificity impact** 


If Assessment Says	It Does Not Risk Adjust	If Assessment Says:	It Risk Adjust
Cardiac dysrhythmia	149.9 Cardiac dysrhythmia, NOS	Atrial fibrillation	I48.91 Afib, NOS
Bronchitis	J40 Bronchitis, NOS	Chronic obstructive bronchitis	J44.9 COPD, NOS
Obesity	E66.9 Obesity, NOS	Morbid obesity	E66.01 Morbid obesity
Hx of breast cancer	Z85.3 Personal hx of breast cancer	Breast cancer	C50.919 Malignant Neoplasm of breast NOS
Pneumonia	J18.9 Pneumonia, NOS	Pneumococcal pneumonia	J13 Pneumonia due to S. pneumoniae

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## Top 10 fails in documentation



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1. Failing to capture HCCs **at least once every 12 months.**
2. Failure to ensure the medical record contains a **legible signature with credential.**
3. Failure to ensure the **diagnosis codes being billed and the actual medical record documentation match.**
4. Failure to document according to the **M.E.A.T. principles.**
5. Failing to annually **document status Z codes and chronic conditions.**
6. Failing to use a **linking statement** or document a **causal relationship** for manifestation codes.

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## Top 10 fails in documentation




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7. Failing to add any diagnosed HCCs or RxHCCs (prescription drug HCCs) to **both the chronic problem list and the acute assessment.**
8. Failing to evaluate each of the HCCs/RxHCCs on a **semiannual basis for updates.**
9. Failing to **review all specialist documentation** related to cardiology, master discharge summaries, radiology, specialty correspondence, pulmonary, echocardiograms, and x-rays, laboratory results, and previous encounters.
10. Failing to **submit more than the standard four ICD-10-CM codes.**


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## PART 3 – The Coding



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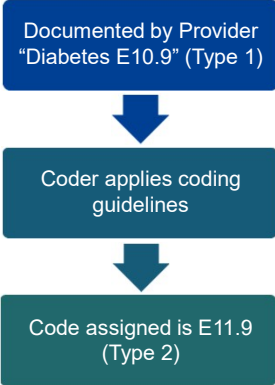
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### Restrictions for Coders

- Medical records must be documented in words, not codes
- A code is not valid documentation of a diagnosis
- Codes without narrative diagnostic descriptions are 'invisible' for coding




```
graph TD; A[Documented by Provider  
"Diabetes E10.9" (Type 1)] --> B[Coder applies coding  
guidelines]; B --> C[Code assigned is E11.9  
(Type 2)];
```

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## Frequently coded conditions in HCC



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Angina	Artificial Openings	BMI & Obesity	Cardiac Conduction Disorders	Cardiomyopathy
CVA	CKD	COPD	Complications of Care	CHF
Cor Pulmonale	DVT	Dementia	Depression	Diabetes
Epilepsy	GERD	Hepatitis & Cirrhosis	HIV	Hyper-Cholesterolemia
Hypertension	Hypothyroidism	Klebsiella Pneumoniae	Malnutrition & Cachexia	Myocardia Infraction
Neoplasms	Neuropathy	Pneumonia	Pulmonary Embolism	Pulmonary Hypertension
Respirator/Ventilator Status	Septicemia & Sepsis	Ulcers & Wounds	Varicose Veins	Vertebral Fractures


*List is not exclusive*

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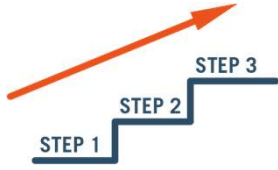
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## Risk Adjustment Coding – The 7 steps



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1. Face-to-face encounters
2. Approved Provider
3. Provider Signature/Authentication
4. Provider Printed Name & Credential
5. Date of Service
6. Documentation supports Diagnosis
  - The problem list alone will not support the diagnosis codes reported. Diagnosis code(s) may be supported by any portion of the documentation for the encounter.
7. Diagnosis part of Medical Decision Making:




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## Chronic Conditions




- Document chronic conditions **annually**, even when stable with treatment
- Document that the **condition is chronic**
- Document **severity/stage of condition** (i.e. stage IV chronic kidney disease/major depression)
- It is important to document **associated conditions or complications** and relationship to the underlying chronic condition (i.e. Cirrhosis secondary to alcoholism, diabetic retinopathy)

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## Complications / Comorbidities




- Complications and comorbidities is important for risk adjustment
- Coding guidelines largely prohibit medical coders from assuming any cause and effect relationships
- Some ICD-10-CM guidelines allow many cause and effect manifestations codes to be assumed
- **Still advisable for providers to clearly document these relationships.**

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## Pertinent Conditions

- Document and code for any patient condition that is
  - Present but stable
  - Therapy managed condition
  - Observation required
  - Requires referral to another provider for management
  - Influences your decision making in care of the patient
- Do not document “history of” when the condition currently exists  
 In coding language, “history of” means that the patient no longer has the condition, in which case it cannot be coded as an active disease
- “One error is to code a past condition as active. The opposite error is to code ‘history of ’ a condition when that condition is still active” (CMS Participant Guide, 2008).

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## CMS interpretation of documentation


Medical Note States:	Coder and CMS Interpretation:
H/O CHF	CHF has resolved
CHF Compensated	CHF active and stable
History of Angina	Angina has resolved
Stable Angina Nitrostat® PRN	Angina is stable on active treatment
H/O Afib	Afib has resolved
Afib controlled on digoxin	Afib is stable on active treatment
Prostate Cancer s/p Chemotherapy	Prostate cancer is eradicated Documentation does not indicate when Patient completed chemotherapy (e.g. Jan '09, Dec '15)
Prostate Cancer Lupron® Injections Q3mo	Prostate cancer is active with active treatment

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## Codes you may not think make an impact



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Body mass index	HCC 22
Encounter for surgery aftercare	HCC 186
Amputation status	HCC 189
Tracheostomy status	HCC 82
Gastrostomy/Ileostomy/Colostomy Status	HCC 188
Transplant status	HCC 186
Vent Dependence	HCC 82
Dialysis Dependence	HCC 134
Long term use of Insulin	HCC 19
Artificial opening Status	HCC 188
Coma Scale	HCC 80

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## Commonly missed chronic conditions



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- Amputations
- Parkinson's Disease
- Rheumatoid Arthritis
- Atherosclerosis of aorta
- Alcohol & Drug Dependency (even in remission)
- Morbid Obesity (BMI >40)
- Ectasia 27
- Organ Transplants
- Multiple sclerosis
- CHF
- Chronic psychiatric diagnoses
- Ostomy (Open? Closed?)
- COPD
- Aneurysm




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Dreamstime.com

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## Non-Recapture: Financial Implications



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Financial Impact of Non-Recapture			
Condition	HCC	HCC Coefficient "weight"	Revenue Impact PMPY*
CHF	85	0.323	\$2,965
CKD Stage 4	137	0.237	\$2,176
Paraplegia	71	1.007	\$9,244
COPD	111	0.328	\$3,011
Ostomy Status	188	0.571	\$5,242
Diabetes with Complications	18	0.318	\$2,919
Amputation Status – (BKA)	189	0.588	\$5,398
Morbid Obesity	22	0.273	\$2,506

\*Values are for illustrative purposes

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## References





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CMS Risk Adjustment and HCC guidelines  
<https://mehima.org/>  
 2018 Risk Adjustment Coding for CRC Preparation  
<http://www.hcpro.com>  
<https://www.codingintel.com/>  
 The Coding Institute – Risk Adjustment Primer E Book

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**Questions?**



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