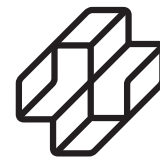


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Tips to Improve Coding for Hierarchical Condition Categories

By Jennifer Swindle

Accurate HCC coding is essential to ensure full payment and minimize audit risk for Medicare Advantage risk patients.

Accurate diagnosis coding is essential for every patient. But it is especially important for patients enrolled in Medicare Advantage managed care plans—currently nearly one-quarter of Medicare beneficiaries. Unless you provide detailed diagnosis codes that completely describe each patient’s medical

status each year, there is a good chance that any health plans that you participate with and that provide services to Medicare Risk members—and your organization—are being underpaid.

Provider revenues can be significantly affected by Medicare Advantage risk adjustment methods in several ways. If your organization is at risk with a Medicare Advantage plan, failing to document chronic patient conditions each year could directly reduce your per-member per-month payments by moving your patients into lower risk categories. If your organization is not at risk,

Annual Process for Accurate Hierarchical Condition Category Coding

Fully assess patient’s health

Document all diagnoses and status completely

Code everything documented

Accurate HCC reporting

All chronic conditions should be assessed, and all conditions evaluated should be thoroughly documented. However, only conditions that are evaluated and addressed should be coded.

providing annual assessments presents an opportunity to work with your health plans to help ensure that they receive appropriate risk payments—and allows you to bill for the services. Either way, accurate coding and proper documentation of all diagnoses and services are essential to protect you in a Medicare audit. Providers are ultimately responsible for documentation in the patients' medical records that support the risk categories claimed by health plans they service.

Why Annual Assessments?

The Medicare Advantage program adjusts payments based on the nature and severity of the patient's entire medical condition. Generally speaking, the greater the number and severity of diagnoses a patient has, the higher the risk and the payment. It can make a big difference in reimbursement. For example, payment for treating a patient diagnosed with diabetes with neurological manifestations (250.6x) along with the identification of the manifestation, such as polyneuropathy (357.2), can be three times higher than for a patient coded with diabetes and no complications (250.00).

These adjustments are made based on a set of codes known as hierarchical condition categories (HCC). The categories are layered on top of the ICD-9 system to capture the projected added cost of treating patients with specific diagnoses. When an ICD-9 code or combination of codes is reported that qualifies a patient for a particular HCC with a higher risk rating, the monthly payment goes up accordingly. Every diagnosis

code reported by physicians during a calendar year goes into determining the HCCs for that patient. Demographic information is also taken into account to predict costs and assign a final risk adjustment for each patient.

The problem is that diagnoses reported in one calendar year do not carry over to the next year. This issue seemingly violates common sense—after all, a patient with diabetes in 2008 will almost certainly still have it in 2009. Nonetheless, from a Medicare Advantage program perspective, until a specific condition has been assessed and coded for the current year, patients do not have that condition for purposes of adjusting their risk or managed care payment. Seemingly, on the first day of each year, all patients return to a “clean bill of health” with no known medical conditions until their conditions are assessed, treated, documented, and coded during that year.

Therefore, to ensure accurate risk adjustment for each Medicare Advantage risk member, all patient chronic conditions should be assessed at least annually. Each condition should be thoroughly documented in the medical record and coded to the highest level of specificity. Anything less puts your plan and your organization at risk for underpayment.

Accuracy and Completeness Pay

The diagnoses that affect a patient's severity score are far too numerous to list here. But it is important to keep in mind that any

current or past medical condition could be relevant and to code accordingly.

For example, Patient Joe had an acute myocardial infarction in 2008. The diagnosis was coded appropriately in 2008, resulting in the correct severity being assigned. But in 2009, Joe is doing well, so the severity increase for an acute MI is no longer applicable. Clinically, however, the fact that Joe has a previous MI puts him at higher risk. Diagnosis 412 should be assigned at the annual assessment to identify that Joe has a healed MI.

Limb amputations are another condition that increases severity scores but often goes uncoded. When a surgeon performs a below-the-knee amputation on a patient, the procedure usually is coded and captured that year. To capture the added risk in later years, the patient's primary care physician should assess the amputation and report the code for a partial limb amputation, V49.75.

Two codes are required to fully identify many conditions. This is true of all diabetic conditions in which the diabetes manifests into an organ system. For example, if a patient has type II diabetes that is not uncontrolled but has caused a diabetic cataract, two codes are needed to report the condition in full: 250.50 identifies diabetes with ophthalmologic manifestations; however, this code does not specify the manifestation, so 366.41 also should be reported to identify the diabetic cataract.

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Additionally, in some cases, only one code is necessary to report a combination of conditions, such as hypertensive heart disease with congestive heart failure, which is reported with 402.91. When a combination code exists, the two conditions should not be split into separate codes.

Remember that the member's total health status needs to be captured for the organization to receive appropriate reimbursement. All chronic conditions should be assessed, and all conditions evaluated should be thoroughly documented. However, only conditions that are evaluated and addressed should be coded. Never code based on historical data. Diagnoses that are treated or

actively affect treatment or the status of the patient should be captured. Document what is done, and code what is documented. The goal is a complete assessment and a comprehensive picture of the patient's health.

Be aware that the Centers for Medicare & Medicaid Services (CMS) regularly conducts risk adjustment diagnosis verification audits of both health plans and providers to ensure that all diagnosis codes are accurately supported for patients during the appropriate data collection period. Each condition needs to be appropriately assessed and documented during the correct time period. Failure to do so could result in disallowed payments plus penal-

ties. Because health plans also must attest to the diagnoses they report to CMS, health plans may also conduct audits of your organization's records.

All physicians and healthcare organizations should make sure their coding is "ironclad" and documentation is clear and accurate. Make sure your HCC coding is hitting the mark so reimbursement is appropriate and audits successful. ☎

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