Maximizing HCC Risk Value to the Patient and to the Practice

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HCC Risk Value

- For years, physicians have argued that their patient population is sicker than other providers'.

- These anecdotal observations were occasionally validated for those who worked in tertiary care centers but have never had a quantifiable basis in the general patient/provider population.

HCC Risk Value

- There is now, however, a way to determine, objectively, how sick a patient population is: Enter the CMS-HCC Risk designations.

- Established in 2004 to reward Medicare + Advantage programs who do not “cherry-pick” only well Medicare beneficiaries, this program is based on ICD-9 Codes.

HCC Risk Value

Structure, Organization and Concepts of the Hierarchical Condition Categories (HCC) Risk

- More than 15,000 ICD-9 codes, all were organized into 189 HCCs.
- Only about 5200 ICD-9 Codes, contained in 70 HCCs, were included in the HCC/RxHCC payment plan.
- Most of those excluded were for various reasons most commonly because of potential for abuse or because they did not add to the cost of care of the patient.

HCC Risk Value

CMS identified ten principles which guided the creation of Hierarchical Conditions Categories. The following of those principles should impact provider documentation of these codes...

Principle 1

Diagnostic categories should be clinically meaningful. Conditions must be sufficiently clinically specific to minimize opportunities for gaming or discretionary coding. Clinical meaningfulness improves the face validity of the classification system to clinicians, its interpretability, and its utility for disease management and quality monitoring.

Principle 5

The diagnostic classification should encourage specific coding. Vague diagnostic codes should be grouped with less severe and lower-paying diagnostic categories to provide incentives for more specific diagnostic coding.

Principle 6

The diagnostic classification should not reward coding proliferation. The classification should not measure greater disease burden simply because more ICD 9-CM codes are present. Hence, neither the number of times that a particular code appears, nor the presence of additional, closely related codes that indicate the same condition should increase predicted costs.

Principle 7

Providers should not be penalized for recording additional diagnoses (monotonicity). This principle has two consequences for modeling: (1) no condition category should carry a negative payment weight, and (2) a condition that is higher-ranked in a disease hierarchy (causing lower-rank diagnoses to be ignored) should have at least as large a payment weight as lower-ranked conditions in the same hierarchy.

Principle 10

Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans/providers, or that are not clinically or empirically credible as cost predictors, should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation, coding proliferation, gaming, and upcoding.

HCC Risk Value

Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate.

For example, a male with heart disease, stroke, and cancer has (at least) three separate HCCs coded, and his predicted cost will reflect increments for all three problems. The HCC model is more than simply additive because some disease combinations interact. For example, the presence of both Diabetes and Congestive Heart Failure (CHF) could increase predicted cost by more (or less) than the sum of the separate increments for people who have diabetes or CHF alone.

HCC Risk Value

HCCs are assigned using hospital and physician diagnoses from any of five sources:

- Principal hospital inpatient
- Secondary hospital inpatient;
- Hospital out-patient
- Physician
- Clinically trained non-physician
  - (e.g., psychologist, podiatrist).

New Auditing Policy

New Auditing Policy Announced Spring 2008

CMS issued a new audit policy regarding HCCs. They have also announced a substantial change in what they will do when they find a problem with coding. In the past, any coding problems were fixed for just the specific codes that were in error in the audit – i.e. the exposure was minimal.

New Auditing Policy

- The new procedure will assume they have audited an appropriate sample of codes and correct the entire payment amount by the sample error rate – i.e. extraordinary exposure. So a 5% error rate in the sample will result in a 5% reduction in premium – big.
- No one has seen detailed audit regulations yet. They may be having difficultly putting such a policy into place – but they strongly believe there is significant over coding going on across the industry – hence the reason for the new policy.

General Concepts About HCC/RxHCC

- In 2007, Medicare Advantage programs were funded by CMS using both demographics (AAPCC) and the Hierarchical Conditional Codes known as HCC.

- 2007 also became the year that RX HCC codes were added to complement the reimbursement for managing patients with other illnesses which while they did not rise to the level of complexity and cost-for-care, as the HCC diagnoses, they did qualify for a lower additional payment due to increased medication costs.

General Concepts

The RxHCC designations cover many diagnoses which were not covered in the HCC.

- As a general rule, almost all HCC diagnoses are also RxHCC codes but all RxHCC are NOT also HCC.

HCC vs. RxHCC

Here are some examples of diagnoses which are not HCC but are RxHCC codes:

1. Hypertension is not an HCC (i.e., 401.1 or 401.9, etc.) but it is an RxHCC.
2. Osteoporosis another common illness is not a medical HCC but is an RxHCC.
3. CAD in itself is not a medical HCC, but it is an RXHCC. Because CAD is a general term, it is imperative that if the patient has angina or an old MI, the chronic problem list should include angina or old MI as they are HCC diagnoses.

Requirements

The requirements for successfully benefiting from the HCC Risk program are:

- You must have a robust ICD-9 code list which is intuitively accessible by healthcare providers in the contest of a patient encounter.

- You must have a means of identifying which codes are HCC, RxHCC or both.

Requirements

- You must have a system which audits the validity of assigning those ICD-9 codes to a particular patient to avoid the potential for abuse in over-diagnosing patients for financial benefit.

- You must have a means for aggregating this information for reporting to the health plan and by the health plan to CMS.

- You must have a means of evaluating each of the HCC and/or RxHCC diagnoses and documenting that evaluation.

Robust ICD-9 Codes

Depending upon how you count, there are over 15,000 ICD-9 codes available to be used. However, the descriptions of those codes are either obscure or incomprehensible in the electronic versions published by CMS. The typical physician utilizes 1-2 hundred ICD-9 codes.

Robust ICD-9 Codes

When SETMA went to charge posting within the context of the patient encounter, it was imperative that ICD-9 Codes and CPT codes be available in a manner which required the provider no more time than that needed to place an order for a test, procedure or treatment.

Robust ICD-9 Codes

This meant that a robust ICD-9 Code list had to be available. Thus SETMA design its own ICD-9 Code list which now has almost 7,400 ICD-9 Codes available. (See the List of SETMA's ICD-9 Codes later in this notebook and a Tutorial for how to use SETMA ICD-9 Code list – a printed version is contained herein and an electronic version are attached in a CD.)

Robust ICD-9 Codes

Identifying ICD-9 Codes which are HCC or RxHCC – Because there are over 5,000 HCC and RxHCC and because some are not obvious, it is imperative that a method for identifying them be available which adds no time or effort to the provider's workflow during a patient encounter.

Robust ICD-9 Codes

Utilizing a function created by NextGen, SETMA has identified over 3,400 ICD-9 Codes which are HCC or RxHCC and which relate significantly to our patients and their treatment. These HCC and RxHCC codes are automatically displayed with the ICD-9 code when a provider selects a diagnosis for his/her patient. When that ICD-9 code is placed in the patient's chart the HCC/RxHCC is automatically displayed on the Chronic Conditions, Assessment, Plan, E&M Coding, and "Associating ICD-9 Diagnoses with Medications" templates, thus solving the second problem.

Robust ICD-9 Codes

Auditing those diagnoses – NextGen provides an efficient means for reviewing charts in order to validate the HCC/RxHCC codes placed in a patient's chart. Because the originators of the HCC Risk Categories recognized that there was potential for abuse of his system, this element of the problem is important.

Robust ICD-9 Codes

Aggregating Information – this is principally done by the CMS forms which are submitted to the health plan but because NextGen only allows for 4 codes to be submitted per claim, a supplementary method had to be implemented which allows for all codes to be captured.

SETMA's Strategy

Evaluating Each Problem Annually

SETMA ways of documenting the evaluation of an HCC/RxHCC which are discussed at length I the tutorial which is contained herein; they are: Disease management tools (Diabetes is included as an illustration along with the Diabetes prevention program); Chronic Conditions evaluation pop-ups; "Detailed Comment" pop-ups which launch from the Assessment Template; the main body of the patient encounter in GP Master.

SETMA's Strategy

What Provider Documentation is necessary in order to qualify a diagnosis as an HCC or RxHCC for payment? Let's start from he end and work our way back to the beginning. Because all of the HCC and/or RxHCC are Chronic Conditions, the following would be required:

- They must be identified in the E&M coding event for that encounter and they must appear on the Chronic Problem list for that patient.
- Lab, x-rays and procedures should be appropriate to that condition, when required.

SETMA's Strategy

- Medications should be reviewed and appropriate medications for the condition should be present in the documentation for the encounter. (It is possible in NextGen to associated a medication with a diagnosis. We will have our staff complete this task on all GTPA patients.)*

- Physical examination should be specific for that condition – for instance if you state the patient has CHF and do not document the lungs and heart, it would not be a valid evaluation. If you say the patient has cancer of the prostate and you do not comment whether they are currently in treatment or are in surveillance, that would not be valid.

- Documented History should be appropriate for that condition.

SETMA's Strategy

What steps must be taken take to qualify a diagnosis as an HCC? The diagnosis must be:

- Established as applying to this patient.
- Documented in the patient's record in the Chronic Problem list
- Evaluated at least once in the year prior to the qualification as an HCC or RxHCC
- Reported to the HMO and via the HMO to CMS

SETMA's Strategy

Provider Responsibilities for HCC/RxHCC…Providers simply need to pay attention to the needs and condition of the patient and

- Add any HCC or RxHCC which you diagnose to both your chronic problem list and to the acute assessment.
- Update your Chronic Problem list so that the HCC and RxHCC are displayed on your diagnoses.
- Evaluate each of the HCC and RxHCC at least once during the year.

SETMA's Strategy

The best way to evaluate whether you have identified ALL of the HCC and/or RxHCC is to review:

- Scanned documents particularly under cardiology, master discharge summaries, radiology, specialty correspondence, pulmonary, echo's, x-rays, etc.
- The patient's past history template.
- Laboratory results and medications.
- Previous encounters.

SETMA's Strategy

Interesting Special Cases which are HCC or RxHCC diagnoses:

- SETMA's ICD-9 code list has 6,832 ICD-9 Codes which are intuitively organized, covering 26 medical and surgical specialties.
- In the HCC/RxHCC list published by CMS there are a total of 5,243 HCC and RxHCC diagnoses.
- SETMA has 1752 HCC and 1362 RxHCC codes (Total 3314) which are associated with our ICD-9 Code list and which are automatically published on the Master GP when an ICD-9 code is chosen.

SETMA's Strategy

- Altered Mental Status see AOC Altered Mental Status
- Amputations – including toes
- Attention to all ostomies
- Aneurysms
- Halitosis Choking Sneezing Mouth Breathing
- Death Sudden Unattended
- Decubitus
- Vegetative state Persistent se AOC Vegetative State Persistent

SETMA's Strategy

- Decubitus and Ulcers of the skin and extremities are HCC Risk diagnoses
- Difficulty walking due to deranged joints
- Drug Depend and addiction including alcohol
- Fluid and electrolyte balance
- Generalized Pain see Pain Generalized
- Hypcalecemia
- Hypercalcemia
- Hyperkalemia
- Hypermagnesemia
- Hypernatremia
- Hypokalemia
- Hypomagnesemia