Comagine Health

Quality Payment Program

Small, Underserved and Rural Support

Q&A: Hierarchical Condition Categories

Understanding Hierarchical Condition Categories (HCC) and their applicability to the Merit-based Incentive Payment System (MIPS) is important as clinicians work to receive recognition for the care they deliver to patients with complex conditions. Beneficiaries with complex health conditions may take additional time and resources to achieve positive health outcomes, and HCC helps recognize the complexity of that care.

Question: What are Hierarchical Condition Categories and why use them?

Answer: Hierarchical Condition Categories look at a beneficiary's demographics and co-existing conditions to calculate a risk score. HCCs use ICD-10 coding to assign a beneficiary risk score or Risk Adjustment Factor (RAF). These numbers factor into the risk-adjustment methodology that the Centers for Medicare & Medicaid Services (CMS) uses to score the Cost category measures and award the Complex Patient Bonus for MIPS.

Using HCC coding for risk adjustment ensures that providers are not unfairly penalized for their care of patients who have complexities that affect outcomes and costs beyond the clinician's control.

Q: How does the HCC system work?

A: The HCC system's goal is to secure reimbursement adjustments for clinicians who are serving at-risk populations. For example, an HCC risk score of one indicates risk associated with expenditures that are similar to the average beneficiary nationwide, whereas a beneficiary risk score greater than one indicates above-average risk. A score below one indicates less than average risk. These risk scores are then applied to various measures in the MIPS program.

Q: Which MIPS measures are affected by appropriate HCC coding?

A: HCC coding affects the following measures in MIPS:

- Complex patient bonus – Up to a 5-point bonus is added to the MIPS final score for clinicians who treat medically complex patients.
  - For 2020, the second 12-month segment of the MIPS determination period (Oct. 1, 2019 – Sept. 30, 2020) will be used when calculating average HCC risk scores and the proportion of full-benefit or partial-benefit dual-eligible beneficiaries for MIPS-eligible clinicians.
  - MIPS-eligible clinicians or groups must submit data on at least one performance category in an applicable performance period to earn the bonus.
- Cost measures:
  - Medicare Spending Per Beneficiary (MSPB-C) – HCCs mapped from the ICD-10 codes are used to calculate expected costs. Accurate coding of claims, including all co-morbidities, is crucial to represent the patient's condition accurately when calculating the measure.
  - Total Per Capita Costs (TPCC) – The HCC/RAF is used in the expected cost calculation of this measure.

Q: How can documentation affect HCC coding?

A: Coding has a direct impact on the calculation of the risk adjustment factor (RAF). Proper provider documentation is required to support diagnoses that map to HCC codes. Including applicable ICD-10 (for all co-morbid conditions as well as the primary diagnosis), correct patient demographic information and CPT/HCPCS codes in claim submissions directly impacts reimbursement and risk scoring. The Medicare Risk Adjustment Eligible CPT/HCPCS Codes published on the CMS.gov website will guide your documentation of these codes.

Q: What is an example of how inaccurate or incomplete documentation and coding could affect the RAF?

A: In this example, a patient is a 76-year-old female who is Medicaid-eligible. She has diabetes with complications, is morbidly obese, and has congestive heart failure and severe chronic kidney disease. The table below shows how incomplete or inaccurate HCC coding can affect the RAF. Note the final RAF based on the lack of coding or inaccurate coding in the following chart. Complete, accurate coding is crucial to receiving an accurate RAF. Remember, this is only an example, and RAF formulas change.

No Condition Coded	**RAF**	**Some Conditions Coded (one error)**	**RAF**	**All Conditions Coded**	**RAF**
76-year-old female	0.468	76-year-old female	0.468	76-year-old female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
Diabetes with complications	None	Diabetes **without** complications	0.118	Diabetes with complications	0.368
Morbidly obese	None	Morbidly obese	None	Morbidly obese	0.365
Congestive heart failure	None	Congestive heart failure	None	Congestive heart failure	0.368
Disease interaction (DM+CHF)	None	Disease interaction (DM+CHF)	None	Disease interaction (DM+CHF)	0.182
Severe chronic kidney disease	None	Severe chronic kidney disease	None	Severe chronic kidney disease	0.224
Total RAF Score	**0.645**	**Total RAF Score**	**0.763**	**Total RAF Score**	**2.152**

Q: What is meant by documentation to support coding?

A: All coding of co-existing conditions must be validated by complete and accurate documentation of the condition and current treatment must be addressed in the patient's medical record. It is not appropriate to code "history of" conditions, resolved conditions or conditions in the problem list without evidence of chronicity or current treatment.

Example: "Patient presents with history of COPD, stable on Sybmicort." COPD is chronic, and Symbicort is the treatment. It is appropriate to code for chronic obstructive pulmonary disease, unspecified.

Example: "Patient has history of breast cancer, had double mastectomy last year. Has finished chemotherapy, no evidence of malignancy and no further plans for treatment at this time." You cannot code breast cancer; instead code Personal history of neoplasm of breast.

Q: What should we do to be certain we are documenting and coding in such a way that our RAF is an accurate reflection of our patient population?

A: The following actions will help your practice provide an accurate reflection of your patient population:

- Ensure correct documentation of patient demographics and verify whether there is dual eligibility (Medicare and Medicaid).
- Review documentation related to co-morbid conditions and specificity that may affect the HCC codes.
  - Is more documentation needed, or should a care plan be established, so that conditions can be coded appropriately?
  - Has the code most specific to the patient's condition been assigned?
- Provide education to all clinicians and support staff regarding required documentation.

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