American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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# An Introduction to Hierarchical Condition Categories (HCC)

When coding and submitting claims for a physician's professional services in a Fee for Service (FFS) world, claims data is used to determine whether a service meets medical necessity criteria and if so, how much money the payer will allow for the billed services. The CPT® code(s) that describe the specific procedure or service performed establishes the payment amount and the diagnosis code(s) (ICD-10-CM) provides support for medical necessity – ie, if any payment is to be issued at all. As new payment methods shift risk from the payer to the provider, this approach may be changing.

The Quality Payment Program (QPP) introduces risk adjustment to physician payments via a method that has long been used for other purposes: The Hierarchical Condition Categories (HCC) first established in 2004. Examples of how the QPP will use HCCs in determining payment for professional services include:

- Calculation of the complex patient bonus under the Merit-based Incentive Payment System (MIPS) and within certain Alternative Payment Models (APMs)
- Application of risk adjustment to the measures in the Cost component of the MIPS program.

To help ensure that the data that the Centers for Medicare & Medicaid Services (CMS) uses to measure an individual eligible clinician (EC) or a group's performance under the QPP present a full and complete picture of the beneficiaries who received care, documentation and coding need to include the elements that contribute to HCC scoring. In this Timely Topic, we provide an introduction to the HCC system.

Of the approximately 70,000 ICD-10-CM codes, about 9,500 map to 79 HCC categories. The diagnoses must be documented by the physicians who provide care. A Risk Adjustment Factor is assigned to each HCC category. Additionally, risk factors are assigned for gender, age, living situation and Medicaid eligibility. The risk factors serve to scale payments to be reflective of the risks associated with the patient. CMS uses the HCCs to risk adjust the payments it makes to Medicare Advantage (MA) plans and for care provided via some demonstration projects. Typically, MA plans receive a capitated amount of money from CMS which they use to pay claims for the care that their policy holders receive. The HCC score is applied prospectively to the capitated rate, using the diagnostic information from a past period to forecast the plan's costs for a future period. *Note: MA plans typically offer physician payment at Medicare FFS rates.*

Patients that are healthier than average will have an HCC score below 1.000 and those that are less healthy than average would have a score above 1.000. The following examples illustrate how the system works; specific issues may influence final figures.

Example 1:

Suppose the capitated rate the plan receives from CMS is $500 per member per month. That represents the starting point and that rate can be adjusted based on the HCC scores. If the patient has diabetes with complications but that is not coded or not fully coded, the payment impact is pronounced:

| Scenario 1 | | | Scenario 2 | | | Scenario 3 | | |
|---|---|---|---|---|---|---|---|---|
| | **HCC** | **Risk Adjustment Factor** | | **HCC** | **Risk Adjustment Factor** | | **HCC** | **Risk Adjustment Factor** |
| 72-Year-Old Female | | 0.346 | 72-Year-Old Female | | 0.346 | 72-Year-Old Female | | 0.346 |
| Diabetes not coded | | *** | E11.9 Type 2 diabetes mellitus w/o complications | HCC19 Diabetes w/o complication | 0.124 | E11.41 Type 2 diabetes mellitus w/ diabetic mononeuropathy | HCC18 Diabetes w/ chronic complications | 0.625 |
| Total RAF | | 0.374 | | | 0.478 | | | 0.692 |
| Payment per month | | 0.346 | | | 0.470 | | | 0.971 |
| Payment per year | | $173.00 | | | $235.00 | | | $485.50 |

Example 2:
That same patient may have multiple conditions that contribute toward the HCC score or adjustment. Missing documentation can carry a cost:

| Scenario 1 | | | Scenario 2 | | | Scenario 3 | | |
|---|---|---|---|---|---|---|---|---|
| | **HCC** | **Risk Adjustment Factor** | | **HCC** | **Risk Adjustment Factor** | | **HCC** | **Risk Adjustment Factor** |
| 72-Year-Old Female | | 0.346 | 72-Year-Old Female | | 0.346 | 72-Year-Old Female | | 0.346 |
| E11.41 Type 2 diabetes mellitus w/ diabetic mono neuropathy | HCC18 Diabetes w/ chronic complications | 0.625 | E11.41 Type 2 diabetes mellitus w/ diabetic mononeuropathy | HCC18 Diabetes w/ chronic complications | 0.625 | E11.41 Type 2 diabetes mellitus w/ diabetic mononeuropathy | HCC18 Diabetes w/ chronic complications | 0.625 |
| | | | K50.00 Crohn's disease of small intestine w/o complications | HCC35 Inflammatory Bowel Disease | 0.279 | K50.00 Crohn's disease of small intestine w/o complications | HCC35 Inflammatory Bowel Disease | 0.279 |
| | | | | | | M05.60 Rheumatoid arthritis of unspecified site w/ involvement of other organs and systems | HCC40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease | 0.423 |
| Total RAF | | 0.971 | | | 1.250 | | | 1.688 |
| Payment per month | | $485.50 | | | $625.00 | | | $844.00 |
| Payment per year | | $5,826.00 | | | $7,500.00 | | | $10,128.00 |

Physicians and physician coders are used to being very exact when selecting a CPT code. They need to take that same amount of care when selecting the ICD-10-CM codes they report. Hospital coders are more accustomed to a focus on the ICD-10-CM codes included in a patient's record since those codes contribute to the Medicare Severity-Diagnosis Related Group (MS-DRG) assignment used in determining the hospital payments. Just as these complex diagnosis effect hospital payments, they may also help physicians document a need for higher professional FFS payment.

The first step is to have a solid understanding of how ICD-10-CM codes are to be used. Start by reviewing the ICD-10-CM Official Guidelines for Coding and Reporting for FY 2019. HCC requires a strong foundation in ICD-10-CM coding. Coders looking to enhance their knowledge of HCCs can do so through courses and materials from the organizations that offer coding certifications or other venues.

Because the QPP impacts payment for professional services under MIPS, it is worth the time it takes to obtain some degree of familiarity with HCCs. Not all ICD-10-CM codes link to an HCC but you should learn which conditions do so you can be sure you are capturing complete information in those instances. Such information is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-

Adjustors.html As you review the files and documents on this site, you will note that many unspecified ICD-10-CM codes do not map. This is another reason why you should be sure that documentation and subsequent code selection is as specific as possible.

This added level of detail may not change the payment you receive for each individual case, but it could help you score better in the cost component of MIPS which will carry more weight and become applicable to more ECs over the coming years. It may be a relevant consideration when you negotiate with private plans as it can establish a more complete and accurate picture of the patients you care for and of the costs of the resources required to provide that care. It may also help you earn some good will with your hospital in terms of their DRG assignments.

**Resources:**

Bernard, S. (2018). Risk Adjustment Documentation & Coding. Chicago. American Medical Association

The Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html