

## Accurate HCC coding benefits providers, patients and health plans

You are asked to be complete and accurate in your documentation and coding to promote correct Hierarchical Condition Category (HCC) code capture. Have you wondered what an HCC is, why it is important and what impact it has for you and your patients? This article will help clarify this and provide resources to learn more about HCC coding.

### Background

HCC coding was implemented by the Centers for Medicare and Medicaid Services (CMS) in 2003 as a risk adjustment payment model. The model determines payment to Medicare Advantage Organizations like Security Health Plan to provide care for their members. In this model, CMS uses each member's acute and chronic conditions diagnosed during a base year, combined with the member's demographic information (age, sex, Medicaid dual eligibility or disability status) to determine the member's risk score. This risk score is factored into an algorithm that determines payment to the health plan to cover the cost of care for that member.

### Basics

Diagnoses that determine a member's risk score come from provider claims for inpatient and outpatient services. It is essential that provider documentation supports the diagnoses on the claim following ICD-10 CM guidelines. Currently more than 11,000 ICD-10 diagnosis codes factor into the 86 HCC categories in the CMS V24 model. Specificity in documentation and coding can make a difference in whether a diagnosis is or isn't an HCC. This affects the revenue received to provide care for the member. Here are some points to remember:

- CMS resets member risk scores annually on January 1 for all conditions, even those that will never go away such as amputations and genetic or metabolic abnormalities.
  - Documentation has to be clear that diagnoses reflect current conditions and not past medical history.
- Be as specific as possible when describing the diagnosis in your documentation and when coding it on your claim.
  - Be sure that the terminology you use matches between the two.
- When CMS completes a risk adjustment validation audit, they require the health plan to submit the provider's documentation that supports the claim diagnoses.
  - CMS will recoup revenue and may assess fines if claim diagnoses are not supported in documentation.

### Impacts

Revenue received through risk adjustment impacts the health plan, providers and members. Affiliated provider groups often have revenue tied to risk adjustment HCC gap closure in their contract with the health plan. Risk adjustment revenue is used to pay for care that members receive, stabilize

premiums and enhance their benefits. The diagnoses on your claims also allow the health plan to identify members who will benefit from the health plan's wellness programs and disease or care management services. You can see how your complete and accurate documentation of a member's health story is valuable to all of us.

Additional information about risk adjustment and HCC coding is available on the Security Health Plan website at <https://www.securityhealth.org/providers/hcc>. You can also contact Brenda Anderson, Security's Revenue Management Educator, at 715-221-9598 with questions.