

Hierarchical Condition Category (HCC) coding of patient comorbid conditions

HCC coding depends on a complete and accurate depiction of a patient's acute and chronic conditions. Patient diagnoses add risk adjustment factors to a patient's risk score. The diagnoses that support HCC coding are received from primary and specialty provider diagnoses submitted to Security Health Plan via the claims process. Sometimes, providers document and consider patient comorbid conditions without submitting the diagnoses on claims for service. Providers report feeling they should not code a condition that they are not responsible for primary management of.

ICD 10 CM Section III Reporting additional diagnosis... J. Code all documented conditions that coexist indicates the following: "Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

Conditions impacting decision-making:

Patient comorbid conditions that impact provider decision-making about patient management should be documented and coded. Common diagnoses and reasons that they may be considered include the following:

Diabetes mellitus type 1 or 2

- Impacts decision-making on the use of steroids or other medication
- Patients are alerted to watch for glucose fluctuation due to illness or steroid use

Kidney disease (specify stage or type of renal disease)

- Influences antibiotic and other medication choices

Liver disease (specify disease, cirrhosis as an example)

- Influences antibiotic or other medication choices

Case example:

Patient with COPD, diabetes mellitus type 2 and CKD 4 presents to urgent care today with cough productive of green sputum, shortness of breath and fever.

Medications:

Metformin 500mg BID

Advair discus 1 inhalation BID
Albuterol MDI 2 puffs prn dyspnea

Exam: Ill appearing male with SOB, VSS except temp of 101 degrees (oral). O2 sat = 90% on room air. Rales in lower lobes bilaterally.
Chest x-ray reveals bilateral lower lobe pneumonia.

Assessment/Plan:

1. Pneumonia, organism unknown – Z-Pak, which has liver metabolism is prescribed due to pt underlying CKD 4 and not wanting to tax his kidneys further.
2. COPD with lower respiratory infection– Pt will continue Advair and Albuterol prn.
3. CKD 4 – patient will continue home meds and fu with PC as scheduled.
4. DM type 2 – glucose currently stable. Pt is cautioned to watch for fluctuation that can occur during acute illness. Encouraged to contact PC if abnormal fluctuation occurs. The patient will be treated with an antibiotic.

Diagnosis coding includes:

1. Pneumonia unspecified organism (J18.9)
2. COPD with an acute lower respiratory infection (J44.0)
3. CKD 4 (N18.4)
4. DM 2 (E11.9)

Case example notes:

While the urgent Care provider is not assuming responsibility for management of the comorbid COPD, CKD 4 and DM2, the conditions did influence patient care. These conditions should be documented and coded on this date of service.

- This concept also applies when a patient is seen by a specialist for management of a specialty specific condition.

Document and code as specifically as possible. Specificity can impact whether a diagnosis is or isn't associated with HCC coding. For example, CKD (unspecified) does not assign a risk factor score in the CMS V28 model for HCC coding, while CKD 4 does assign a risk factor score.

Do not code more specifically than your documentation supports. In this case example, pneumonia is coded as organism unknown. A more specific code should be documented and coded if the organism is identified.

Additional Information about risk adjustment is available on the SHP provider website at
<https://www.securityhealth.org/providers/hcc>