Hierarchical Condition Categories:
Diagnosis Coding From a Different Point of View

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Submitting claims is easy—you report the correct codes for the services performed and the cancer diagnosis; reimbursement is guaranteed. (Note: ICD-9 and ICD-10 have diagnosis codes for "unspecified malignancies," and these codes are used too often in oncology. Whenever possible, use specific cancer diagnosis codes.) And then there are your Medicare Advantage patients. If you treat this patient population, you must also know your HCCs (hierarchical condition categories) and your ICDs (International Classification of Diseases).

Medicare Advantage Plans: 101

Medicare Advantage was created in 1997 with the signing of the Balanced Budget Act and was previously referred to as Medicare Managed Care, Medicare Part C, or the Medicare+Choice program. The Medicare Modernization Act of 2003 renamed the program Medicare Advantage. New types of plans were offered, including provider-sponsored organizations (PSOs), preferred-provider organizations (PPOs), and private fee-for-service plans (PFFS).

Congress created Medicare Advantage to encourage private insurance companies to venture into the senior care market. The plans now insure 16 million elderly and disabled people, nearly a third of those eligible for Medicare.[1] These plans are popular among beneficiaries because they often provide extra benefits, such as vision and dental care, with lower out-of-pocket costs.

The traditional model for physician reimbursement has been fee-for-service; physicians get paid for each service they provide to a patient. Under fee-for-service, the CPT® procedure codes and their individual relative values drive reimbursement and the ICD-9-CM diagnostic codes support the medical necessity of those services. In 2007 the risk adjustment phase-in was completed for the participating Medicare Advantage plans and the Medicare Advantage Hierarchical Condition Categories model turns this reimbursement system upside down.

The Risk-Adjusted Reimbursement Model: 101

In the HCC system, the patient's number and severity of medical problems is factored into a capitated payment using an actuarial prediction of costs. The Centers for Medicare & Medicaid Services (CMS) pays the Medicare Advantage plans on a per-member, per-month base, adjusted for each member's medical risk score. This means that the ICD-9-CM diagnosis codes do more than support the reason for the services; they now drive CMS payments to the Medicare Advantage plans for their members. In addition, the government trusts these plans to accurately report the health status of their participants.

This risk-adjusted reimbursement model is based on chronic and cumulative conditions (or HCCs).[2] HCCs are used to adjust capitation payments to these private healthcare plans for the health expenditure risk of their enrollees. This means that the Medicare Advantage plan must ensure that all appropriate diagnosis codes are included when the claim is processed: the primary diagnosis, other signs and symptoms, patient comorbidities, side effects of treatment, etc. Proper coding results in the revenue used to pay the medical bills of the membership and to prepare for those who have unpredictable medical problems.

The CMS Risk Adjustment Model measures the disease burden using approximately 70 HCC categories, which are correlated to about 3,300 diagnosis codes. Diagnoses are classified into groups to include clinically related conditions with similar cost-of-care ramifications, called diagnostic groups (DXGs). About 80 percent of the diagnoses used in the Risk Adjustment Processing System (RAPS) originate from the claim forms submitted by physicians and hospitals.

The RAPS creates a Risk Adjustment Factor (RAF) that identifies the individual patient's status. All of this is highly influenced by the historic costs of caring for specific chronic diseases, and payments are based upon the most severe disease manifestation. Comorbidities can have a significant impact on the RAF and HCC determination, and consequently the resulting reimbursement.

Physicians, hospitals, and cancer programs must then focus attention on accurate and complete diagnosis reporting according to the ICD-9-CM Official Guidelines for Coding and Reporting[3] (such as, coding diagnoses completely and to the highest level of specificity). The codes submitted are derived from physician documentation of face-to-face encounters; only medical record documentation can be used to support an HCC. This means that a Medicare Advantage plan can use an office

visit, hospital inpatient, or hospital outpatient medical record to support the diagnosis code(s) and resulting HCC, when more than one option is available.

Underlying Principles Behind the HCC Model

The following 10 principles guided the creation of this diagnostic classification system:[4]

1. Diagnostic categories should be clinically meaningful; conditions must be sufficiently clinically specific to minimize opportunities for gaming or discretionary coding.
2. Diagnostic categories should predict medical expenditures; diagnoses in the same HCC should be reasonably homogenous with respect to their effect on both current and future costs.
3. Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
4. In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate. Because each new medical problem adds to an individual's total disease burden, unrelated disease processes should increase predicted costs of care.
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.
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.
7. Providers should not be penalized for recording additional diagnoses.
8. The classification system should be internally consistent. For example, if diagnostic category A is ranked higher than category B in a disease hierarchy, and category B is ranked higher than category C, then category A should be ranked higher than category C.
9. The diagnostic classification should assign all ICD-9-CM codes; since each diagnostic code potentially contains relevant clinical information, the classification should categorize all ICD-9-CM codes.
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.

The HCC model is cumulative, meaning that individual patients can have more than one HCC category assigned to them. There is a hierarchy of categories, and some categories override others. In addition, Medicare Advantage plans can look backward in the medical records to correct incomplete coding. This involves reviewing the patients' medical records to look for documentation that supports any of those 3,300+ previously unreported diagnoses (unreported because they may not have been documented to support medical necessity of a previously reported service).

Oncology-Specific HCCs

The following are some of the HCCs that relate specifically to oncology:[5]

- ***HCC 8:*** Metastatic Cancer and Acute Leukemia
- ***HCC 9:*** Lung and Other Severe Cancers
- ***HCC 10:*** Lymphoma and Other Cancers
- ***HCC 11:*** Colorectal, Bladder, and Other Cancers
- ***HCC 12:*** Breast, Prostate, and Other Cancers and Tumors
- ***HCC 46:*** Severe Hematological Disorders
- ***HCC 47:*** Disorders of Immunity.

Clinical Vignette

In addition to various documents that incorporate coding instructions, CMS provides the following example:[5]

To illustrate the CMS-HCC model, we have created a hypothetical clinical vignette of a female, age 76, who lives in the community and has several chronic conditions. She received eight ICD-9-CM diagnosis codes from visits to hospitals and physicians, which are grouped into seven DXGs: acute myocardial infarction (AMI); angina pectoris; emphysema/chronic bronchitis; chronic renal failure; renal failure, unspecified; chest pain; and sprains. These seven DXGs in turn group into six CCs [condition categories], with the chronic renal failure and unspecified renal failure DXGs mapping to a single CC of renal failure. Finally, the six CCs result in three

payment HCCs—AMI, chronic obstructive pulmonary disease (COPD), and renal failure—that are used in risk adjusting Medicare capitation payments. Although this female receives CCs for both AMI and angina, she receives no payment HCC for angina because AMI is a more severe manifestation of coronary artery disease, and thus excludes angina in the coronary artery disease hierarchy. The HCCs for major symptoms and other injuries are also excluded from the payment calculation. Chest pain is a symptom associated with a variety of medical conditions ranging from minor to serious, and sprains are typically transitory, with minimal implications for next year's cost.

Along with the demographic factors of age 76 and female ($3,409), each of the three payment HCCs identified in the clinical vignette contributes additively to this person's risk profile (AMI $2,681; COPD $2,975; renal failure $2,745). Her total predicted expenditures are the sum of the individual increments, or $11,810. Her total risk score is the sum of the individual relative factors, or 1.583. [Calendar Year 2011].

HHS Study

The Medicare & Medicaid Research Review, Volume 4, Number 2 (2014) discusses "Measuring Coding Intensity in the Medicare Advantage Program."[6] According to this report, the average Medicare Advantage risk score has increased faster than the average FFS (fee-for-service) score every year. This means that the number of patients diagnosed with diseases that result in higher payment increased faster at Medicare Advantage plans than among beneficiaries enrolled in the Original Medicare. If Medicare Advantage health plans intentionally exaggerated the severity of a patient's medical condition, this would be considered "upcoding." For example, "drug and alcohol dependence" is as much as eight times more common in the highest coding Medicare Advantage plan than among patients in standard Medicare. The report states, in part:[6]

> *If MA [Medicare Advantage] enrollees are, in fact, getting sicker more quickly than FFS [Fee For Service] beneficiaries, we would expect to see MA mortality rates increase relative to FFS mortality.*

While upcoding is always a possibility, Medicare Advantage plans have a vested interest in complete diagnosis coding and they may be working harder to obtain comprehensive diagnosis information to ensure each patient is accurately classified. This report adds:[6]

> *Concerns about coding intensity in MA [Medicare Advantage] plans would be minor if coding in FFS were relatively complete, because in that case there would be little opportunity for MA [Medicare Advantage] plans to legitimately increase risk scores through efforts at increasing diagnostic reporting. However, FFS coding is known to be both incomplete and variable. Incomplete coding is evidenced by lack of persistence in coding of chronic conditions.*

Incomplete and variable coding provides ample opportunities for Medicare Advantage plans to increase risk scores of beneficiaries through coding intensity efforts, and a number of vendors actively market services that help plans to do so, often advertising high returns on investment (ROIs) for their services.

In addition to the HHS study, a whistleblower case filed under the False Claims Act has recently become public, alleging that providers and Medicare Advantage plans have defrauded the Medicare program by manipulating data to make members appear to be sicker and generate higher capitation payments.[7] According to the Kaiser Family Foundation, CMS was projected to pay Medicare Advantage plans $156 billion in calendar year 2014, accounting for about one-third of all Medicare spending.

The Bottom Line

It all boils down to the data collection process, which of course always points back to the physician's office and/or hospital and the documentation of the patient encounter. Good documentation begins at the time of the patient's face-to-face encounter with the oncologist when the physician documents the clinical findings in the medical record, and the medical record is used to determine ICD-9-CM codes. Coding Clinic, Third Quarter 2013 (authoritative coding guidance) states:[8]

Question: *Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes? Does each visit or admission stand alone? Would the coder go back to the previous encounter records to assist in the coding of a current visit or admission?*

Answer: *Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.*

Conditions documented on previous encounters may not be clinically relevant on the current encounter. The physician is responsible for diagnosing and documenting all relevant conditions. A patient's historical problem list is not necessarily the same for every encounter/visit. It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's medical record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.

This is an area where coders and/or department managers may need to educate physicians and/or practice managers on the need to include complete diagnoses when outpatient services are ordered and to continue to document chronic or longstanding conditions on each admission/encounter record. Please note this advice applies to both ICD-9-CM and ICD-10-CM.

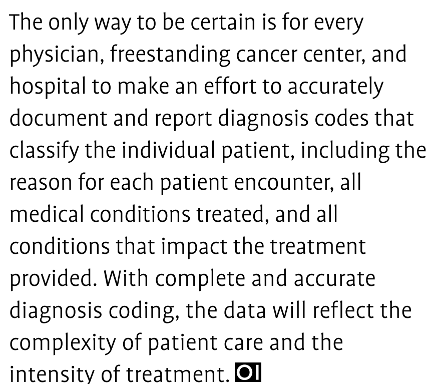
In addition, Coding Clinic, First Quarter 2012 states:[9]

Question: *Since our facility has converted to an electronic health record, providers have the capability to list the ICD-9-CM diagnosis code instead of a descriptive diagnostic statement. Is there an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-9-CM code number?*

Answer: *Yes, there are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient's diagnosis, condition, and/or problem. Therefore, it is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-9-CM is a statistical classification, per se, it is not a diagnosis. Some ICD-9-CM codes include multiple different clinical diagnoses and it can be of clinical importance to convey these diagnoses specifically in the record. Also, some diagnoses require more than one ICD-9-CM code to fully convey. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.*

Finally, the HHS report states:[1]

Coding more carefully may have real health benefits. Better identification of problems and better documentation of problems that have been identified could improve the quality of treatment provided and may even lower costs—or they may lead to unnecessary treatment and higher costs.



The only way to be certain is for every physician, freestanding cancer center, and hospital to make an effort to accurately document and report diagnosis codes that classify the individual patient, including the reason for each patient encounter, all medical conditions treated, and all conditions that impact the treatment provided. With complete and accurate diagnosis coding, the data will reflect the complexity of patient care and the intensity of treatment. OI

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References

1. Schulte F. HHS Report Finds Medicare Advantage Plans Exaggerate Members' Diseases To Make More Money. Available online at: www.kaiserhealthnews.org/news/medicare-advantage-plans-exaggerate-diseases-to-make-money-says-study. Last accessed Feb. 4, 2015.

2. CMS. Medicare Managed Care Manual. Chapter 7: Risk Adjustment. Available online at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf. Last accessed Feb. 4, 2015.

3. CDC. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Available online at: www.cdc.gov/nchs/icd/icd9cm.htm. Last accessed Feb. 4, 2015.

4. CMS. Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. Available online at: www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04Summerpg119.pdf. Last accessed Feb. 4, 2015.

5. CMS. Evaluation of the CMS-HCC Risk Adjustment Model: Final Report. Available online at: www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf. Last accessed Feb. 4, 2015.

6. Kronick R, Welch WP. Measuring coding intensity in the Medicare Advantage Program. *MMRR*. 2014;4(2):E1-E19. Available online at: www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a06.pdf. Last accessed Feb. 4, 2015.

7. Schencker L. Were patients really sicker? Lawsuits say Medicare Advantage plans inflated diagnoses to boost payments. *Modern Healthcare*. Available online at: www.modernhealthcare.com/article/20141122/MAGAZINE/311229981. Last accessed Feb. 4, 2015.

8. American Hospital Association. *Coding Clinic*, Third Quarter 2013.

9. American Hospital Association. *Coding Clinic*, First Quarter 2012.

Top 3 Takeaways about HCCs

1. Medicare Advantage plans require all relevant patient diagnosis codes for correct payment.
2. All diagnosis codes should be reported at the highest level of specificity (no unspecified codes).
3. Complete and accurate diagnosis coding reflects the complexity of care and intensity of treatment.