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HCC ReClaim™

Endorsed Business Partner of the Indiana Hospital Association

An Overview of HCC Risk Adjustment

Whitepaper | 2022

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Understanding the Differences in Payment Models...

Fee for Service	HCC Risk Adjustment
• Providers are paid based on services performed. • Payment is based on CPT/HCPCs accuracy. • Critical that documentation support the level of service and procedures performed. • ICD-10-CM codes reported to support the medical necessity of the service provided.	• Patient demographics and coded/reported ICD-10-CM codes establish payment. • Concentrates on patient's current conditions. • Payment is based on the overall complexity of the patient's conditions over a calendar year.

Fee for Service Payment Model...

We are all very familiar with the fee for service reimbursement model. In this model, healthcare providers charge based on individual services rendered and are paid based on the services they perform. The billing claim form itemizes these services on separate line items and then the payment is based on each CPT code accuracy. It is critical that documentation supports the level of service and the procedure(s) performed.

In the fee-for-service model, the ICD-10-CM codes have historically been reported mainly to support the medical necessity of the services provided, and it is common that not all ICD-10-CM codes are captured and/or captured at the highest level of specificity, If captured, they are not necessarily always thoroughly documented.

HCC Risk Adjustment Model...

With the HCC Risk Adjustment model, payment is based on specific patient demographic factors, as well as the overall complexity of the patients health status. This is based on documented and reported ICD-10-CM codes.

This payment methodology concentrates on a patient's current conditions and the payment is based on the overall complexity of the patient's condition(s) over a calendar year. Each specific diagnosis is used to determine the Risk Adjustment Factor (RAF) score. The RAF score is used to calculate not only the payer reimbursement but also predict potential future costs associated with each patient.

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What Factors Contribute to a RAF Score?

The diagnosis factors that contribute to a patient's RAF score...

- All reported CMS HCC ICD-10-CM codes for chronic and acute conditions over a calendar year.
- Disease interactions based on the CMS HCC ICD-10-CM codes reported.
- Multiple reported HCC payment conditions.

The ICD-10-CM diagnosis codes that are coded and reported over a calendar year contribute to a patient's RAF score. The coded and reported ICD-10-CM codes are mapped to a hierarchical condition category (HCC). HCCs are groupings of clinically related diagnosis with similar associated cost to the healthcare system. It is important to note that not all ICD-10-CM codes are HCC codes. There are over 10,000 ICD-10-CM codes that map to one of the 86 HCCs.

How a RAF score is determined...

ICD-10-CM codes are submitted on health claims. All coded and reported ICD-10-CM diagnosis codes that are mapped to an HCC are considered. Each HCC is assigned a value. The HCCs are cumulative. Higher risk scores or RAF scores, represent patients with a greater than average disease burden. Lower risk scores represent a healthier population view, but may also falsely indicate a healthy population when there is poor chart documentation. This could result in inaccurate payment.

Documentation and coding for conditions that impact a patient's risk score...

HCC Risk Adjustment reimbursement depends on complete and accurate reporting of patient diagnoses. Thorough documentation and accurate ICD-10-CM code assignment is critical to predicting the risk and future cost associated with a patient's care.

To ensure maximum reimbursement and compliance, the submitted diagnoses and the plan of care related to the diagnoses must be documented in the patient's medical record and reported at least once every calendar year. Documentation in the medical record must support all diagnosis codes reported, including specificity and the documentation for each visit must stand alone.

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What does documentation look like?

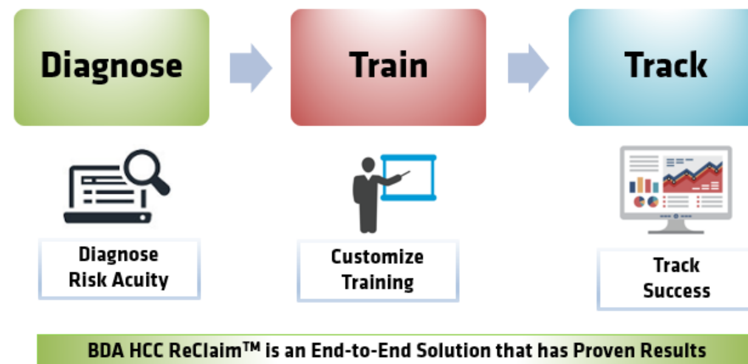
Each patient's RAF score depends on the documentation and then the coding. If your providers are not clearly and completely documenting a patient's chronic condition, your coders won't be able to include appropriate and specific diagnosis codes on the claim. CMS requires that a qualified healthcare provider describe all chronic conditions and severe diagnoses for every patient, every year, to establish a health profile. Documentation in the content of the medical record must indicate the provider's plan for the patient.

You have heard of M.E.A.T. We see it as **T.E.A.M.**

- **T**reat–medications, therapies, procedures, modalities.
- **E**valuate–test results, medications, patient response to treatment.
- **A**ddress–ordering tests, patient education, review records, counseling patient and family member.
- **M**onitor–signs and symptoms, disease process.

Using HCC risk adjustment coding, this data is then used to predict health costs for the subsequent contract year. Inaccurate or non-specific diagnoses can impact patient care, outcomes and reimbursement payment for ongoing care of that patient.

WHAT ARE YOU DOING TO DIAGNOSE, TRAIN, AND TRACK YOUR HCCs?



SO..., WHAT ARE YOU DOING TO DIAGNOSE, TRAIN, AND TRACK YOUR HCCs?

Healthcare organizations should educate and monitor their value-based reimbursement programs. And, that is what HCC ReClaim™ can do for you...

HCC ReClaim™ is Designed to Diagnose HCC Risk Acuity through useful analytics and reports that precisely identify groups/providers/patients with low RAF scores, Missing HCCs that have been reported historically, HCCs reported incorrectly and trends in HCC capture and re-capture.

The benefits of HCC ReClaim™ Training increases the accuracy of documentation and ICD-10-CM coding for organizations/groups/providers who have been identified with problem trends in HCC capture, high percentage of missing HCCs, and low RAF scores.

The results of HCC ReClaim™ Tracking Success results in accurate documentation and coding of ICD-10-CM. Accurate HCC capture. And accurate RAF scores.

Before you engage **BDA HCC ReClaim™**, we'll review your ***Hierarchical Condition Category (HCC)*** potential lost revenue opportunities — **free and at no obligation to you.** This service, called the BDA Preliminary Analysis, or Prelim, helps to identify your lost opportunities for HCC capture.

This analysis will contain potential growth opportunities related to your organization.
Contact BDA at info@billdunbar.com

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