Handout For Intro HCC (Hierarchical Condition Category)/RAF (Risk Adjustment Factor)

Coding Workshop

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Learning Objectives:

- Define and understand HCC/RAF Coding as opposed to CPT/RVU Coding.
- Describe how HCC Codes are captured and reported.
- Understand the impact of precision and timing of HCC Codes.
- A working familiarity with most common HCC Codes and most common under-reported HCC Codes.
- Handout now updated for v28 that began phasing in 2024, will be fully implemented in 2026.

Some Useful Facts:

- Relative Value Units are intended to capture the intensity of work that goes into an individual service.
- HCC Codes/RAF Scores are intended to capture the overall complexity of a patient to be cared for o ver the course of a year.
- RVU's based payment models incentivize production of more services.
- HCC based payment systems incentivize more specific diagnosis of patients. (when combined with risk bearing).
- 93% of CPT charges are from sub-specialists.
- 83% of HCC Codes are best coded by Primary Care Providers.
- Beware:
  - The HCC cure—All codes reset January 1st every year, if not coded that year, they disappear from the Risk Adjustment Score.
  - Active vs historical DX. (COPD risk adjusts, history of COPD does not).
  - Specificity of DX (morbid obesity risk adjusts, obesity does not).
  - Chronic Conditions (easily missed in future years—below knee amputation).

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Who, What, When, Where, How and Why of HCC coding.

- **Who?**
  - Each patient is coded separately.
  - PCPs are responsible for over 80% of HCC Codes (or can and should be).

- **What?**
  - HCC is coding/risk adjustment rubric based on complexity of the illness over time.
  - (CPT/RVU is based on complexity of each and every individual service).

- **When?**
  - HCC Codes are captured on an individual basis in the course of a calendar year.
  - Payment is delayed at least one year (MA) or can be 3 years or longer in other models.
  - Yet the codes reset every year. (no one is obese, has COPD or an amputation until it is coded again).
  - Example in MA. (Similar things are at play in other Risk Adjusted Plans).
    - YR 2024—Morbid Obesity DX made—No payment.
    - YR 2025—No DX Entered—$2232 received based on 2024 code.
    - YR 2026—xxxx (N/A for current yr)—$0 (no code in 2025).

- **Where?**
  - Must be face to face visit (video, home, office, hospital, etc).
    - Note from visit has to support each diagnosis—think MEAT.
      - Monitor
      - Evaluate
      - Assess
      - Treat
  - Must be coded on a claim submitted to Medicare/insurer.

- **How?**
  - Yes, you can and must track DX on problem list.
  - But you only get credit when you submit DX to insurer/Medicare during a calendar year.
    - Max 4 codes per regular visit.
    - Unlimited codes on Medicare Annual Wellness Visit.

How to calculate revenue estimate from HCC/RAF Score for Medicare Advantage Patient:

Rationale - It is simplest to do on an individual patient, but similar rubrics are at work for other programs with risk adjustment in play. (ACO, Primary Care First, etc).

Assumption - The average PMPM for Medicare Advantage payments is $1000 PMPM. (This is not ChenMed contractual numbers).

1) HCC WT. _____

2) MA Avg PMPM X_____

3) Months / Yr X 12

4) Annual Revenue*

_____

* Revenue is a year following coding (and code must be resubmitted each to get credit for the following year).

Example Morbid Obesity:
DX E66.01, HCC48, HCC Wt: 0.186

1) HCC WT. **0.186**

2) MA Avg PMPM X **$1000**

3) Months / Yr X **12**

4) Annual Revenue* **$2232**

* Revenue is a year following coding (and code must be resubmitted each to get credit for the following year).

For this example, if you code Morbid Obesity in 2021, you get the $2400 in 2022. (though if you do not code in 2022, you will not receive the revenue in 2023 regardless of patient not losing weight).

Table 1: Top 10 Reasons For Adult Outpatient Visits.

DX	ICD10	HCC	HCC Wt. (RAF)	Notes
URI	J06.9	---	N/A	
HTN	I10	---	N/A	
DJD	M19.90	---	N/A	
Type II DM	E11.9	38	0.166	
Depression	F32.A	---	N/A	MDD risk adjusts.
Anxiety	F41.9	---	N/A	
Pneumonia	J18.9	---	N/A	
Back pain	M54.9	---	N/A	
Dermatitis	L30.9	---	N/A	
Routine Health Maintenance	Z00.0	---	N/A	

Table 2: Top 10 Most Common HCC Codes.

DX	ICD10	HCC	HCC Wt. (RAF)	Notes
DM 2 w/o complications	E11.9	38	0.166	Dx criteria: A1c ≥6.5 FBG- ≥126 RBG ≥200 (need 2 readings).
Breast, Prostate, Other Cancers or Tumors	C50.9 (breast) C61 (prostate)	25	0.186	Must be active to use DX.
DM2 with Chronic complications	E11.42 (neuro) E11.22 (CKD) others	37	0.166	There are numerous others.
Sz disorder	G40.909	201	0.245	
Specified Arrythmias	I48.91 (afib) others	238	0.299	
CHF	I50.9	226	0.360	
Other Endocrine and Metabolic Disorders	E21.0 (↑PTH)	51	0.510	Thyroid does not risk adjust).
COPD	J44.9	280	0.319	Dx Criteria FEV1/EVC < 0.7
Major Depressive Disorder	F33.9	155	0.299	Need specific DX. PHQ 9 ≥10 (moderate Major depression).
Morbid Obesity	E66.01	48	0.186	BMI > 40 or BMI > 35 with co-morbidities.

Table 3: Commonly Missed Chronic HCC Codes.

DX	ICD10	HCC	HCC Wt. (RAF)	Notes
Ostomy Status	Z93.1 (Ileostomy) Z93.3 (Colostomy)	463	0.673	
Amputation Status	Z89.511 (r BKA) z89.512 (L BKA)	409	0.598	
Diabetes with Neuropathy	E11.40	37	0.166	
Dialysis Status	Z99.2	326 (CKD 5)	0.815	No additional adjustment beyond CKD5
CKD 3 or greater	N 18.31 (3)	329	0.127	
Hemiparesis—from CVA	G81.90	153	0.387	
CHF	I50.9	226	0.360	

Table4: CPT wRVU's 2023.

CPT (est)	wRVU/tRVU	work$/total$	CPT (new)	wRVU/tRVU	work$/total$
99212	0.7/1.68	$23.72/$56.93	99202	0.93/2.15	$31.51/$72.88
99213	1.3/2.68	$44.05/$90.81	99203	1.6/3.33	$54.22/$112.84
99214	1.92/3.79	$65.06/$128.43	99204	2.6/4.94	$88.10/$167.40
99215	2.8/5.31	$94.88/$179.94	99205	3.5/6.5	$118.61/$220.27

https://www.aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist--administrators/billing-and-coding/medicare-fee-for-service/medicare-2023-physician-fee-schedule.pdf

2023 RVU Conversion Factor $33.8872

Table5: CPT Coding.

Level of Medical Decision Making				
Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

* Each unique test, order, or document contributes to the combination of two or combination of three in Category 1.

https://aafp.s3.amazonaws.com/2021-EM-Coding-Guidelines/content_GL/assets/xLxw9GcFqjuWX71K_Cy13r82T0hdWI_3L.png

First Task (To Be Completed Individually).

Please decide if each statement below is true **or** false**. And why for each one?**

1. HCC Coding is better and more useful than CPT Coding.
T or **F**. Why? _____

_____

2. Primary Care Physicians get rewarded more from HCC Coding than CPT Coding.
T or **F**. Why? _____

_____

3. Once a patient has COPD they always have COPD.
T or **F**. Why? _____

_____

4. In HCC coding the problem list does not matter.
T or **F**. Why? _____

_____

5. In HCC coding you can bill all the codes in one encounter.
T or **F**. Why? _____

_____

6. A new diagnosis of Morbid Obesity creates an additional payment of $2232.
T or **F**. Why? _____

_____

7. What is the sum of HCC WTs (RAF score) and estimated annual revenue for a patient with:
- Surgical absence of left lower leg.
- BMI of 35:
- Type II DM:
- H/o COPD

HCC WT Total _____
$ Revenue per year _____

Task 2

Which case below A or B is most complex? And Why?

CASE A	CASE B
72 yo female with history of COPD, htn, dm with increasing dyspnea on exertion for the last 2 weeks. Accompanied by slight nausea and diaphoresis. Current Meds: Lisinopril 10mg daily. Metformin 500mg daily. Advair 250/50 diskus BID. NKDA PE - Elderly female appearing somewhat SOB. VS BP 150/90, pulse 80, rr 24, t 98.6, wt 150 lbs. POC Glucose - 155. Heart RRR without MRG's. Lungs CTAP. Ext - trace edema, no cc or cyanosis. EKG - NSR at 90 with frequent PVC's non specific ant lat ST-T changes. (PVC's and ST-T changes are new since 6 months prior). A/P • DOE - in patient with risk factors of htn and DM. EKG changes. • High risk for CAD will send to ED by EMS for cardiac workup. • HTN - less than optimal control. Continue current meds. • DM - stable.	72 yo female with COPD (FEV1/FVC 0.65 January 2020), Hypertensive Cardiomyopathy (Moderate LVH with preserved EF on Echo July 2019) and DM (last a1c in april 2022 8.0) with peripheral neuropathy is here for follow up with no new complaints. Current Meds: Lisinopril 10mg daily. Metformin 500mg daily. Advair 250/50 diskus BID. O) Healthy female in NAD. VA - Bp 120/70, HR 80, RR 15, Wt 150lbs. POC Glucose - 155. Heart - RRR. Lungs - CTA. Ext - feet decreased sensation over ball of each foot, skin intact. A/P • Hypertensive cardiomyopathy - stable, continue current treatments. • Diabetes with neuropathy - stable. Continue current meds. • COPD - stable continue current meds.

Task 3

It is December 31st and you have 1 open appointment left for the day. Your office manager says that there are two people trying to get the appointment. Which one will you give the appointment to Patient A or Patient B?

Why?

PATIENT A

Mr. Smith is a 65 yo male with HTN, DM, CHF and ETOH abuse. He chronically misses appointments. The last time he was in the office was 18 months ago. But as he just got into Medicare this month (and picked an MA Plan that you have a risk contract with and chose you as his PCP), he says that he wants prescription refills. He has no complaints.

Meds:
Lisinopril 20mg daily
Metformin 500mg bid
Lasix 40mg daily.

PATIENT B

Ms. Jones is a 70 yo female who is one of your favorite patients. She wants to go dancing tonight with her husband, but her knee is bothering her, and she wants you to put a steroid shot in. Her last one was 9months ago. She also needs a refill on her HCTZ for high blood pressure

Meds:
HCTZ 12.5mg per day.

Task 4

What DX's would you code and what total HCC weight would you get for each of the following patients based on HPI?

Patient A _____

Patient B _____

PATIENT A

HPI: Mr. Smith is 68 yo female with history of COPD here for follow up of type II Diabetes.

DX	ICD10	HCC	HCC Wt. (RAF)	Notes

PATIENT B

HPI: Mr. Jones is a 70 yo male with CHF, Diabetic Neuropathy and surgical absence of right lower leg, here for follow up.

DX	ICD10	HCC	HCC Wt. (RAF)	Notes

Task 5

What DX's would you code and what total hcc weight would you give the following patient?

S) 68 yo female with, Hypertension, COPD, Diabetes, and history of Breast Cancer is in to establish care. Denies any SOB or chest pain.

PMHx: S/P Mastectomy 10 years ago.

Current Meds:
Lisinopril 10mg qday
Metformin 500mg bid
Lasix 40mg qday

O) Healthy Female in NAD
VS - BP150/80, Pulse 80 irreg, RR- 14, HT 64 in WT 205lbs BMI 35 (morbid obesity)
Glucose 126, PHQ9 - 10
(major depression-moderate)
HEENT - Moist non-icteric MM's, PERLA, TM's Clear
Neck-No masses or bruits
Heart-Irreg Irreg, no murmurs (Afib)
Lungs - Good air movement, few Ronchi, no rales or wheezes
Ext - Trace Edema - No Clubbing or Cyanosis
Neuro-A and O x 3. Decreased sensation bilat MTP joints plantar surface (neuropathy)
Psyc - Appearance – Neat
Mood Down
Speech normal
Thought process – intact
Denies SI

EKG - Rate - 80
Rhythm - Irreg Irreg - Normal Axis
Impression - Afib at 80

Spirometry - FEV1/FVC - 0.65

ECHO - EF 40%, no wall motion abnormalities. (HFrEF)

DX	ICD10	HCC	HCC Wt. (RAF)	Notes