OPERATOR INSIGHTS

presented by ENSEMBLE HEALTH PARTNERS

Physician Revenue Cycle Coding

The Importance of HCC Coding

Hierarchical Condition Category (HCC) coding is the risk adjustment (RA) model that is used by the Centers for Medicare and Medicaid (CMS) for determining future healthcare costs associated to a specific patient. By coding chronic conditions to the highest level of specificity, a picture can be drawn of what healthcare resources will be needed in the future to treat the patient.

For years, Medicare Advantage plans and other insurers have used this RA model to predict future costs for their enrollees. HCC coding for a current year is used to predict expenses for the following year. Since more healthcare dollars are spent treating a patient with congestive heart failure than it does to treat a patient with no chronic health concerns, the coding of HCCs becomes important in budgeting healthcare spending by insurers.

Considering the gender, sex, and geographical area of the patient, the RA score formula allows CMS to have the most up to date information on the health of the patient. Medicare advantage payors, Medicaid replacement plans, and Insurers on the Health Exchange, are paid a higher capitation amount for these at-risk patients.

By supplying insurers with HCCs and accurately affecting the RA score, the provider will also benefit from an optimal level of reimbursement for claims. By not having an HCC coding plan, a provider group could be leaving "revenue on the table". The benefit of HCC coding for RA provides is a well-rounded view of a patient's health status to the staff as well, creating a better outcome for patient care.

Telling the Story

The words in our clinical documentation are the means we use to convey a convincing and understandable story about our patient. If we are able to do that, the payer has little choice but to pay for our services.

Telling an effective story is an art that can be learned with a little practice. An effective story has the following attributes at a bare minimum:

Understandable: Your patient story must be easy to understand. Even if the reader doesn't have your deep technical background in anatomy, kinesiology, and physiology they should still be able to understand the basics of the story without understanding every detail.

Chronological: Most stories do have a beginning, middle and an end. The beginning of your patient-story relates what happened in the past, including the medical history and onset. The middle is what has happened more recently in the patient's recovery and the end will include a word-picture of the current status of the patient.

Rational: You are building a case. The treatment plan must have a reasonable rationale that is grounded in some degree of science combined with common sense, and the prognosis needs to be believable.

Empathetic: The reader needs to be engaged so they put themselves in your patient's shoes. It is critically important for your story to convey what the patient is going through, and why their recovery from their current situation is important.

Look at your last initial evaluation closely. Does it convey an understandable, chronological, and rational story that makes it easy for the reader to understand your patient's condition?

Keep your coding eye on the prize

Healthcare professionals commonly report E/M codes on insurance claims to request reimbursement for services. The process required for accurate E/M coding and documentation has caused a lot of confusion and frustration for medical coders and providers over the years. That is one reason why the American Medical Association (AMA), which holds copyright in CPT®, and the Centers for Medicare & Medicaid Services (CMS) are planning major revisions to office and outpatient E/M codes 99201-99215 in 2021.

AMA's website re: CPT E/M Revisions:
AMA-assn.org Implementing CPT E/M Revisions

More detailed info, including prolonged services:
AMA-assn.org 2021 CPT E/M & Prolonged Services Guidelines

Helpful Tips:

- Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code.*
- The volume of documentation should not be the primary influence upon which a specific level of service is billed.*
- It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted.*

*CMS Publication 100-04 Medicare Claims Processing Manual Chapter 12

Helpful Links:

CMS.GOV Covid-19 Toolkit

AMA-assn.org Covid-19 Coding Card

AmericanTelemed.org Telehealth Basics

MGMA.com Telehealth requirements

CMS.mlnconnects Medical Learning Network

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