HCC Transition from V24 to V28
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CodingIntel
AT THE CORNER OF CODING AND GETTING PAID

Recorded June, 2023

What's all the fuss about?

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- CMS proposal and a compromise
- Differences between V24 and V28
- Is there a "to do" to prepare? What do you need to know and do?

Bonus: the briefest of HCC overview

2020 V24 will transition to 2024 V28

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CMS believes that MA plans are ***upcoding,*** resulting in payments to MA plans that are too high and thus, V28. Why?

1) Multiple OIG audits of MA plans show diagnoses not supported in the record that resulted in overpayments
2) Analysis comparing MA patients and fee for service payments/complexity

Conditions not included in V28

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- Conditions that didn't accurately predict costs
- Coefficients (risk scores) were small
- Conditions were uncommon
- Conditions that didn't have well-specified diagnostic coding criteria

V28

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- # of HCC categories increases from 86 to 115
- Assigns risk scores to 2,294 **fewer** codes
- Current HCC categories were developed based on ICD-9-CM; V28 uses ICD-10-CM structure
- Takes advantage of clinical concepts in ICD-10-CM

V28

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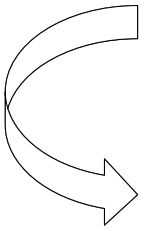
- Some common conditions will no longer map to a risk score
- CMS is using "constraining" which means related HCCs are given the same coefficients



And: diabetes uncomplicated, with acute complication and with chronic complications now have the same coefficient (slightly higher than current diabetes uncomplicated, lower than with complications)

Will result in a decrease in overall risk for patients with diabetes

V28 additional conditions

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- 268 codes that didn't map to an HCC category in V24 will map in V28
- Some are from Ch. 16, "Certain conditions originating in the perinatal period" and Ch. 17, "Congenital malformations, deformations and chromosomal abnormalities"
- Don't represent conditions common in Medicare patients
- Will be a help for risk scores for commercial groups

The entire list V24 versus V28

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- Citation is on slide at end of presentation
- Examples in slides are …. Examples
  - Not meant to be inclusive

V28: a few conditions that won't map to HCC score

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- Protein-calorie malnutrition (E43, E44.0, E44.1, E46, E64.0, R64)
- Hypoparathyroidism (E20.-)
- (Some) major depressive disorder codes (F32.0, F32.4, F32.5, F33.0, F33.40, F33.31, F33.42, F33.8, F33.9)
- (Some) polyneuropathy codes (in categories G61.-, G62.-, G63.-, G65.-)
- Angina codes (I20.1, I20.2, I20.8, I20.9)

V28: conditions that won't map to HCC score

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- (Some) aneurysm codes, without rupture
- Thoracic, abdominal aortic ectasia
- (Some) atherosclerosis codes
- Acute kidney failure
- Acquired absence of great toe, other toe

Next steps

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- Review the CMS excel file, V24 to V28
- If possible, do a provider inservice on HCC coding
- Review your use of the codes with changed/deleted risk scores

The basics haven't changed:

- Follow ICD-10-conventions and guidelines
- Code accurately and specifically

HCCs

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- Hierarchical Condition Categories (HCCs)
- Used by Medicare to establish monthly rates to Medicare Advantage Organizations for MA patients
- Varies payment by demographics, geography, and diagnoses

How HCCs are calculated

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- Age/gender
- Living at home or in an institution
- Dual Medicare/Medicaid eligible
- Diagnosis risk adjustment based on inpatient and outpatient hospital claims, physician claims, and other health care professional claims data
- Geography

RAF= risk adjusted factor

HCCs

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Diagnosis codes are sorted into diagnosis groups, which are sorted into condition categories and given a risk adjusted factor

- Related conditions are assigned in one category and only the most serious is counted
- Two conditions in the same group are only counted once
- A higher ranked condition causes lower ranked conditions in same category to be ignored (some exceptions to this rule)
- Unrelated conditions in different categories are both counted, score is additive

Disease interactions: a boost

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When certain conditions occur together, the risk score increases

- Immune disorders and cancer
- CHF and diabetes
- CHF and COPD
- CHF and renal disorders
- CHF and specified heart disorders
- COPD and chronic renal failure
- Substance use disorder and psychiatric conditions

HCCs and ICD-10-CM

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- Precedence for assigning codes:
- Coding instructions in the tabular list and alphabetic index
- Official Guidelines
- AHA Coding Clinic

ICD-10-CM sections I & IV only for outpatient

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- Section I applies to both facility and outpatient service
- Sections I & II & III apply to non-outpatient settings
- Section IV applies to outpatient services

ICD-10 Guidelines

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Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment. Do not code conditions which no longer exist.

Add to the assessment (and claim)

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- Conditions evaluated and treated at the encounter
- Chronic conditions that affect treatment of an acute problem
- Documenting a treatment plan shows evidence of the assessment and management or how condition affects treatment

Condition: status: plan

Citations V24/V28 sheet

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https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors-items/riskothermodel-related

Download PY 2024 Proposed Clinical Revision Part C Model ICD-10 Mappings (ZIP)

- This is an excel sheet that shows diagnosis codes that have HCC coefficients (scores) in V24 and V28

Citations

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https://www.cms.gov/files/document/2024-announcement-pdf.pdf

PDF of CMS rulemaking file

- Coefficients by age/demographics start on page 183
- Policy and actuarial discussion

Citations: CMS guidance, google these citations

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1) 2008 Risk Adjustment Technical Data
   - Sections 6 & 7 related to coding
2) CMS "Risk Adjustment 101 Participant Guide" 2013
3) CMS "Contract-Level Risk Adjustment Data Validation: Medical Record Reviewer Guidance In Effect as of 03/20/2019

When reading the CMS documents, pay attention to facility versus outpatient rules

Thank you

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