MIPS, RAF and HCC:
What Does it All Mean?
White Paper

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ICD-10CM, HCC and Risk Adjustment Factor

The purpose of this white paper and the following ICD-10CM/HCC Crosswalk is to provide you with information on changes in Medicare reimbursement (and potentially commercial payor reimbursement) beginning in 2019 based on 2017 diagnosis coding.

Not everyone is aware of what CMS calls "the risk adjustment model." It was developed under the Patient Protection and Affordable Care Act (also known as the PACA). By January 2017, a provider should understand this system and how it will affect future reimbursements. The PACA provides for positive and negative incentive payments under the Medicare Incentive Payment System (MIPS) based on a risk adjustment model. The risk adjustment model addressed in this white paper is linked to a series of conditions called Hierarchical Condition Categories (HCCs), and has been used to reimburse Medicare Advantage plans (Medicare Part C) since 2004. An HCC is simply used to estimate future healthcare costs for members for their next year of coverage. These estimates are based on information such as a patient's sex, age and medical conditions documented by a physician during a patient encounter in a given calendar year. A provider's patients' HCC scores from 2017 will be used to determine if a provider is furnishing patient care at a reasonable cost under the MIPS program, and that determination will affect the provider's 2019 reimbursement. The system works like this: A provider selects an ICD-10CM code, the ICD-10CM code is converted to an HCC, and then the HCC is assigned a numerical value referred to as a Risk Adjustment Factor (RAF). Each RAF score of 1.0 is the equivalent of $9,185.29 in 2017 dollars.

For example, CMS automatically assigns all healthy 65-year-old male patients a RAF value of 0.300. In dollars, that's about $2,755.59 (0.300 multiplied by $9,185.29) in expenses for the following year. If this patient has expenditures greater than that dollar amount, CMS can interpret that the provider as an excessive cost provider. If this trend continues with many of the provider's patients, the provider's future reimbursements can be impacted by as much as negative four-percent for the first year of MIPS implementation (2019). This will occur if the composite of the provider's patients' HCC scores indicate that the provider delivers care at a higher cost than the patients' HCC scores dictate. However, accurate ICD-10CM coding may increase the HCC values which, in turn, increases the RAFs for a provider's patients. Improving the accuracy of ICD-10CM coding across multiple patients helps to ensure that costs associated with patients do not exceed these estimates. CMS interprets providers who deliver patient care at a cost that is in line with the HCC score as low cost providers. Low cost and high quality providers are eligible for as much as a twelve percent increase in reimbursement in 2019. The provider would receive a 12% increase

if they scored high enough under MIPS and received the largest Risk Adjustment Factor (RAF) increase. In 2019 the highest MIPS percentage increase in the fee schedule would be 4% times the largest RAF increase of three (4% MIPS X 3 RAF increase = 12%).

The good news is that if a provider documents and codes correctly, their patients' HCCs will better reflect those future costs and can potentially increase the provider's reimbursements under the various Medicare payment-for-performance models. The bad news is that if a provider does not do an acceptable job of capturing HCCs the provider can face decreased reimbursements under those same models beginning in 2019. CMS's determination of a provider's performance for reimbursement during 2019 began on January 1, 2017.

This white paper, and the attached "ICD-10CM/HCC Crosswalk," show several diagnosis codes for common chronic conditions that a provider may have never used in the past. For example, there are multiple manifestations that occur as a result of HTN and DM such as Heart Disease and Chronic Kidney Disease. The diagnosis codes in the attachment have been around since the 1970s, but until now have never directly affected reimbursement as it will beginning in January 2019. Other examples a provider may have never seen include the diagnosis code(s) for a patient diagnosed with Hypertensive Heart Disease with Heart Failure and Stage 5 or 6 Chronic Kidney Disease. These diagnosis codes exist and when appropriately used will help increase the provider's patients' HCC scores. A provider has an increase in the likelihood of additional reimbursements from Medicare and other commercial insurances under new Payment for Performance models with increased HCC scores.

How to Properly Reflect Your Risk Adjustment Factor

There are currently 60,000 plus ICD-10CM codes that a provider can use every day in the office, nursing home and hospital. Those codes are found in the 21 chapters of the ICD-10CM manual. Of those 60,000 codes, only about 10,000 ICD-10CM codes are linked to a specific set of HCC codes. Remember, HCC codes help predict future health care costs for a patient. A provider won't see the HCC because it's selected by the insurance company based on the ICD-10CM code(s) reported.

Here's how it works: A provider sees a patient, documents their ICD-10CM code(s) and files a claim to the insurance company. The insurance company looks at the diagnosis code(s) the provider submitted and converts it to one of a dozen HCC codes. That HCC code is then linked to a RAF. That RAF is what is used to project future health care costs for the next year for that specific patient. As mentioned above, there are only about 10,000 ICD-10CM codes that link to an HCC that have these RAF scores. The ICD-10CM/HCC Crosswalk will help a provider identify the HCC linked to the ICD-10CM codes so a provider will be able to better record an accurate diagnosis of his/her patients. Once the RAF score is determined, the RAF is then multiplied by a "conversion factor." For 2017, that factor is $9,185.29 dollars.

Clinical Example of Patient Future Cost Expenditures

A patient with Hypertension is seen in a provider's office. The patient also has stage 4 CKD, uncontrolled DM and is currently taking insulin. The patient's BMI is 40 and has a history of left great toe amputation because of uncontrolled DM. Currently the patient is Alcohol Dependent, in remission.

The following two tables show the difference in CMS's assessment of appropriate patient costs based on ICD-10CM coding affecting a patient's HCC code.

Table 1 below shows how most providers under a fee-for-service model would record the ICD-CM codes for the patient:

TABLE 1

Diagnosis	Diagnosis ICD-10	HCC	RAF	Projected Expenditures
Hypertension	I10	NA	0	0
DM, Controlled	E11.9	19	0.104	$955.27
Future Expenditures			0.104	$955.27

Table 2 shows how properly coding the above scenario increases the true expected costs for next year, which in turn may help you qualify for the additional 4% to 12% reimbursement:

TABLE 2

Diagnosis	Diagnosis ICD-10	HCC	RAF	Projected Expenditures
Hypertension with Stage 4 CKD	I12.9	NA	0	
Stage 4 CKD	N18.4	137	0.237	
Uncontrolled DM	E11.65	18	0.318	
Alcohol Dependence in Remission	F10.21	55	0.383	
Long Term Use of Insulin	Z79.4	19	0.104	Can't bill a 19 and 18 together
Acquired Absence of Great Toe	Z89.412	189	0.588	
BMI of 40	Z68.41	22	0.273	
Future Expenditures			1.799	$16,524.34

You can see that accurately coding all of the applicable ICD-10CM codes for this patient has allowed CMS to more accurately project the expenses that this patient is likely to incur over the next year. Coding the patient as shown in Table 1 projects the expenditures to be $955.27, while

improving the coding as shown in Table 2 increases the patient's projected expenditures to $16,524.34.

What Do You Need to Know Next?

There are some very common conditions that have excellent HCC values but are often never used by a provider because they fail to select proper ICD-10CM codes at the time of the patient's service. Specifically, conditions like DM, HTN, COPD, CKD, HF, Drug Dependency, Renal Status and certain extremity amputations are often not coded correctly by providers.

An accurate HCC score occurs when a provider is aware of all the codes for the above conditions and select the patient's specific ICD-10CM code correctly. Once a provider selects the appropriate ICD-10CM code for a condition and CMS or an insurance company converts it to the proper HCC, the provider will see the full impact of future costs associated with that patient. Appropriate coding can help decrease the chances of a reduction in reimbursement and improve the chances of an increase in reimbursement in the future. Again, the higher the average HCC is for a provider's patient population, the greater the likelihood for additional reimbursement under MIPS.

Following this white paper is the ICD-10CM/HCC Crosswalk for the top HCC codes. This will help the provider code correctly. This ICD-10CM/HCC crosswalk tool can help the provider achieve the reimbursements outlined above.

ICD-10 Selection Requirements

Under the Medicare Incentive Payment System (MIPS) and HCC risk adjustment models a provider must begin coding more accurately beginning on January 1, 2017. To ensure proper conversion of your work into money, **CMS will only require a diagnosis code to be used once by you in each year**. In other words, a provider doesn't have to code the great toe amputation for that patient at each visit. It's fine to bill some of the more obscure conditions that affect treatment just once during your annual well visit, preventive service or other annual comprehensive examination, regardless of your specialty.

CMS will allow a provider to select specific diagnosis codes only if they are found in the following five areas of the patient's note:

1. The history of the present illness
2. The physical exam
3. The impression
4. The assessment
5. The plan

The provider should document these medical conditions under the impression/plan. A provider can't code from the problem list, or the medical, family or social section of the note. Remember, a provider isn't "coding" for these conditions as much as the provider is "reporting" these conditions.

The ICD-10 manual instructs providers to do the following in regards to selecting ICD-10CM codes that the provider isn't directly treating:

> **J. Code all documented conditions that coexist**
>
> Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

This is best described when a specialist sees a patient for a surgical procedure – say a Total Hip Arthroplasty. In addition to the diagnosis for the clinical condition warranting the surgery, other medical conditions such as HTN, DM, CAD, COPD might impact your plan of care or negatively impact the post-operative outcome. Therefore it is critical to remember: "If the condition exists at the time of treatment and affects patient care or management – code it."

ICD-10CM Documentation

Once a provider reviews the additional information on the common ICD-10CM to HCC links, the provider should ensure that his/her documentation supports the "causal" relationship between certain diseases and conditions.

For example – a patient with diabetes and stage three chronic kidney disease requires ***two*** ICD-10CM codes:

- E11.22 & N18.3

The note, however can't just read: DM and CKD stage III. A "causal" relationship has to be documented between diabetes and any other associated condition that are present because of the diabetes. So, in our example the Assessment would read:

Stage III CKD secondary to Type 2 DM.

Here are some examples, to be used only when appropriate, on how to document manifestation diagnosis codes under the HCC risk adjustment model:

Document This	Not This
Uncontrolled diabetes	Diabetes
Peripheral Vascular disease due to diabetes	PVD, Diabetes
Neuropathy due to diabetes	Diabetes, Neuropathy
CKD, stage 5 due to diabetes, on dialysis	Diabetes, CKD
Diabetic CKD stage 3 with diabetic PVD and retinopathy secondary to Diabetes	Diabetes, CKD, PVD, Retinopathy

The ICD-10CM/HCC crosswalk tool identifies ICD-10CM codes that are required and when a clinical condition is secondary to a primary diagnosis – specifically the provider will see this in Hypertension and Diabetes conditions. Please remember the documentation in a provider's note must show the causal relationship.

In Conclusion

It's one thing to know which ICD-10CM codes relate to high value HCCs, but maintaining the documentation is just as important in your notes to support the use of these ICD-10CM codes. A provider should remember to only use the ICD-10CM codes in the ICD-10CM/HCC crosswalk tool when the patient's condition warrants their use.