South Carolina Academy of Family Physicians

2025 Summer Breakaway and Annual Meeting

"My People Are Sicker": Understanding Hierarchical Condition Categories

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Disclaimer/Conflicts

E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:

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The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).

- Search www.cms.gov and "Who are the MACs" to locate yours.

Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives

- Define what HCCs are and how they are important in showing a provider's clinical value
- Explain the reasons behind the Version 24 —> Version 28 transition and how we should change our diagnosis coding
- Explain the economic alignment for HCCs and how they impact our financial viability with respect to population health and risk-based contracting

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What and Why are HCCs….?

- Finding ways to correctly capture the degree of physicians' clinical work has always been a challenge for payors.
- This is done is through the documented medical record which includes words and alpha numerical code sets
  - The 2025 ICD-10-CM has 74,044 (252 new, 13 revisions, 36 deletions)[1] diagnoses
- All diseases are not equal in clinical "weight" (complexity)
  - streptococcal pharyngitis is not equal to peritonsillar abscess
- HCCs, or Hierarchical Condition Categories are sets of medical codes that are linked to specific clinical diagnoses. The more complex the diagnosis, the more clinical "risk" associated with managing the condition– the more "weight"

[1]https://www.Wolterskluwer.com

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[1]https://www.Wolterskluwer.com

The Hierarchical Condition Category (HCC)

- HCC Model
  - Risk-adjustment model originally designed to estimate future health care costs for patients. Relies on ICD-10 coding to assign risk scores to patients.
  - Higher risk = sicker → more costly to care for (and harder to achieve quality scores)
  - HCC is "mapped" to a group of diagnoses and grouped into a hierarchy
- Two primary HCC systems: CMS-HCC and HHS-HCC
  - HHS-HCC is used for managed commercial plans (wider age range)
  - CMS-HCC is used with Medicare Advantage (senior heavy)
- Demographic factors are linked into calculation with conditions (age, gender, socioeconomic factors, disability, etc.)

Pinson&Tang 2022 CDI Pocket Guide, p49..

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Pinson&Tang 2022 CDI Pocket Guide, p49..

Risk Adjustment Factor (RAF) Calculation

- Average patient of average health — RAF = 1.0
- Healthy patient — RAF < 1.0
- Patient with multiple illnesses — RAF > 1.0

Why the fuss over documentation….?

- Since 2004, HCCs have been used by the Centers for Medicare and Medicaid Services (CMS) as part of a risk-adjustment model that identifies individuals with serious acute or chronic conditions.[1]
- And …. People change each year, so **documentation** must follow the change via **redocumenting** and updating our documentation so we can "show our work" and capture the patient's full clinical picture.
  - HTN w IIIa CKD and BMI 37 w A1c of 6.3 can become HTN w stage IV CKD and a BMI of 39 and A1c of 6.6 by end of year – captured via documentation/redocumentation
  - Yearly clinical re-assignment keeps it "fair" for providers contracted with CMS
- And … ***quality*** is tied to the "weight"

[1] https://www.Wolterskluwer.com

CMS, Risk Adjustment, and **YOU**

- Risk adjustment used when calculating Medicare quality metrics as:
  - Per capita costs, Medicare patients attributed to the provider
  - Per capita costs, Medicare patients with specific conditions (DM, COPD, CAD, HF)
  - Medicare Spending Per Beneficiary (MSPB)
  - Hospital Value-Based Purchasing Program metrics
  - Hospital Readmissions Reduction Program
  - A1c control for diabetics
  - BP control in hypertensive patients
  - Medication Adherence for diabetic, hyperlipidemic, and hypertensive meds
  - Preventive screenings for cancer in patients with elevated HCCs

Correct diagnosis capture will correctly apply clinical risk across a broad swath to affect and align the clinical quality picture

2025 Stars/ACO Quality Metrics (10.24.2024)

Measure	Program		Star Category & Weight		Thresholds 10/23/2024	
	Stars	ACO	Part C or D?	Weight	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	1	77%	91%
Care for Older Adults - Medication Review	✓		C	1	92%	98%
Care for Older Adults - Pain Screening	✓		C	1	92%	96%
Medication Adherence for Diabetes	✓		D	3	87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3	90%	92%
Medication Adherence for Cholesterol (Statins)	✓		D	3	89%	93%
TRC: Medication Reconciliation Post-Discharge	✓		C	0.5	73%	87%
TRC: Patient Engagement After Inpatient Discharge	✓		C	0.5	63%	77%
Follow-Up After ED Visit for MCC	✓		C	1	60%	69%
Plan All-Cause Readmissions*	✓		C	3	10%	8%
Osteoporosis Management in Women w/ Fracture	✓		C	1	52%	71%
Kidney Health Evaluation for Patients with Diabetes	✓		C	1	52%	67%
Statin Use in Persons with Diabetes	✓		D	1	89%	93%
Eye Exam for Patients with Diabetes	✓		C	1	77%	83%
Glycemic Status Assessment for Patients with Diabetes (<=9%): HbA1c Control	✓	✓	C	3	84%	90%
Breast Cancer Screening	✓	✓	C	1	75%	82%
Colorectal Cancer Screening	✓	✓	C	1	75%	83%
Controlling Blood Pressure	✓	✓	C	3	80%	85%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	88%	92%
Falls: Screening for Future Fall Risk		✓				
Depression Screening		✓				
Depression Remission at Twelve Months		✓				
Influenza Immunization		✓				
Tobacco Screening and Cessation Intervention		✓				

*inverse measure

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The HCC Transition from v24 →v28 … *WHY?*

- The metrics and calculations in v24 were on ICD-9, so updated diagnoses were needed from ICD-10. And, if the old conditions did not predict cost … or if they were too uncommon … or not as clinically sound and pertinent as they were once thought … THEN they were removed or updated. ICD-10 additions as well.
  - # diagnoses went UP (added 2168 new diagnoses)[1] in v28
  - 2294 dx NO LONGER had HCC risk scores asso. w/ them (of the 9797 that were previously in play)
    - Some diagnoses had risk scores removed, some decreased, some increased….some "constrained"
    - Diabetes: In V24, HCC risk for DM with complications had HCC weight 3x of DM without complications. Now DM is "constrained" (ie, all the same weight)
  - # of HCCs went UP from 86 → 115
- The v24 → v28 transition occurred over a three-year time frame.
  - 1/3 of the diagnosis codes in 2023 were v28…this year 100% v28 weighted
- Expected savings when v28 fully implemented to be a 3% decrease ($11B)

https://www.cms.gov/files/document/2024-announcement-pdf.pdf [1]

ICD-10-CM Diagnoses: HCC Basics

- **All** clinical conditions that affect the patient are to be assigned each year as CMS does an annual "clearing of the slate" for each patient …must redocument !!!!
  - "The leg does not grow back"... eGFR of 25? …The urostomy/PEG …RA …home O_2 use…
- "history of" means the condition is gone. "History of COPD, stable on budesonide/formoterol" means they had COPD in the past, but not now…
- The clinically active diagnoses are additive – show active management in note
  - Update diagnoses in A/P (put on the bill) at least once a year (MWV is best time)
- No documentation, no credit. BMI 40+ → is an HCC risk score. But needs to be A/P.
- Not all diagnosis codes are linked to HCCs (hypertension, lipids, simple depression) no risk as base condition

Specify Disease State: CKD

- Avoid "Chronic Kidney Disease, unspecified" if stage is known
- Chronic Kidney Disease is defined as
  - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
  - GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR ***albumin/Cr > 30mg/g*****

**recommended method to assess albuminuria

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Stage I	normal,	eGFR > 90ml/min		N18.1
Stage II	mild,	eGFR 60-89ml/min		N18.2
*Stage III**	*mod*	*eGFR 30-59 ml/min*	*+.127**	N18.30 or N18.31 or N18.32
Stage IV	*severe*	*eGFR 15-29 ml/min*	*+.514*	N18.4
Stage V	*kid. failure with eGFR < 15 ml/min*		*+.815*	N18.5 (ESRD 18.6, Z99.2 dialysis)

** 2019*

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- *Stage V kid. failure with eGFR < 15 ml/min +.815*

CKD is NOT constrained

** 2019*

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- Prove stability before assigning condition
- Add ICD10 Dx code to problem list
- Educate patients as to the "why"
- If comorbid, add to base code
- Reassess each year to insure correct

** 2019*

**recommended method to assess albuminuria

v28 still has disease interactions as v24 did

- Capture all pertinent conditions at each visit you are managing.
- “Disease Interactions” are added HCC risk weights when co-morbid conditions exist in a patient that you show in your documentation you are managing
- If you document in the A/P, the specific condition weight gets applied, PLUS a disease interaction weight gets added on

"HCC Math"

59 yo with HTN, Stage IIIb CKD and unspecified heart failure:

- Hypertension (I10.) 0.000
- (Hypertension) Kidney Disease, Stage IIIb (no HCC with Stages < III)
  - Hypertensive Chronic Kidney Disease (I12.9) 0.000 → 0.000
  - Chronic Kidney Disease, Stage IIIb (N18.32) 0.127 → 0.127

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Chronic Kidney Disease, Stage IIIb (N18.32)		0.127 →	0.127
▪ Heart Failure, unspecified (I50.9)	(HF is constrained)		0.360
	subtotal ……..		0.487

"HCC Math w Disease Interactions"

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The combination of the heart failure and the chronic kidney disease evaluated in the same encounter is seen as a comorbid disease interaction and adds HCC risk to the encounter. *No additional ICD 10 diagnoses are required* as the combination of the two diseases in the same encounter automatically adds the disease interaction HCC weight.

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subtotal …….. 0.487

Disease interaction between HF and CKD *0.176*

TOTAL HCC **0.663**

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Disease Interaction "HCC Math"

- Heart Failure – constrained, still document to highest specificity!!

Make sure to assess/manage HF at every encounter that it is present in your patients!

Disease interactions

Heart Failure and Diabetes	0.112
Heart Failure and chronic lung disorder	0.078
Heart Failure and kidney	0.176
Heart Failure and specified heart arrhythmias	0.077
Chronic lung disorder and cardiorespiratory failure	0.254
Substance Disorder and psychiatric	0.087

Where are significant shifts with V28 HCCs…?

- Vascular diseases
  - Atherosclerotic disease with intermittent claudication is now not risk adjusted, only the rest pain PAD – native or bypass
  - Thoracic/Abd Aorta, Renal artery aneurysm risk only if ruptured
- ASCVD
  - Cardiomyopathy due to drugs, no risk now; other c-myopathies OK
  - Angina pectoris is only risk adjusted if unstable
  - SVT is no longer risk adjusted but all other abnormal rhythms are
- Pulmonary
  - Added severe persistent asthma
- Renal
  - Transitory dialysis and acute renal failure have no RAF
- Psychiatric
  - Major Depression only risk-adjusts if seen with psychosis or if Moderate or Severe is documented

Why the fuss over documentation….?

- Since 2004, HCCs have been used by the Centers for Medicare and Medicaid Services (CMS) as part of a risk-adjustment model that identifies individuals with serious acute or chronic conditions.[1]
- And …. People change each year, so documentation must follow the change via redocumenting and updating our documentation so we can "show our work" and capture the patient's full clinical picture.
  - HTN w IIIa CKD and BMI 37 w A1c of 5.9 can become HTN w stage IV CKD and a BMI of 39 and A1c of 6.4 and IGT – done via documentation/redocumentation
- And … and quality is tied to the "weight" (*tied to our disease diagnoses*)

  … and **$$$** is tied to the "weight" → more money for more complex

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The HCC Hierarchy

- Diseases "roll up" into a hierarchy
  - Chronic Hepatitis →
  - HCC 65 (0.185) →

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Acute Hepatitis does not have HCC risk assigned

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2024 CMS-HCC Model Denominator is $10,402.34 = 1.0 (for this example we will use $10,000)

The HCC **funding** Hierarchy

- Diseases "roll up" into a hierarchy
  - Chronic Hepatitis → Cirrhosis of Liver → End-Stage Liver Dz/Failure
  - HCC 65 (0.185) → HCC 64 (0.447) → HCC 63 (0.962)

$1850 **$4470** **$9620**

2024 CMS-HCC Model Denominator is $10,402.34 = 1.0 (for this example we will use $10,000)

The HCC **funding**

- CMS (a payor) will provide funds to care for a patient based on their clinical risk (the HCC)
  - Money is to be used to care for the patient that calendar year (office/ED/hospital/NH visits; diagnostic procedures/tests; medications)
  - Money "left over" at the end of the year – depending on the contract with CMS (or the payor) – can be "shared" based on the contracted relationship
    - The "left over" money is usually adjusted based on the quality scores – 100% Stars score keeps 100% of the money in play
- The Affordable Care Act made it possible for entities to be in corporate-clinical relationships if money was tied to quality and parties are at risk if they do not perform
  - Accountable Care Organizations come in various forms: hospitals can form, large medical groups, others … and the market is filling with these opportunities for physicians to add income to their lines of business in both the CMS and Commercial spaces

How Does Do We (inclusive) Show Our Value

- Manage cost
  - Per capita costs, Medicare patients attributed to the provider
  - Per capita costs, Medicare patients with specific conditions (DM, COPD, CAD, HF)
  - Medicare Spending Per Beneficiary (MSPB)
  - Hospital Value-Based Purchasing Program metrics (hospital quality metrics, etc.)
  - Hospital Readmissions Reduction Program (TCM and clinical optimization)
- Manage quality
  - Disease prevention (breast/colon CA)
  - A1c control for diabetics, BP control in hypertensive patients
  - Medication Adherence for diabetic, hyperlipidemic/CV, and hypertensive meds
  - Preventive screenings/practices
- Patient Experience
  - "Win the game at the bedside"

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Capture this via our documentation and coding in our encounters

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Measure	Program		Star Category & Weight		Thresholds 10/23/2024	
	Stars	ACO	Part C or D?	Weight	4 Star	5 Star
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Care for Older Adults - Medication Review	✓		C	1	92%	98%
Care for Older Adults - Pain Screening	✓		C	1	92%	96%
Medication Adherence for Diabetes	✓		D	3	87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3	90%	92%
Medication Adherence for Cholesterol (Statins)	✓		D	3	89%	93%
TRC: Medication Reconciliation Post-Discharge	✓		C	0.5	73%	87%
TRC: Patient Engagement After Inpatient Discharge	✓		C	0.5	63%	77%
Follow-Up After ED Visit for MCC	✓		C	1	60%	69%
Plan All-Cause Readmissions*	✓		C	3	10%	8%
Osteoporosis Management in Women w/ Fracture	✓		C	1	52%	71%
Kidney Health Evaluation for Patients with Diabetes	✓		C	1	52%	67%
Statin Use in Persons with Diabetes	✓		D	1	89%	93%
Eye Exam for Patients with Diabetes	✓		C	1	77%	83%
Glycemic Status Assessment for Patients with Diabetes (<=9%): HbA1c Control	✓	✓	C	3	84%	90%
Breast Cancer Screening	✓	✓	C	1	75%	82%
Colorectal Cancer Screening	✓	✓	C	1	75%	83%
Controlling Blood Pressure	✓	✓	C	3	80%	85%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	88%	92%
Falls: Screening for Future Fall Risk		✓				
Depression Screening		✓				
Depression Remission at Twelve Months		✓				
Influenza Immunization		✓				
Tobacco Screening and Cessation Intervention		✓				

*inverse measure

Some significant opportunities (audit concerns)…?

- Capture BMI, chronic kidney disease correctly
- Use of "CVA" post discharge instead of "history or CVA" and then use of a condition residual to the CVA ("RUE paresis")
- Pulmonary Embolism when not acute and no active mgmt
- Diagnosing DVTs when not acute
- Using "cancer" diagnoses when there is no cancer (thyroid, etc.)
- Surgically corrected conditions (AAA, etc.) still being assessed

Closing comments

- Don't worry about the "risk score"…..
- Practice medicine at top of your skill set. Clinically Correct Documentation to Capture Severity…
- KEY in the Ambulatory
  - Capturing the highest degree of clinical specificity increases our risk score
  - Risk is tied to revenues and when quality scores are reported, our "grade" can be impacted
  - Redocument conditions YEARLY (make a plan – MWV, first visit each year, etc.)
- OUR JOB: Be CLINICALLY CORRECT in our documentation capture and in our medical management of the patients we care for

Defining HCCs in Primary Care

- Thanks for taking this session!
- Post-test is next– Good Luck!

- Nick Ulmer, MD CPC FAAFP
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Practice Enhancement Through
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2025 Curriculum

Defining Hierarchical Condition Categories (HCCs) in Primary Care

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RHP Insight Education Curriculum

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Resource Materials

Key Areas *Not* to Miss (Yearly)

- Amputations (AKA, BKA, toes) and how it affects functional state
- ***BMI, especially 40+ with a plan to address***
- ***Asthma and pulmonary conditions (esp chronic respiratory failure – Home O_2)***
- ***CHF: specifying type (systolic or diastolic) and condition (acute/chronic)***
- Ostomy: urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- Transplanted organs: heart, liver, lung, pancreas, bone marrow (not kidney!) and status
- Functional quadriplegia: complete inability to move due to disability (not neuro)
- ***Stage III,*** IV, and V kidney disease ***(silent disease)***
- Rheumatoid Arthritis

What are the most OVERdocumented HCCs…?

- Surgically corrected conditions (AAA repair)
- Malnutrition that is now not
- Strokes that are not acute (look for residual effects)
- Embolic diseases (DVT) - post thrombotic syndrome w ulcer, yes, but not a DVT from past without sequela
- Vascular diseases (abnormal ABI, no treatment/symptoms noted, then not a disease)
- Cancers that are no longer (thyroid cancer post removal)
- CKD (stage III from last year, that for this year is Stage II)

Disease Interaction “HCC Math”

Disease interactions defined (all types HF) :

- HF and DM -- all types of diabetics
- HF and chronic lung d/o – COPD, trnsplnts, CF, Pulm Fibrosis, asthma (if severe, persistent)
- HF and kidney – Stages III-V
- HF and specified heart arrhythmias – SSS, Afib/flutter, Ht Block, etc., (but not SVT)
- Chronic lung disorder and cardiorespiratory failure – home O_2, chest wall abn., etc.
- Substance Disorder and psychiatric – opioids/anxiolytics, severe major depression (note psychosis)

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"Brevitas" offering

There is an additional
"***Brevitas***" educational offering for this session

Brevitas resource sessions are brief (5-10 minute) overview sessions designed for "quick review" of the session content

Brevitas sessions alone are **not** approved for
Self Study AAFP Prescribed/AMA PRA Category 1 credit(s)™ and
are offered only as a time-saving review opportunity

The Hierarchical Condition Category (HCC)

- HCC Model
  - Risk-adjustment model originally designed to estimate future health care costs for patients. Relies on ICD-10 coding to assign risk scores to patients.
  - Higher risk = sicker → more costly to care for (and harder to achieve quality scores)
  - HCC is "mapped" to a group of diagnoses and grouped into a hierarchy
- Two primary HCC systems: CMS-HCC and HHS-HCC
  - HHS-HCC is used for managed commercial plans (wider age range)
  - CMS-HCC is used with Medicare Advantage (senior heavy)
- Demographic factors are linked into calculation with conditions (age, gender, socioeconomic factors, disability, etc.)

Pinson&Tang 2022 CDI Pocket Guide, p49..

Risk Adjustment Calculation

- Average patient of average health — RAF = 1.0
- Healthy patient — RAF < 1.0
- Patient with multiple illnesses — RAF > 1.0

CMS, Risk Adjustment, and **YOU**

- Risk adjustment used when calculating Medicare quality metrics as:
  - Per capita costs, Medicare patients attributed to the provider
  - Per capita costs, Medicare patients with specific conditions (DM, COPD, CAD, HF)
  - Medicare Spending Per Beneficiary (MSPB)
  - Hospital Value-Based Purchasing Program metrics
  - Hospital Readmissions Reduction Program
  - A1c control for diabetics
  - BP control in hypertensive patients
  - Statin use for CAD patients
  - Preventive screenings for cancer in patients with elevated HCCs

Correct diagnosis capture will correctly apply clinical risk across a broad swath to affect the clinical quality picture

Why the fuss over documentation….?

- Since 2004, HCCs have been used by the Centers for Medicare and Medicaid Services (CMS) as part of a risk-adjustment model that identifies individuals with serious acute or chronic conditions.[1]
- And …. People change each year, so documentation must follow the change via redocumenting and updating our documentation so we can "show our work" and capture the patient's full clinical picture.
  - HTN w IIIa CKD and BMI 37 w A1c of 5.9 can become HTN w stage IV CKD and a BMI of 39 and A1c of 6.4 and IGT – done via documentation/redocumentation
- And … and quality is tied to the "weight" (*tied to our disease diagnoses*)

[1] https://www.Wolterskluwer.com

The HCC Transition from v24 →v28 … *WHY?*

- The metrics and calculations in v24 were on ICD-9, so updated diagnoses were needed from ICD-10. And, if the old conditions did not predict cost … or if they were too uncommon … or not as clinically sound and pertinent as they were once thought … THEN they were removed or updated. ICD-10 additions as well.
  - # diagnoses went UP (added 2168 new diagnoses)[1] in v28
  - 2294 dx codes had NO LONGER had HCC risk scores mapped to them (of the 9797 that were previously in play)
    - Some diagnoses had risk scores removed, some decreased, some increased….some "constrained"
    - Diabetes: In V24, HCC risk for DM without complications had HCC 1/3 of DM with complications. Now DM is "constrained" (ie, all the same weight)
  - # of HCCs went UP from 86 → 115
- The v24 → v28 transition was set to occur over a three-year timeframe.
  - 1/3 of the diagnosis codes year ONE were v28…this year 100% v28 weighted
- Expected payout when v28 fully implemented to be a 3% decrease to providers ($11B)

https://www.cms.gov/files/document/2024-announcement-pdf.pdf [1]

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- And … and quality is tied to the "weight" (*tied to our disease diagnoses*)

  … and **$$$** is tied to the "weight" → more money for more complex

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*inverse measure

ICD-10-CM Diagnoses: HCC Basics

- **All** clinical conditions that affect the patient are to be assigned each year as CMS does an annual "clearing of the slate" for each patient …must redocument !!!!
  - "The leg does not grow back"... eGFR of 25? …The urostomy/PEG …RA …home O_2 use…
- "history of" means the condition is gone. "History of COPD, stable on budesonide/formoterol" means they had COPD in the past, but not now…
- The clinically active diagnoses are additive – show active management in note
  - Update diagnoses in A/P (put on the bill) at least once a year (MWV is best time)
- No documentation, no credit. BMI 40+ → is an HCC risk score. But needs to be A/P.
- Not all diagnosis codes are linked to HCCs (hypertension, lipids, simple depression)

The HCC Hierarchy

- Diseases "roll up" into a hierarchy
  - Chronic Hepatitis → Cirrhosis of Liver → End-Stage Liver Dz/Failure
  - HCC 65 (0.185) → HCC 64 (0.447) → HCC 63 (0.962)

$1850 **$4470** **$9620**

2024 CMS-HCC Model Denominator is $10,402.34 = 1.0 (for this example we will use $10,000)

Specify Disease State: CKD

- Avoid "Chronic Kidney Disease, unspecified" if stage is known
- Chronic Kidney Disease is defined as
  - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
  - GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR ***albumin/Cr > 30mg/g*****

Stage I	normal,	eGFR > 90ml/min		N18.1
Stage II	mild,	eGFR 60-89ml/min		N18.2
*Stage III**	*mod*	*eGFR 30-59 ml/min*	*+.127**	N18.30 or N18.31 or N18.32
Stage IV	*severe*	*eGFR 15-29 ml/min*	*+.514*	N18.4
Stage V	*kid. failure with eGFR < 15 ml/min*		*+.815*	N18.5 (ESRD 18.6, Z99.2 dialysis)

** 2019*

**recommended method to assess albuminuria

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Stage IV	*severe*	*eGFR 15-29 ml/min*	*+.514*
Stage V	*kid. failure with eGFR < 15 ml/min*		*+.815*

- Prove stability before assigning condition
- Add ICD10 Dx code to problem list
- Educate patients as to the "why"
- If comorbid, add to base code
- Reassess each year to insure correct

** 2019*

**recommended method to assess albuminuria

v28 still has disease interactions as v24 did

- Capture all pertinent conditions at each visit you are managing.
- “Disease Interactions” are added HCC risk weights when co-morbid conditions exist in a patient that you show in your documentation you are managing
- If you document in the A/P, the specific condition weight gets applied, PLUS a disease interaction weight gets added on

"HCC Math"

59 yo with HTN, Stage IIIb CKD and unspecified heart failure:

- Hypertension (I10.) 0.000
- (Hypertension) Kidney Disease, Stage IIIb (no HCC with Stages < III)
  - Hypertensive Chronic Kidney Disease (I12.9) 0.000 → 0.000
  - Chronic Kidney Disease, Stage IIIb (N18.32) 0.127 → 0.127

"HCC Math"

59 yo with HTN, Stage IIIb CKD and unspecified heart failure:

- Hypertension (I10.) 0.000
- (Hypertension) Kidney Disease, Stage IIIb (no HCC with Stages < III)
  - Hypertensive Chronic Kidney Disease (I12.9) 0.000 → 0.000
  - Chronic Kidney Disease, Stage IIIb (N18.32) 0.127 → 0.127

"HCC Math"

59 yo with HTN, Stage IIIb CKD and unspecified heart failure:

▪ Hypertension (I10.)			0.000
▪ (Hypertension) Kidney Disease, Stage IIIb	(no HCC with Stages < III)		
Hypertensive Chronic Kidney Disease (I12.9)		0.000 →	0.000
Chronic Kidney Disease, Stage IIIb (N18.32)		0.127 →	0.127
▪ Heart Failure, unspecified (I50.9)	(HF is constrained)		0.360
	subtotal ……..		0.487

"HCC Math w Disease Interactions"

59 yo with HTN, Stage IIIb CKD and unspecified heart failure:

- Hypertension (I10.) 0.000
- (Hypertension) Kidney Disease, Stage IIIb
  - Hypertensive Chronic Kidney Disease (I12.9) 0.000
  - Chronic Kidney Disease, Stage IIIb (N18.32) 0.127
- Heart Failure, unspecified (I50.9) (HF is constrained) 0.360

subtotal …….. 0.487

Disease interaction between HF and CKD *0.176*

TOTAL HCC **0.663**

The combination of the heart failure and the chronic kidney disease evaluated in the same encounter is seen as a comorbid disease interaction and adds HCC risk to the encounter. *No additional ICD 10 diagnoses are required* as the combination of the two diseases in the same encounter automatically adds the disease interaction HCC weight.

Disease Interaction "HCC Math"

- Heart Failure – constrained, still document to highest specificity!!

Make sure to assess/manage HF at every encounter that it is present in your patients!

Disease interactions

Heart Failure and Diabetes	0.112
Heart Failure and chronic lung disorder	0.078
Heart Failure and kidney	0.176
Heart Failure and specified heart arrhythmias	0.077
Chronic lung disorder and cardiorespiratory failure	0.254
Substance Disorder and psychiatric	0.087

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