

Professional Coding System Overview



ACHIEVE REVENUE
MANAGEMENT

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Hierarchical Condition Categories



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Hierarchical Condition Categories (HCC)



WHAT?



WHY?



HOW?

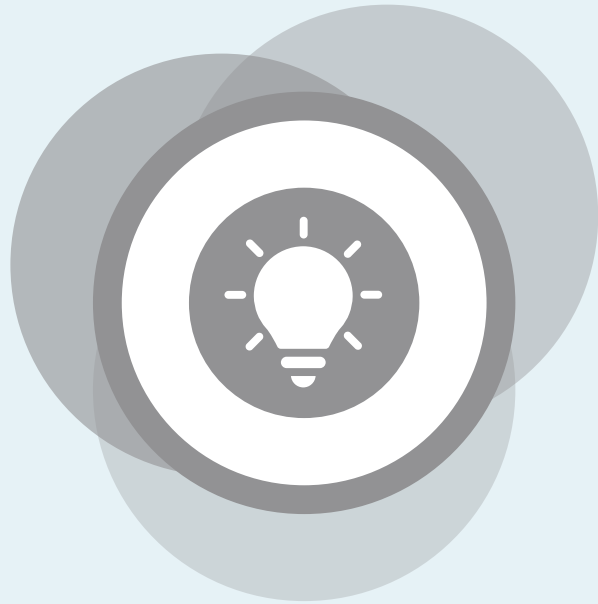


WHAT

are Hierarchical Condition Categories (HCCs)?

- Groupings of clinically similar diagnoses
- Conditions are categorized hierarchically
- Each HCC is assigned a value relative to other conditions
- Used by CMS (and others) as part of determining risk or conducting a risk adjustments model

Hierarchical Condition Categories (HCC)



WHAT?



WHY?

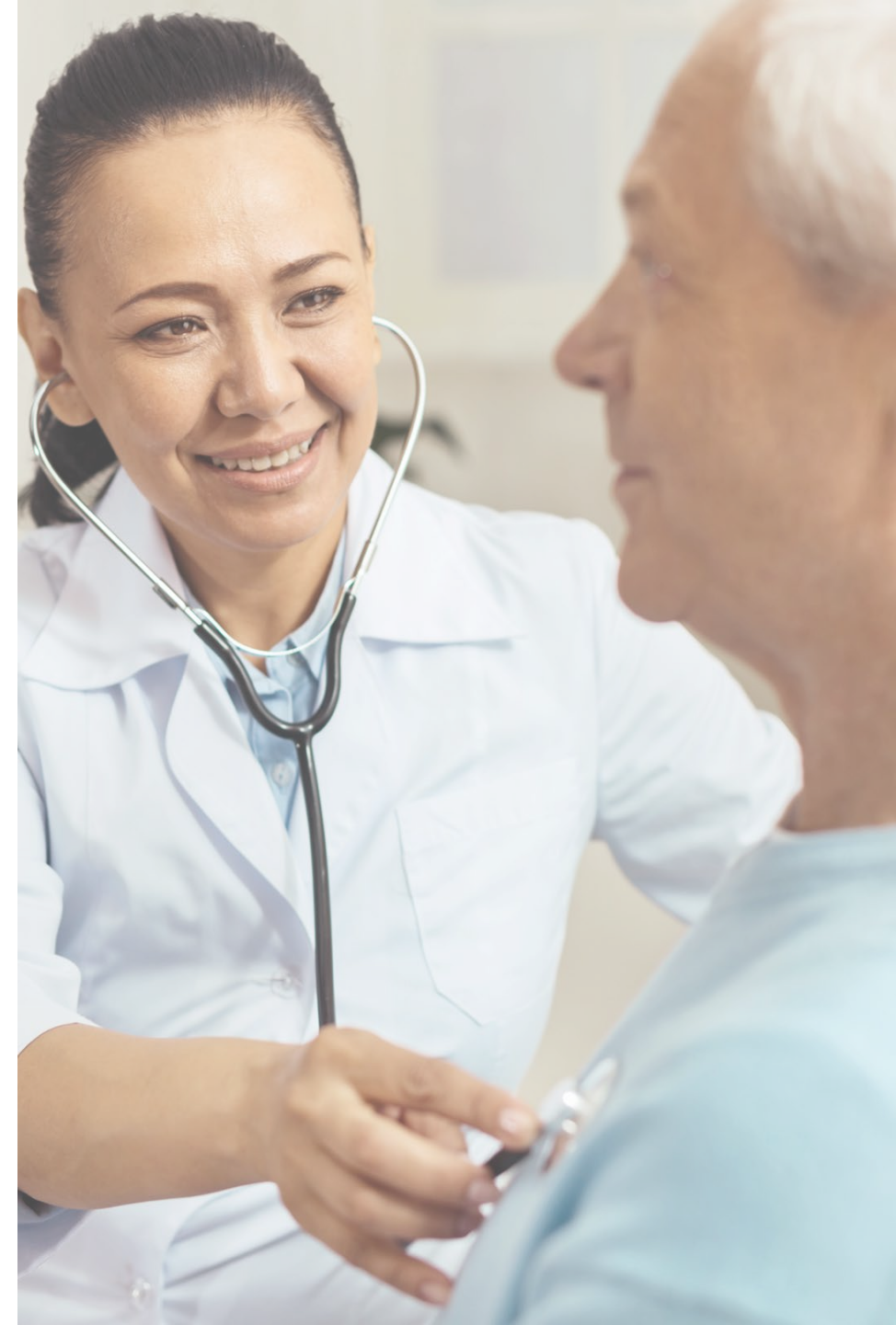


HOW?

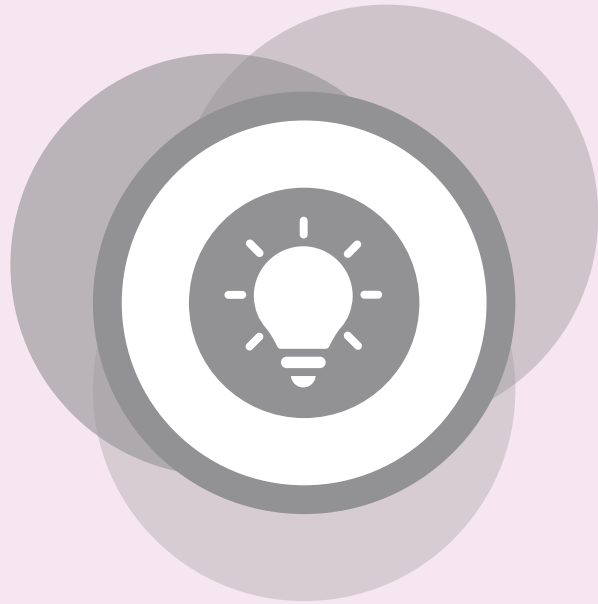


WHY **HCC codes are important to FQHCs?**

- Accurate HCCs should translate to better determination of risk score associated with individual patients
- Often impact Accountable Care Organization (ACO) benchmarking
- Can be used internally to determine specific scores to target for services or resources
- Providers directly impact HCC assigned to patient



Hierarchical Condition Categories (HCC)



WHAT?



WHY?



HOW?



HOW: **HCC codes are determined**

- Health conditions are identified via International Classification of Diseases–10 (ICD–10-CM) diagnoses that are submitted by providers on incoming claims
- ICD-10 codes map to HCC category
- Distinct HCCs are assigned specific values used to calculate individual patient risk score



HOW:

HCC coding and ICD-10-CM codes work together

ICD-10-CM Codes	HCC Category Description	HCC	Disease Hierarchy
B20, B97.35, Z21	HIV/AIDS	1	
A02.1, A20.7, A22.7, A26.7, A32.7, A39.2-A39.4, A40.-, A41.-, A42.7, A48.3, A54.86, B00.7, B37.7, P36.-, R57.1, R57.8, R65.1-, R65.2-, T81.12XA	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock	2	
A07.2, A31.0, A31.2, B25.-, B37.1, B37.7, B37.81, B44.0-B44.7, B44.89, B44.9, B45.-, B46.-, B48.4, B48.8, B58.2, B58.3, B59	Opportunistic Infections	6	
C77.1-C77.2, C77.4-C77.8, C78.-, C79.00-C79.72, C79.89, C79.9, C7B.-, C80.0, C91.0-, C92.00-C92.02, C92.40-C92.A2, C93.0-, C94.00-C94.22, C94.40-C94.42, C95.0-	Metastatic Cancer and Acute Leukemia	8	9, 10, 11, 12
C15.-, C16.-, C17.-, C22.-, C23, C24.-, C25.-, C33, C34.-, C38.4, C45.-, C48.-, C90.00-C90.22, C92.10-C92.32, C92.Z0-C92.92, C93.10-C93.92, C94.30-C94.32, C94.80-C94.82	Lung and Other Severe Cancers	9	10, 11, 12
C40.-, C41.-, C46.-, C47.-, C49.-, C56.-, C57.00-C57.4, C58, C70.-, C71.-, C72.-, C74.-, C75.1-C75.3, C77.3, C77.9, C79.2, C79.81, C79.82, C81.-, C82.-, C83.-, C84.-, C85.-, C86.-, C88.2-C88.9, C90.3-, C91.-, C95.10-C95.92, C96.-	Lymphoma and Other Cancers	10	11, 12
C01, C02.-, C03.-, C04.-, C05.-, C06.-, C07, C08.-, C09.-, C10.-, C11.-, C12, C13.-, C14.-, C18.-, C19, C20, C21.-, C26.-, C30.-, C31.-, C32.-, C37, C38.0-C38.3, C38.8, C39.-, C51.-, C52, C53.-, C57.7-C57.9, C64.-, C65.-, C66.-, C67.-, C68.-	Colorectal, Bladder, and Other Cancers	11	12
C43.-, C4A.-, C50.-, C54.-, C55, C60.-, C61, C62.-, C63.-, C69.-, C73, C75.0, C75.4-C75.9, C76.-, C7A.-, C80.1, C80.2, D03.-, D18.02, D32.-, D33.-, D35.2-D35.4, D42.-, D43.-, D44.3-D44.7, D49.6, E34.0, Q85.-	Breast, Prostate, and Other Cancers and Tumors	12	
E20.0, E20.1, E20.01, E20.0, E20.1, E20.01, E10.1, E10.01, E11.0, E11.1, E11.01	Diabetes with Acute	17	10, 12



HOW: **to assist with accurate HCC coding**

- Assign all ICD-10 codes to the highest level of specificity possible
- Maintain an accurate and up-to-date problem list
- Address (in face-to-face encounter), document and code for all chronic conditions every year
 - Scores are reset January 1st of each year in some plans



HOW: **to assist with accurate HCC coding**

Tips or Tools for documenting chronic conditions:

- M** Monitoring signs, symptoms, disease progression, disease regression
- E** Evaluated test results, medication effectiveness, response to treatment
- A** Addressed ordered tests, discussion, review records, counseling
- T** Treated medications, therapies, other modalities



HOW: **to assist with accurate HCC coding**

Tips or Tools for documenting chronic conditions:

TAMPER

- T** Treatment
- A** Assessment
- M** Monitoring or Medicate
- P** Plan
- E** Evaluate
- R** Referral

<https://ionhealthcarepulse.com/2016/09/28/faqs-on-risk-adjustment/>

Reimbursement Tips: CMS/Medicare Care Management

This compendium of care management tools is available free of charge on NACHC's Elevate platform



PAYMENT Reimbursement Tips:
FQHC Requirements for Medicare Behavioral Health

The general Behavioral Health Integration (BHI) model of care refers to the BHI and behavioral health services similar to core services offered under the Care Model (CoCM), but without several additional components.

Program Requirements
General Behavioral Health Integration (BHI) covers models of care that focus on integrative treatment for patients with mental or behavioral health conditions that do not require, though they may use, the services of a behavioral health care manager or psychiatric consultant as required under the Psychiatric Collaborative Care Model (CoCM).

Patient Eligibility & Consent
Eligible patients are those requiring integrated behavioral health and primary care services, but not a psychiatric consultation or designated behavioral health manager. The patient must provide consent prior to initiating services. Consent may be verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing (e.g., co-insurance) applies.

Timeframe & Services
Start-up An initiating visit with the billing provider (separately billable) required for new patients or patients not seen within one year prior to the start of BHI services.
Subsequent Months Minimum of 20 minutes of behavioral health services.
 BHI services are billed based on the calendar month rather than per 30 days. Reporting can occur any time in the calendar month after the 20-minute time threshold is met. Face-to-face services are not required during the calendar month. Patients should periodically be reminded

PAYMENT Reimbursement Tips:
FQHC Requirements for Medicare Chronic Care Mgmt. (CCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) chronic conditions to coordinate care and develop a care plan to achieve health goals.

Program Requirements
Chronic Care Management (CCM) refers to a comprehensive set of services administered to help a patient coordinate and manage multiple chronic conditions. CCM services are typically provided outside of face-to-face visits. CCM services include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Care transition management
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation

Patient Eligibility & Consent
Eligible patients include those who have multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

- Medication
- Non-Physician Assistants (PA), Certified Nurse Practitioners (CNS)
- Behavioral Health Care Manager (specialized training in behavioral health psychology) and at least a bachelor's degree, oversight and direction of the billing practitioner
- Psychiatric Consultant: Medical professional trained in qualified to prescribe the full range of medications.

Timeframe & Services
CMS/Medicare covers several types of chronic care management services. These include CCM and complex CCM. These services vary in the amount of clinical staff time provided, the level of involvement of the billing practitioner, and the extent of care planning performed. CCM services include:

- Non-complex (CPT 99490)** 20 mins or more of CCM services in a month (ancillary staff + provider)
- Complex (CPT 99487)** 60 mins or more of CCM services in a month (ancillary staff + provider)
- Provider only (CPT 99491)** 30 mins or more of CCM services in a month (provider only)
- Additional time (CPT +99489)** Each add'l 30 mins; only added to complex/99487 (ancillary staff + provider)

CCM services (see Program Requirements) are extensive and require the development of a care plan that is shared with outside providers, the patient, and/or caregiver. The care plan must be coordinated with the management of transitions between and among health care providers and settings. (See Transitional Care Management information for reimbursement guidance.) Patients/caregivers are to be offered the ability to communicate with the provider through a variety of electronic communication options, including: secure

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