

HCC Overview

Risk Adjustment Coding Guide

HCCs, or Hierarchical Condition Categories, are part of a risk adjustment model with sets of medical codes linked to specific diagnoses. One goal of risk adjustment is to align payment and benchmarks to reflect acuity of illness.

HCC coding is based on a patient’s health status. HCC codes represent severe acute and chronic health conditions documented on outpatient and some inpatient claims. Diagnoses are arranged in a hierarchy within body systems or disease processes. **All HCCs must be documented and coded at least once per year.**

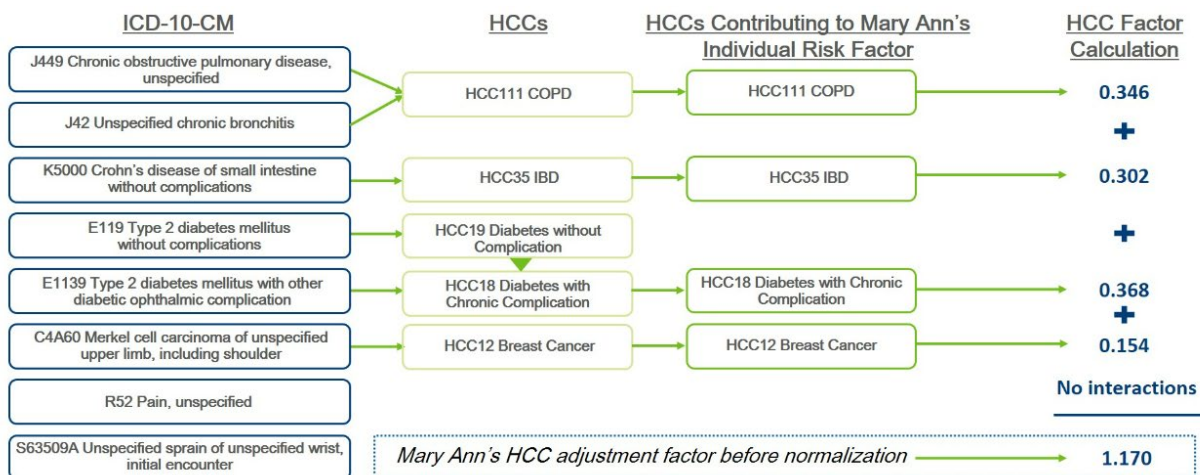
As of 2021, there are over 9,700 ICD-10-CM codes that risk adjust, each representing one medical condition. Not every ICD-10-CM code will risk adjust.

A Risk Adjustment Factor, known as a RAF score, is a measure of the estimated complexity of an individual’s care based on their disease burden and demographic information. The RAF score is then used to calculate payments to healthcare organizations. Scores are calculated on an annual basis.

The average patient’s RAF is 1.0. Lower risk adjustment scores can signify a healthier population, inadequate documentation, or incomplete coding. A higher score indicates a sicker patient group, unsupported documentation, or overcoding.

In order to ensure that all coexisting conditions that require or affect their care, treatment or management are coded for each visit, **the most effective way to document is MEAT (Monitor, Evaluate, Assess, Treat).**

The challenge of COVID-19 has changed the dynamics of healthcare. CMS now allows risk adjustment to be captured with telemedicine visits if the same criteria as a face-to-face visit is met and the visit was conducted via audio and video in real time.



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