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Passing the HCC Audit: What you need to know

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The Centers for Medicare & Medicaid Services (CMS) introduced Hierarchical Condition Categories (HCCs) and the architecture of the Risk Adjustment Factor with their mandate in 1997. The implementation of HCCs by CMS for the Medicare Advantage plans began in 2000, and they have been steadily phasing in this process over time. Since its inception, the understanding and significance of HCCs has grown and taken on considerable financial importance for physicians, physician groups (and physician extenders), health systems, and Medicare Advantage plans.

CMS defines HCCs as a risk adjustment model used to calculate risk scores to predict future healthcare costs. It is a predictive model — based on medical record documentation and submitted ICD-10-CM diagnosis codes for the plan enrollees — with an underlying purpose to adjust capitated payments made to providers in these plans based on the beneficiaries' health. Of note, like any other CMS reimbursement methodology, the HCC Risk Adjustment Factor platform is subject to audit by CMS and its contractors.[1]

Tips for passing the audit

When thinking about data submission for the HCC Risk Adjustment Data Validation (RADV) audit, it's best to approach it in components. Here's what you need to know to successfully pass the audit.

Code to the guidelines

The majority of conditions submitted for HCCs are chronic conditions (a few acute conditions qualify as well) that the patient has, which have been documented by the provider with ICD-10-CM diagnosis code(s) submitted on the claim form. In the HCC system structure, patients are placed into categories based on the ICD-10-CM diagnosis code assignment; the ICD-10-CM code assignments group patients who are clinically similar into the same group (HCC). The structure is then further divided so that the groups break down into similar predictive costs for the beneficiaries' future healthcare costs. For consideration, there are more than 9,500 ICD-10-CM diagnosis codes that map to one or more of the 79 HCC codes in the CMS-HCC Risk Adjustment model. An ICD-10-CM code can map to more than one HCC, because ICD-10-CM contains combination codes (i.e., a code can represent two diagnoses or a diagnosis with a complication).

At the foundation of HCCs is accurate coding of the ICD-10-CM diagnosis code based on the documentation found in the medical record. The following should be adhered to when coding:

- All ICD-10-CM coding assignments should be based on the ICD-10-CM Official Guidelines for Coding and Reporting[2] for the current fiscal year.
- Section IV of the guidelines has specific instructions for coding and reporting of outpatient services. Section I for conventions, general coding guidelines, and chapter-specific guidelines applies to the

outpatient setting and professional fee coding for physician and non-physician provider services.

- Section IV of the guidelines requires that all documented conditions must be directly "relevant" to or "affect" the specific encounter. Providers are required to document all conditions evaluated during each face-to-face visit; this documentation should include the history of present illness (HPI), examination, and medical decision making.
- Per Section IV, subsection J:
    - 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.
- Per Section IV, subsection I, chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the conditions.

Put MEAT in the documentation

The coding for HCCs is only as good as the documentation found in the medical record. As HCCs continue to evolve, best practices for documentation in the HCC world follow the culture of MEAT, which is an acronym that auditors have used to describe the four requirements for complete and accurate documentation:

- **Monitor** – the patient's signs, symptoms, disease progression, disease regression;
- **Evaluate** – test results, medication effectiveness, response to treatment;
- **Assess/Address** – ordering tests, discussion, review records, counseling; and
- **Treat** – medications, therapies, other modalities ordered by the provider

The MEAT acronym can be used as a valuable general guideline for physicians and auditors, but there is no "official" regulation to substantiate the use of this personnel guideline. As stated previously, always use guidelines and regulations published from official sources to ensure compliance.

A documentation area that continues to be problematic for providers is the Problem List. Simply making a list of diagnoses and adding them either in the electronic health record (EHR) or under the Assessment and Plan, without documenting in the face-to-face encounter that the patient's condition has been properly addressed during the visit and met the components of MEAT, is unacceptable (See Table 1).[3]

As noted in Table 1, the diagnoses on the problem list must have documentation that supports that all diagnoses listed were addressed and evaluated in the face-to-face encounter.

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action

What the Reviewer May Encounter	Explanation/Examples	Reviewer Guidance	RADV Auditor Action
Problem Lists (within a medical record)	See related topic of Chronic and Other Additional Diagnoses. Lists of diagnoses (conditions, problems) may be numbered, bulleted, or separated by commas. A list may be documented in the patient history, assessment, discharge summary, or other areas of a medical record. When conditions commonly associated are listed under the same number or bullet, the conditions can assume to be linked. These diabetes examples are effective for ICD-9-CM and will be updated for ICD-10-CM. **Example 1:** 1. Hypertension 2. DM, neuropathy (link diabetes and neuropathy) **Example 2:** 1. Hypertension 2. DM 3. Neuropathy (do not link diabetes and neuropathy) **Example 3:** 1. Diabetes with hypertension (Although these conditions could occur together and berelated, unless the documentation clearly shows a cause and effect relationship, do not link diabetes and other condition if not typically a known manifestation of	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment. Do not submit conditions from lists labeled as PERTINENT NEGATIVES.	Problem lists are evaluated on a case-bycase basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS. Lists of conditions written by the patient are not acceptable. Lists of code numbers without narratives are not acceptable. Mention or EMR population of diagnoses in a list will be considered on a caseby-case basis for RADV once all other coding rules and checks for consistency have been applied.

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	diabetes.)		

Table 1: CMS Contract-Level RADV Medical Record Reviewer Guidance

Valid signatures are a must

The physician/provider must include a valid signature for the dates of service submitted for review and audit on each encounter. This applies if the physician/provider is on an EHR and signs with an electronic signature or, if the records are submitted in paper format, the physician/provider must sign the actual paper record. Of note, CMS-generated attestations can be submitted for physician/practitioner and hospital outpatient medical records only. These must be completed, signed, and dated by the physician/practitioner who provided those services. No other forms of attestation will be accepted. The completed fields must include the printed physician/practitioner's name, the date of service on the medical record to which they are attesting, the physicians/practitioner's specialty or credential, and must be signed and dated by the physician/practitioner that conducted the face-to-face visit. If the encounter does not have a valid physician/provider signature, it is not considered a valid submission for audit.

Date of service is required

The date of service for the face-to-face encounter must be easily accessible and validated on the encounter. An encounter submitted without a date of service that can be validated is considered invalid and is unacceptable for audit.

Addendums/amendments to the medical record

Medical record addendums/amendments are accepted and considered valid documentation for audit if they are based on an observation of the patient made on the date of service/encounter by the attending physician. The most common form of addendum/amendment is based on a diagnostic test ordered on the date of service and the test results received following the patient's visit. The addendum/amendment must contain ample information to verify that it was completed in a timely manner; this timeframe generally means 90 days. Most facilities and practices have a 30-day time limit for the completion of addendum/amendments.