HCC CODING AND CGM: WHAT PROVIDERS NEED TO KNOW

Trinity Health Mid-Atlantic | Quality Health Alliance

HCCs, or Hierarchical Condition Categories, are part of a risk adjustment model with sets of medical codes linked to specific diagnoses. HCC coding is based on a patient's health status.

HCC codes represent severe acute and chronic health conditions. All HCCs must be documented and coded at least once per year. One goal of risk adjustment is to align payment and benchmarks to reflect acuity of illness.

As of 2024, there are 74,000 ICD-10 Codes (conditions), and 9,500 ICD-10 codes associated with increased resource intensity, totaling 266 CMS HCCs. 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 Medicare beneficiary'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. 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).

- **Monitor:** Review signs and symptoms; review logs (blood sugar, BP); Disease progression/regression noted
- **Evaluate:** Reviewing lab/test results; review of diagnostic tests, medication/treatment effectiveness; Relevant physical examination
- **Assess:** Stable, improving, worsening, etc.; Discussion/Counseling; Exacerbation of condition; Relevant record review
- **Treat:** Referral to specialist; Adjusting, refilling, prescribing medication; surgical procedures

Example: Diabetes with Complications

- To capture accurate burden of illness for the patients, complications should be linked
- Common complications:
- Diabetic neuropathy
- Retinopathy
- Nephropathy, CKD or kidney failure
- Peripheral vascular disease (PVD)
- Use as many complicated DM codes as necessary to convey the patient's full burden of illness
- Reporting complications separately from diabetes can result in a negative and inaccurate risk score.

E11.22 | **Type II with CKD (additional character for stage)**

E11.3592 | **Type II with proliferative diabetic retinopathy without macular edema, left eye**

E11.42 | **Type II with diabetic polyneuropathy**

E11.51 | **Type II with diabetic peripheral angiopathy without gangrene**

E11.65 | **Type II with hyperglycemia**

Why Continuous Glucose Monitoring (CGM) in Primary Care?

- Integration into primary care improves access otherwise limited to endocrinology.
- Prevent short and long-term complication of diabetes.
- Disparities exist in access to CGM across the region due to health literacy, affordability and social care barriers best addressed in primary care.

Benefits of CGM

- Can uncover undetected hypoglycemia and other glucose trends. Possible verification with finger-stick may be warranted.
- Can provide direction and rate of change of glucose
- Can provide alerts if glucose is or is predicted to be outside target range
- Can contribute to improved glucose control and detecting the impact of food and activities.
- May pair with select insulin pumps for automated insulin delivery systems
- Reduce the number of finger sticks

PCP Integration of CGM

PRIMARY CARE BENEFIT

- Consolidation of the patient data. Ability of multiple providers to see trends in patient's glucose data and GMI%
- Quality metrics
  - Patient data can be tracked and trended for safety and quality efforts.
  - Trending data can help support care in diabetic population.
  - Review of CGM data is a billable code

PATIENT BENEFIT

- Quality of Life Improvement
  - No need for finger sticks
  - Real time readings to support glucose self-management
- Decrease in medication burden
  - A1C reduction can enable patients to decreaseor eliminate medications

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