Example of HCC and ICD-9 Code Mapping

ICD9	ICD-9-CM Description	2013 HCC Payment	2014 Payment HCC	2013 RxHCC Payment	2014 Payment RxHCC
042	Human immuno virus dis	1	1	1	1
20400	Ac lym leuk wo achv rmn	7	8	11	11
25000	DMII wo cmp nt st uncntr	19	19	15	15
25060	DMII neuro nt st uncntrl	16	18	14	14
2724	Hyperlipidemia NEC/NOS			23	23
27801	Morbid obesity		22	21	21
5851	Chro kidney dis stage I	131		125	125
4540	Leg varicosity w ulcer		107		
2875	Thrombocytopenia NOS		48		
V8541	BMI 40.0-44.9, adult		22	21	21
412	Old MI	83		89	89

2014 Hcc Model Icd9 Codes

Anne B. Casto

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   Health Care Finance and the Mechanics of Insurance and Reimbursement Michael K. Harrington,2023-11-06 Health Care Finance and the Mechanics of Insurance and Reimbursement combines financial principles unique to the health care setting with the methods and process for reimbursement including coding reimbursement strategies compliance financial reporting case mix index and external auditing It explains the revenue cycle correlating it with regular management functions and covers reimbursement from the initial point of care through claim submission and reconciliation Updated throughout the Third Edition offers expanded material on financial statements new and expanded Skilled Nursing Facility examples and enhanced sections on PDPM Practice Management for Primary Care and other Specialties Clearinghouse Processes Predictive Modeling data mining and more   Federal Register ,2013-03   **Readmission Prevention: Solutions Across the Provider Continuum** Josh Luke,2015-01-07 As a result of the Affordable Care Act ACA readmissions have become a new area of focus as care delivery moves from a volume based model to a value based one Acute hospitals are calling upon post acute providers to assist them in improving care coordination to avoid penalties Post acute providers are taking steps to become the provider of choice as hospitals health systems and managed care organizations turn to them for support In the absence of proven historical programs this book gives hospital executives and post acute care providers proven tactics and tools they can apply to reduce and prevent unnecessary hospitalizations Written in a conversational style by a seasoned healthcare executive the book starts by defining the origins of readmissions and the impact of the ACA then describes three phases of readmission prevention planning and offers innovative strategies for executives to position their facility as a provider of choice Specific readmission prevention tactics are addressed for different levels of post acute care including Acute care hospitals and health systems Skilled nursing facilities Physicians and Pharmacists Long term acute care and acute rehabilitation hospitals Home health agencies Hospice and palliative care agencies Assisted living facilities Home care and private duty nursing Throughout the book short perspectives written by experts in the different specialty areas provide additional viewpoints on critical issues in care transitions The book concludes with case examples from healthcare organizations that have successfully implemented new tactics and strategies as part of a larger coordinated program in preventing readmissions   *Field Guide to the Business of Medicine* Christopher Clyne,Britton Jewell,2018-09-17 Publisher s Note Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality authenticity or access to any online entitlements included with the product Today s health care is much more than Medicine Health care professionals and administrators must be familiar with the non medical aspects of health care if they are to be successful From the basics of government and private insurance to reimbursement methods payment models practice paradigms and new industry trends this indispensable guide provides much needed information for medical students and residents emerging health care professionals and anyone who wants a clear perspective on the requisites protocols and regulations of today s health care

system   Industrial and Labor Relations Review ,2016   2018 Risk Adjustment and Hierarchical Condition Category Coding Guide The Coders Choice LLC,2017-12-15 Risk Adjustment and Hierarchical Condition Category HCC coding is a payment model mandated by the Centers for Medicare and Medicaid Services CMS in 1997 Implemented in 2003 this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual s health conditions and demographic details The individual s health conditions are identified via International Classification of Diseases 10 ICD 10 diagnoses that are submitted by providers on incoming claims There are more than 9000 ICD 10 codes that map to 79 HCC codes in the Risk Adjustment model CMS requires documentation in the person s medical record by a qualified health care provider to support the submitted diagnosis Documentation must support the presence of the condition and indicate the provider s assessment and or plan for management of the condition This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition The Centers for Medicare and Medicaid Services CMS Risk Adjustment Model includes nearly 80 HCC categories of chronic illnesses with thousands of diagnosis codes Beginning HCC coders need solid instruction on HCC coding to properly map codes and ensure the organization receives the reimbursement payments This webinar educates the audience on HCC coding and discusses popular risk adjustment coding guidelines It identifies what makes a document valid for submission including which sources of documentation should or should not be used Attendees will have the opportunity to review common mistakes like a lack of specificity in provider documentation Often overlooked conditions which are frequently undocumented by the provider are also explained The presenter will give a brief demonstration on how to determine if a condition is reimbursed or not as well as a case study showing how to apply the theories learned Through clarification of codes and specific examples the speaker underscores the importance of provider documentation and its impact on reimbursement This session is a great overall introduction for beginners and the perfect refresher course for those who have already begun and want to enhance their knowledge in the field ObjectivesLearn about HCC coding and risk adjustment coding guidelines Demonstrate how mapping tools help to properly identify HCCs Understand the importance of provider documentation and its impact on reimbursement Risk adjustment in the CMS HCC model characteristics is based on multiple factors which are analyzed and reduced to offer the right risk management plan for a patient The factors that influence risk adjustment includes Hierarchy of diseases Ensuring that diagnoses are included in the appropriate disease groups and are in accordance with the necessary hierarchy Disease Interactions The additional factors that recognize and assess the severity of multiple conditions Demographic Variables These focus on the demographic of the patient s living conditions and demographics Diagnostic Sources CMS recognizes diagnoses from a hospital s inpatient outpatient and physician settings only Prospective model The diagnoses based on last year are used to extrapolate the possible payments for the next year Multiple conditionsA patient can have multiple HCC categories assigned to them based on their medical conditions In some cases specific conditions can override

others when documenting This is based on the strict hierarchy of the coding procedures HCCs are captured once a year every year in order for the CMS to reimburse payments to the Medicare Advantage However diagnoses from previous years are used to establish capitation payments to the Medicare Advantage plan   *Medicare Risk Adjustment and Hierarchical Condition Category (HCC)* V. G,2018-08-21 Risk Adjustment and Hierarchical Condition Category HCC coding is a payment model mandated by the Centers for Medicare and Medicaid Services CMS in 1997 Implemented in 2003 this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual s health conditions and demographic details The individual s health conditions are identified via International Classification of Diseases 10 ICD 10 diagnoses that are submitted by providers on incoming claims There are more than 9000 ICD 10 codes that map to 79 HCC codes in the Risk Adjustment model CMS requires documentation in the person s medical record by a qualified health care provider to support the submitted diagnosis Documentation must support the presence of the condition and indicate the provider s assessment and or plan for management of the condition This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition The Centers for Medicare and Medicaid Services CMS Risk Adjustment Model includes nearly 80 HCC categories of chronic illnesses with thousands of diagnosis codes Beginning HCC coders need solid instruction on HCC coding to properly map codes and ensure the organization receives the reimbursement payments This webinar educates the audience on HCC coding and discusses popular risk adjustment coding guidelines It identifies what makes a document valid for submission including which sources of documentation should or should not be used Attendees will have the opportunity to review common mistakes like a lack of specificity in provider documentation Often overlooked conditions which are frequently undocumented by the provider are also explained The presenter will give a brief demonstration on how to determine if a condition is reimbursed or not as well as a case study showing how to apply the theories learned Through clarification of codes and specific examples the speaker underscores the importance of provider documentation and its impact on reimbursement This session is a great overall introduction for beginners and the perfect refresher course for those who have already begun and want to enhance their knowledge in the field Objectives Learn about HCC coding and risk adjustment coding guidelines Demonstrate how mapping tools help to properly identify HCCs Understand the importance of provider documentation and its impact on reimbursement Risk adjustment in the CMS HCC model characteristics is based on multiple factors which are analyzed and reduced to offer the right risk management plan for a patient The factors that influence risk adjustment includes Hierarchy of diseases Ensuring that diagnoses are included in the appropriate disease groups and are in accordance with the necessary hierarchy Disease Interactions The additional factors that recognize and assess the severity of multiple conditions Demographic Variables These focus on the demographic of the patient s living conditions and demographics Diagnostic Sources CMS recognizes diagnoses from a hospital s inpatient outpatient and physician settings only Prospective model The diagnoses

based on last year are used to extrapolate the possible payments for the next year Multiple conditions A patient can have multiple HCC categories assigned to them based on their medical conditions In some cases specific conditions can override others when documenting This is based on the strict hierarchy of the coding procedures HCCs are captured once a year every year in order for the CMS to reimburse payments to the Medicare Advantage However diagnoses from previous years are used to establish capitation payments to the Medicare Advantage plan **ICD 9-CM to ICD 10-CM in a SNAP(TM) 2014** Rochelle Woodruff,2014-02-01 **The Complete Coding and Documentation Guidelines for Hierarchical Category Conditions (HCC)** David Shogan,2017-06-24 Risk Adjustment and Hierarchical Condition Category HCC coding is a payment model mandated by the Centers for Medicare and Medicaid Services CMS in 1997 Implemented in 2003 this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual s health conditions and demographic details The individual s health conditions are identified via International Classification of Diseases 10 ICD 10 diagnoses that are submitted by providers on incoming claims There are more than 9000 ICD 10 codes that map to 79 HCC codes in the Risk Adjustment model CMS requires documentation in the person s medical record by a qualified health care provider to support the submitted diagnosis Documentation must support the presence of the condition and indicate the provider s assessment and or plan for management of the condition This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition Accurate HCC coding information helps create a more complete picture of the complexity of a patient population improves the value of the problem list and enables better management of a patient s chronic diseases And better documentation that captures the full complexity of the patient often results in appropriately higher reimbursement Current challenges and opportunities Provider organizations are facing several challenges as they plan for HCC coding and documentation 1 Provider engagement education and incentive alignment Impacts to workflow and efficiency 2 Insufficient or incomplete medical record documentation in the EHR 3 EHR disconnect and poor problem list utilization 4 Incorrect coding 5 Inferior or non existent HCC specific analysis and prioritization The Medicare Annual Wellness Visit AWV is a yearly preventative care visit offered at no cost to all Medicare Part B beneficiaries The purpose of the visit is to identify patient risk factors and plan for future preventative service needs This visit is well reimbursed and can be conducted by any licensed health professional or a team of professionals under the direct supervision of a physician While the AWV is recognized as an important benefit 82 3% of Medicare beneficiaries did not receive an AWV in 2015 The bottom line is that patients want time with their physicians to discuss their health Our clients have professed repeatedly that they see a difference in patient engagement as they capture more AWVs With changes like value based purchasing putting revenue at risk accurate documentation is even more critical A good physician query process helps but relying on queries alone leaves money on the table You need to prevent documentation errors from happening in the first place by getting your physicians to pay closer attention to what they write

down The medical record should tell a story Coding specialist need to understand what the physician is thinking and know when the provider isn t documenting the complete information to assign the most specific diagnosis code Ensure that all opportunities for documentation improvement are identified For the medical record to be accurate and timely a physician query process should be in place Ongoing chart reviews and provider education reinforces the essential points of good documentation and helps to bridge the gap between what the provider needs clinically documented in the medical record from one visit to the next and the coding guidelines that are required to support the codes being submitted *ICD-10-CM Code Book, 2014 Draft* Anne B. Casto,2013-12-04 The American Health Information Management Association AHIMA proudly introduces the ICD 10 CM Code Book 2014 Draft to help you learn about and prepare for the International Classification of Diseases Tenth Revision Clinical Modification A portion of the proceeds from each book are donated to the AHIMA Foundation Key Features Color coding helps make navigation and code selection easier MCC and CC codes as identified by the MS DRG system Chapter specific coding guidelines are the front of each chapter in the Tabular References to coding guidelines included throughout the Tabular Anatomical art included throughout the Tabular Identification of diagnoses that impact Medicare Code Editor edits Identification of diagnosis that impact MS DRG pathways and edits Identification of diagnoses included in Medicare s Hospital Acquired Conditions Program Appendices include Principal Diagnosis Collections for CC and MCC Exclusions and Hospital Acquired Conditions HAC Listings and Conditional Logic *2014 Icd-9 Endocrinology Codes Pocket Guide* Mary Compton,2014-03-01 2014 Enhanced Generic ICD-10-PCS Craig D. Puckett,2014-10-01 The International Classification of Diseases Tenth Revision Procedure Coding System ICD 10 PCS was created to accompany the World Health Organization s WHO ICD 10 diagnosis classification The new procedure coding system was developed to replace ICD 9 CM procedure codes for reporting inpation procedures Unlike the ICD 9 CM classification ICD 10 PCS was designed to enable each code to have a standard structure and be very descriptive and yet flexible enough to accomodate future needs **ICD-10-PCS: Draft** Optum,2013-09 Now with Medicare Code Edits MCE for the new ICD 10 MS DRG reimbursement system the 2014 ICD 10 PCS the Complete Official Draft Code Set makes facing the challenge of learning a new code set easier Prepare for the future of coding using the resource that contains the latest version of the official government draft of the ICD 10 PCS code set plus the features you have come to rely upon for coding accuracy in your ICD 9 CM code books Ease the learning curve and face the challenges ahead with confidence Key Benefits and Features Optum Edge Color coding and symbols for the Medicare Co ICD-10-PCS Code Book, 2014 Draft Anne B. Casto,2013-12-10 The American Health Information Management Association AHIMA proudly introduces the ICD 10 PCS Code Book 2014 Draft to help you learn about and prepare for International Classification of Diseases Tenth Revision Procedure Coding System A portion of the proceeds from each book are donated to the AHIMA Foundation Key Features Color coding of sections helps make navigation and code selection easier Medical Surgical and OB sections include Code

Listings References to coding guidelines included throughout the Code Listings Anatomical art included in each body system section of the Medical and Surgical Tables and Code Listings Identification of procedures that impact Medicare Code Editor edits Identification of procedures that impact MS DRG pathways and edits Identification of procedures that are included in Medicare s Hospital Acquired Conditions program Appendices include Root Operation Definitions Type and Qualifier Definitions Medical and Surgical Approach Definitions Body Part Key and Device Key and Aggregation Table **ICD-10 to HCC Mappings** Kameron Gifford,2020 Includes a complete list of ICD 10 codes included in the CMS HCC and Rx HCC Models for PY 2020 That is 9 700 ICD 10 codes in V24 HCC and 4 347 ICD 10 codes in V05 Rx HCC **ICD-10-CM: The Complete Official Draft Code Set for Hospitals EBook on CD** Optum,OptumInsight, Inc.,2013-09-01 Now with our hallmark features and format the 2014 ICD 10 CM The Complete Official Draft Code Set for Hospitals makes facing the challenge of learning a new code set easier Prepare for the future of coding with the latest and most comprehensive update to the code set The current rule published in the Federal Register sets the adoption of ICD 10 CM to replace ICD 9 CM Volumes 1 and 2 to go into effect October 1 2014 Start down the road to success using the resource that contains the latest version of the official government draft of the ICD 10 CM code set plus the Optum features you have come to rely upon for coding accuracy in your ICD 9 CM code books Ease the learning curve and face the challenges ahead with the confidence only an Optum product can deliver Features and benefits Optum Edge Exclusive This symbol designed and used exclusively by Optum alerts the coder to a new ICD 10 CM convention the use of a placeholder x Optum Edge PDx acting as CC and MCC Alert This symbol designed and used exclusively by Optum alert the coder to a new key factor in the ICD 10 DRG system that some diagnoses act as both the PDx as well as the CC or MCC Optum Edge Color coding and symbols for the Medicare Code Edits This edition includes all our hallmark color coding and symbols for the most comprehensive coverage of MCEs for diagnoses Age Sex Manifestation codes Unacceptable PDx Hospital Acquired Condition MCC and MCC as PDx CC and CC as PDx HIV Optum Edge ICD 10 CM focused coding illustrations Optum Edge Intuitive features and format Ease into the new classification system using intuitive visual alerts to highlight code groupings as well as the distinctions between code choices plus added features that make finding specific sections easier Complete 2014 draft ICD 10 CM code set View all 21 chapters from infectious and parasitic diseases to injuries including external causes and reasons for visit ICD 10 CM *2014 ICD-10-CM Modification Draft Code Set* Aapc,2013 ICD-10-CM for Hospitals: Draft Anita Hart,2013-09 Now featuring our hallmark color coding and symbols reflecting the new ICD 10 MS DRG reimbursement edits the 2014 ICD 10 CM The Complete Official Draft Code Set makes facing the challenge of learning a new code set easier Prepare for the future of coding with the latest and most comprehensive update to the code set The current rule published in the Federal Register sets the adoption of ICD 10 CM to replace ICD 9 CM Volumes 1 and 2 to go into effect October 1 2014 ICD-10-CM 2021: The Complete Official Codebook with Guidelines American Medical Association,2020-09-20 ICD 10 CM 2021 The Complete

Official Codebook provides the entire updated code set for diagnostic coding organized to make the challenge of accurate coding easier This codebook is the cornerstone for establishing medical necessity determining coverage and ensuring appropriate reimbursement Each of the 21 chapters in the Tabular List of Diseases and Injuries is organized to provide quick and simple navigation to facilitate accurate coding The book also contains supplementary appendixes including a coding tutorial pharmacology listings a list of valid three character codes and additional information on Z codes for long term drug use and Z codes that can only be used as a principal diagnosis Official coding guidelines for 2021 are bound into this codebook FEATURES AND BENEFITS Full list of code changes Quickly see the complete list of new revised and deleted codes affecting the FY 2021 codes including a conversion table and code changes by specialty QPP symbol in the tabular section The symbol identifies diagnosis codes associated with Quality Payment Program QPP measures under MACRA New and updated coding tips Obtain insight into coding for physician and outpatient settings New and updated definitions in the tabular listing Assign codes with confidence based on illustrations and definitions designed to highlight key components of the disease process or injury and provide better understanding of complex diagnostic terms Intuitive features and format This edition includes full color illustrations and visual alerts including color coding and symbols that identify coding notes and instructions additional character requirements codes associated with CMS hierarchical condition categories HCC Medicare Code Edits MCEs manifestation codes other specified codes and unspecified codes Placeholder X This icon alerts the coder to an important ICD 10 CM convention the use of a placeholder X for three four and five character codes requiring a seventh character extension Coding guideline explanations and examples Detailed explanations and examples related to application of the ICD 10 CM chapter guidelines are provided at the beginning of each chapter in the tabular section Muscle tendon translation table This table is used to determine muscle tendon action flexor extensor other which is a component of codes for acquired conditions and injuries affecting the muscles and tendons Index to Diseases and Injuries Shaded guides to show indent levels for subentries Appendices Supplement your coding knowledge with information on proper coding practices risk adjustment coding pharmacology and Z codes

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