

# CMS-HCC hierarchies determined based on ICD-10

## HCC diagnostic classification system



Associated codes for HCC category:  
"diabetes body system"

0101  
1100  
1111

HCC 17 - Diabetes with  
Acute Complications

HCC 18 - Diabetes with  
Chronic Complications

HCC 19 - Diabetes  
without Complications

Diabetes coding hierarchy example



HCC 18 - Diabetes with  
Chronic Complications



~~HCC 19 - Diabetes  
without Complications~~



Only one code per HCC category is  
assigned; highest severity code used  
when both could apply

## Hcc Diabetes Coding Cms

**Centers for Medicare and Medicaid Services (U.S.), Office Of The Federal Register (U.S., Centers for Medicare and Medicaid Services (U.S.)**

## **Hcc Diabetes Coding Cms:**

Health Care Finance and the Mechanics of Insurance and Reimbursement Michael K. Harrington, 2019-10-01 Health Care Finance and the Mechanics of Insurance and Reimbursement stands apart from other texts on health care finance or health insurance in that it 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 in detail correlating it with regular management functions and covers reimbursement from the initial point of care through claim submission and reconciliation Thoroughly updated for its second edition this text reflects changes to the Affordable Care Act Managed Care Organizations new coding initiatives new components of the revenue cycle from reimbursement to compliance updates to regulations surrounding health care fraud and abuse changes to the Recovery Audit Contractors RAC program and more

*AAPC CRC 2025-2026 Exam Prep* Brielle Morgan, 2025-09-13

Pass the AAPC CRC 2025 Exam on the First Try Without Wasting Months on Outdated Prep Are you ready to earn your CRC credential boost your career and step into higher paying medical coding roles The AAPC CRC 2025 2026 Complete Study Guide is your no fluff exam focused roadmap to certification success Designed for real world coders retakers career changers and students this guide cuts through the noise and zeroes in on exactly what the exam tests Inside you'll find Complete CRC 2025 Exam Blueprint breakdown with domains explained in plain language Step by step coverage of risk adjustment models HCC mapping RAF scoring and MEAT criteria ICD 10 CM rules for high impact chronic conditions including diabetes CHF COPD CKD and cancer Audit readiness tools for documentation abstraction RADV prep and compliance safeguards 750 exam style practice questions with full rationales so you know why each answer is correct Quick reference tables that simplify complex coding rules for rapid review Every chapter simplifies complex rules without losing the accuracy coders need in Medicare Advantage ACA and risk adjustment settings From navigating hierarchies and trumping conditions to linking diagnoses correctly this book prepares you to pass the exam and perform with confidence on the job If you're ready to stop second guessing start coding with precision and secure your CRC certification grab your copy now and take the final step toward exam day success

*Medicare and Medicaid Guide* , 1969 **Medicare Risk Adjustment and HCC Clinical**

**Documentation Overview** The Coders Choice LLC, 2019-03-09 Risk adjustment is a method to offset the cost of providing health insurance for individuals such as those with chronic health conditions who represent a relatively high risk to insurers Under risk adjustment an insurer who enrolls a greater than average number of high risk individuals receives compensation to make up for extra costs associated with those enrollees In the absence of risk adjustment policies insurers have a financial incentive to deny coverage to higher risk individuals and to write exclusions into policies or impose unaffordable premiums for individuals with pre existing medical conditions Risk adjustment aims to make comprehensive insurance available to all individuals regardless of risk and to allow plans that insure sicker than average populations to charge similar average

premiums as plans that insure relatively healthy populations. The risk adjustment model enacted under the Affordable Care Act (ACA) or Obamacare is budget neutral. Total payments to insurers do not increase. Rather, insurers covering a relatively greater number of healthy individuals must contribute to a risk adjustment pool that funds additional payments to those insurers covering a larger portion of high risk individuals. Risk adjustment models typically use an individual's demographic data (age, sex, etc.) and diagnoses to determine a risk score. The risk score is a relative measure of the probable costs to insure the individual. To cite a simple example, an individual with diabetes will have a higher risk score than his or her predicted healthcare costs will be greater than an otherwise statistically identical individual without diabetes. Older individuals typically have a higher risk score than younger individuals and those individuals with a personal or family history of certain conditions may garner a higher risk score than individuals without such a history. There are several risk adjustment models. The Centers for Medicare however, some risk adjustment models may include severe conditions relevant to a young demographic such as pregnancy and congenital abnormalities. All risk adjustment models depend on complete and accurate reporting of patient data. CMS requires that a qualified healthcare provider identify all chronic conditions and severe diagnoses for each patient to substantiate a base year health profile for those individuals. Documentation in the medical record must support the presence of the condition and indicate the provider's assessment and plan for management of the condition. This must occur at least once each calendar year for CMS to recognize that the individual continues to have the condition. This information is used to predict costs in the following year. As such, incorrect or non-specific diagnoses can affect not only patient care and outcomes but also reimbursement for that care going forward. *Journal of AHIMA*, 2008.

**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.

**Code of Federal Regulations, Title 42, Public Health, Pt. 414-429, Revised as of October 1, 2017** Centers for Medicare and Medicaid Services (U.S.), Office Of The Federal Register (U.S.), Centers for Medicare and Medicaid Services (U.S.), 2018-01-11. The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the United States Federal Government. This print ISBN is the official U.S. Federal Government edition. 2 CFR Parts 414-429 covers federal regulations, rules and processes for the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services. This print volume part of the annual 2017 print subscription covers topics such as payment for Part B Medical and other health services, ambulatory surgical services, hospice care, Medicare Advantage Program conditions for Medicare payment, Medicare contracting and more. Medicare beneficiaries and participants, internal medicine and geriatric physicians, health practitioners, hospice care facilities and home services personnel and volunteers may be interested in this volume. Additionally, students pursuing coursework in personal and community health, health science, terminology, patient care

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**REPORT TO THE CONGRESS NEW APPROACHES IN MEDICARE ., Aapc crc certified risk adjustment coder exam prep 2025-2026** Elliot Spencer,2025-07-25 The AAPC CRC Certified Risk Adjustment Coder Exam Prep 2025 2026 by Elliot Spencer is expertly crafted to address the challenges faced by aspiring and current medical coders who want to advance their careers in the lucrative field of risk adjustment coding This book is more than just a study manual it is a powerful learning tool packed with over 600 meticulously designed practice questions detailed answer explanations and proven test taking strategies that mirror the real exam environment Every page is tailored to reinforce critical concepts improve coding accuracy and enhance your understanding of complex risk adjustment models HCC coding and compliant documentation standards Are you struggling to master the complexities of Certified Risk Adjustment Coding and worried that your exam preparation isn't enough to secure your certification Do you find yourself overwhelmed by the vast coding guidelines intricate documentation requirements and constantly evolving healthcare regulations If you're looking for a proven comprehensive and results driven study guide that not only prepares you but empowers you to confidently pass the AAPC CRC Certified Risk Adjustment Coder Exam your search ends here The AAPC CRC Certified Risk Adjustment Coder Exam Prep 2025 2026 by Elliot Spencer is expertly crafted to address the challenges faced by aspiring and current medical coders who want to advance their careers in the lucrative field of risk adjustment coding This book is more than just a study manual it is a powerful learning tool packed with over 600 meticulously designed practice questions detailed answer explanations and proven test taking strategies that mirror the real exam environment Every page is tailored to reinforce critical concepts improve coding accuracy and enhance your understanding of complex risk adjustment models HCC coding and compliant documentation standards In an industry where precision and compliance are paramount this guide equips you with the skills and knowledge to navigate ICD 10 CM coding intricacies understand CMS guidelines and interpret hierarchical condition categories with confidence Elliot Spencer's clear concise explanations break down complicated topics into manageable lessons making study time efficient and effective Whether you're a beginner or a seasoned coder this book

bridges the gap between theory and practice transforming your exam preparation into a focused successful journey This indispensable exam prep guide also integrates the latest industry updates ensuring you stay ahead in a rapidly changing healthcare landscape With targeted practice questions and detailed answer rationales you ll develop critical thinking skills essential for passing the CRC exam on your first attempt It s more than just memorization it s about mastering the application of coding knowledge in real world scenarios If you are serious about certification and career growth in risk adjustment coding investing in this comprehensive study guide is your first step toward success Don t let uncertainty or inadequate preparation hold you back from achieving your goals Empower yourself with the best tools practice smart and walk into your exam with confidence Take control of your future today Add AAPC CRC Certified Risk Adjustment Coder Exam Prep 2025 2026 to your cart and start your journey toward certification excellence now Translator Nicolle Raven PUBLISHER TEKTIME

**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

### **Hazzard's Geriatric Medicine and Gerontology,**

**Eighth Edition** Jeffrey B. Halter,Joseph G. Ouslander,Stephanie Studenski,Kevin P. High,Sanjay Asthana,Mark A. Supiano,Christine S. Ritchie,Kenneth Schmader,2022-06-06 The undisputed leader on the subject of geriatrics updated to reflect the most recent advances in the field A Doody s Core Title for 2024 2023 The leading text on the subject of geriatrics this comprehensive guide combines gerontology principles with clinical geriatrics offering unmatched coverage of this area of medicine Anchored in evidence based medicine and patient centered practice Hazzard s Geriatric Medicine and Gerontology presents the most up to date medical information available This updated eighth edition reflects the continued growth and increasing sophistication of geriatrics as a defined medical discipline The book focuses on the implementation of key concepts and covers the foundation for geriatrics as well as frequently encountered syndromes found in older adults In addition it provides valuable insights into the simultaneous management of multiple conditions including psychological and social issues and their interactions an intrinsic aspect of geriatric patient care Features A greater emphasize on the growing knowledge base for key topics in the field including gerontology geriatrics geriatric conditions and palliative medicine NEW chapters on Social Determinants of Health Health Disparities and Health Equity Age Friendly Care Geriatrics Around the World The Patient Perspective Substance Use and Disorders Applied Clinical Geroscience Managing the Care of Patients with Multiple Chronic Conditions UPDATED contributions from a respected and diverse team of geriatricians and subspecialists to reflect clinical breakthroughs and advances NEW Extensive coverage of the COVID 19 pandemic and its impact on vulnerable older adults Updated Learning Objectives and Key Clinical Points Hundreds of full color images

**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: Official Guidelines for Coding and Reporting - FY 2019 (October 1, 2018 - September 30, 2019)** Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), U.S.

Department of Health and Human Services (DHHS), 2018-08 These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD 10 CM the American Hospital Association AHA the American Health Information Management Association AHIMA CMS and NCHS These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD 10 CM itself The instructions and conventions of the classification take precedence over guidelines These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD 10 CM but provide additional instruction Adherence to these guidelines when assigning ICD 10 CM diagnosis codes is required under the Health Insurance Portability and Accountability Act HIPAA The diagnosis codes Tabular List and Alphabetic Index have been adopted under HIPAA for all healthcare settings *The Comparative Guide to American Hospitals, Volume 1* David Garoogian, 2007 4 383 hospitals with key personnel and 24 quality measures in treating heart attacks heart failure pneumonia pregnancy and surgical infection prevention Medicare Coding Essentials Kameron Gifford, 2020 All NEW for the V24 Model Prepare your team for victory this risk adjustment season with the CMS HCC Coding Essentials Pack Medical Coding Patricia Aalseth, 2014-08-06 In clear and straightforward language Medical Coding What It Is and How It Works Second Edition provides an overview of the evolution of medical coding and all the various coding systems how they relate and how they function Reasoning and consequences of the delayed ICD 10 implementation are explained along with a sound overview of the ICD 10 CM and PCS classification systems For those contemplating a career in the coding field this book is ideal as a basic orientation Other individuals in healthcare management and administration will also benefit from a basic understanding of how coding works Unlike other publications that focus only on coding this book integrates coding guidelines and principles into the billing and reimbursement process giving the student a more practical foundation in the rationale for correct coding Healthcare fraud and abuse is addressed as well to assure that readers understand ethical concerns inherent in coding for reimbursement Instructor Resources Instructor s Manual PowerPoint slides Test Bank Risk Adjustment Documentation and Coding Sheri Poe Bernard, 2020-03-02 Risk adjustment practices consider chronic diseases as predictors of future health care needs and expenses Correct and detailed documentation and compliant diagnosis coding are critical for proper risk adjustment Risk Adjustment Documentation Coding 2nd Edition provides Risk adjustment parameters to improve documentation related to severity of illness and chronic diseases Code abstraction guidelines and recommendations to improve diagnostic coding accuracy without causing financial harm to the practice or health facility Chronic disease ICD 10 CM coding summaries for quick reference and study The impact of risk adjustment coding hierarchical condition category HCC coding on a practice should not be underestimated More than 75 million Americans are enrolled in risk adjusted insurance plans This population represents more than 20% of those insured in the United States Insurance risk pools under the Affordable Care Act include risk adjustment CMS has proposed expanding audits on risk adjustment coding FEATURES AND BENEFITS Five chapters

delivering an overview of risk adjustment common administrative errors best practices and guidance for development of internal risk adjustment coding policies Ten chronic disease ICD 10 CM coding summaries for quick reference and study Two appendices offering mappings and tabular information of ICD 10 CM codes that risk adjust to HCCs and RxHCCs Learning and design features Vocabulary terms highlighted within the text and defined at the bottom of the page Advice Alert Notes that highlight important coding and documentation advice from federal regulatory sources Sidebars that provide derivative story and additional information such as Coding Tips that guide coders with practical advice from sources like AHA's Coding Clinic and cautionary notes about conflicts and exceptions Clinical Examples that underscore key documentation issues for risk adjustment Clinical Coding Examples that provide snippets or full encounter notes and codes to illustrate risk adjustment coding and documentation concepts Documentation tips that highlight recommendations to physicians regarding what should be included in the medical record or how ICD 10 CM may classify specific terms Examples that explain difficult concepts and promote understanding of those concepts as they relate to a section FYI call outs that provide quick facts Abstract Code It exercises that test diagnosis abstraction and coding skills exclusive to Chapter 4 Extensive end of chapter Evaluate Your Understanding sections that include multiple choice questions true or false questions audit and Internet based exercises Two downloadable course tests and slide presentations for each chapter Exclusive content for academic educators A test bank containing 100 questions and a mock risk adjustment certification exam with 150 questions [CMS-HCC Quick Coder](#) Kameron Gifford, 2020 This 40 page guide contains everything you need to calculate a risk score in one place Includes of the most common HCC codes in the Medicare CMS HCC model This guide was designed for providers with codes sorted alphabetically rather than by code Includes List of ICD 10 Guidelines 270 ICD 10 Codes Rx and HCCs Quality CPT II codes for MIPS MACRA 2020 CMS HCC Factors includes demographic medicaid disabled disease interactions and payment counts Trump Chart [Buck's Step-by-Step Medical Coding, 2020 Edition E-Book](#) Elsevier, 2019-11-28 NEW Coding updates include the latest information available promoting accurate coding and success on the job [Diabetes Care Documentation and Coding](#) Jerome S. Fischer, 2002

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