# FAQ's for HCC

**Q1. Why are you asking for HCC verification each year?**

A1. Per the Center for Medicare and Medical Services (CMS) the patient's health status must be re-confirmed on a yearly basis, otherwise they assume that the patient is "healthy".

**Q2. What if a medical condition is listed, but is unknown to PCP?**

A2. This gives the PCP an opportunity to discuss condition(s) with the patient to see if this is still relevant and how did this condition occurred without the PCP knowing (e.g.; patient went out of network, previous condition with a different PCP, did not mention when giving PMH).

**Q3. Why do some chronic conditions not qualify?**

A3. CMS has a specific set of ICD-9 codes that they decided that qualifies for HCC. Common Dx codes that do not qualify are LBP, HTN, Alzheimer, Dementia, Hyperlipidemia, anxiety, BPH, CAD. There is a list of non-qualifying common conditions viewing and/or printing from www.ppmsi.com/login, in the news section under "HCC Information and References" and then click on file" What Qualifies and Often Forgotten".

**Q4. Which ICD-9 Codes qualify?**

A4.The list of qualifying diagnosis codes associated to chronic and/or acute conditions can be downloaded for viewing and/or printing from www.ppmsi.com/login, in the news section under "HCC Information and References" and then click on file "ICD9HCC with descriptions"

**Q5. How many times do I need to discuss this condition with the patient?**

A5. Each condition only needs to be "confirmed" only once a year.

**Q6. Why should I do this?**

A6. As of 1/1/07 CMS is paying 100% based on HCC's. The effect on Affinity will be lower reimbursement from the insurance companies, if patients with chronic and/or acute conditions are not "confirmed". Make sure that each one of your senior patient's are seen at least once a year, their conditions are documented and coded.

**Q7. How did we get the information that is on the HCC Member Editor?**

A7. We do claims and authorizations sweep daily. We get data from the insurance companies and CMS on a monthly or quarterly basis.

**Q8. What does not qualify?**

A8. **Physician:** Telephone Consults, Telemedicine

**Outpatient:** Laboratory Services, Radiology Services, Durable Medical Equipment, Supplies, Orthotics, Prosthetics, and Ambulance.

**Inpatient:** Hospice, Skilled Nursing Facilities (SNF), Hospital Inpatient Swing Bed Components, Intermediate Care Facilities, and Respite Care.

**Q9. Do I have to document the HCC condition before I confirm it on the HCC Member Editor?**

A9. Yes, documentation (see FAQ #8 for non qualifying documentation) in the patients chart prior to confirmation in the HCC Member Editor.

**Q10. What if a diagnosis is not listed on the HCC Member Editor?**

A10. Locate the member in the HCC Member Editor. Click on "Add New ICD9 Code" or "Add New ICD9 Code – By HCC Category". Enter in ICD-9 code or locate by HCC Category.

**Q11. What if a diagnosis that is listed is no longer relevant or was incorrect?**

A11. The HCC Member Editor does allow you to exclude one diagnosis code at a time. Locate the member in the HCC Member Editor. Click on "Edit" next to the ICD-9 code you would like to exclude. Click on "Exclude?" and a drop down of exclusion reasons will appear. Click on the specific exclusion reason and the system will automatically refresh which will take off the diagnosis from the patient's HCC diagnosis summary.

**Q12. Why should the PCP document a condition that the specialist is seeing the patient for?**

A12. There is a possibility that the specialist may not see the patient that year, but the PCP does process an authorization request and/or refill medication associated to the condition that the specialist sees the patient for.

**Q13. How many "confirmations" can I enter into the HCC Member Editor?**

A13. Providers and/or staff can enter in as many Dates of Service(s) associated to as many diagnosis codes as you have. There is no limit.