Risk Adjustment Toolkit

For clinics using the Optum In-Office Assessment program

This packet provides convenient access to risk adjustment information, including educational materials you can share with your staff. We appreciate your attention to this important topic, which helps predict patient healthcare needs and costs.

Contents

Title	**Media Type** (all PDFs)
Risk Adjustment 101 for Providers	PowerPoint presentation
Risk Adjustment and the Optum IOA Tool 2025 FAQ (Optum deployment only)	Flier
2025 Common HCC ICD-10 Codes	Flier
What to know about CMS-HCC Version 28	Flier
Risk Adjustment - Closing HCC Gaps – Sample Workflow Using the Optum Program - 2025 (Optum deployment only)	Flier
Risk Adjustment Documentation and Coding Part I: Introduction and Coding for Diabetes and Neoplasm	PowerPoint presentation
Risk Adjustment Documentation and Coding Part II: Coding for Obesity and Major Depressive Disorder	PowerPoint presentation
Risk Adjustment Documentation and Coding Part III: Coding for Circulatory Disorders	PowerPoint presentation
Risk Adjustment Documentation and Coding Part IV: Coding for Seizures, Epilepsy, and Dementia	PowerPoint presentation
Risk Adjustment Topics: Transitioning from Model V24 to V28 and Provider Query	PowerPoint presentation

If you have questions, please contact the Population Health Team at PopulationHealth@PacificSource.com.

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal.

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Risk Adjustment 101
For Providers

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Discussion topics

- Why is risk adjustment important for providers?
- What is risk adjustment?
- Risk adjustable populations
- Risk adjustment model
- Risk adjustment success – tips and tricks

Why is risk adjustment important for providers?

- Ensures that health conditions, health status, and demographics are accurately documented to reflect patient complexity
- Helps to ensure that Medicare and Affordable Care Act beneficiary health conditions are being addressed at least annually
- Helps to ensure that the health plans managing these beneficiaries are adequately compensated, which can result in:
  - More affordable health plans
  - Additional value-added health plan benefits (such as wellness and fitness programs, and “Meals as Medicine” programs)
  - Higher payments to providers with value-based payment arrangements

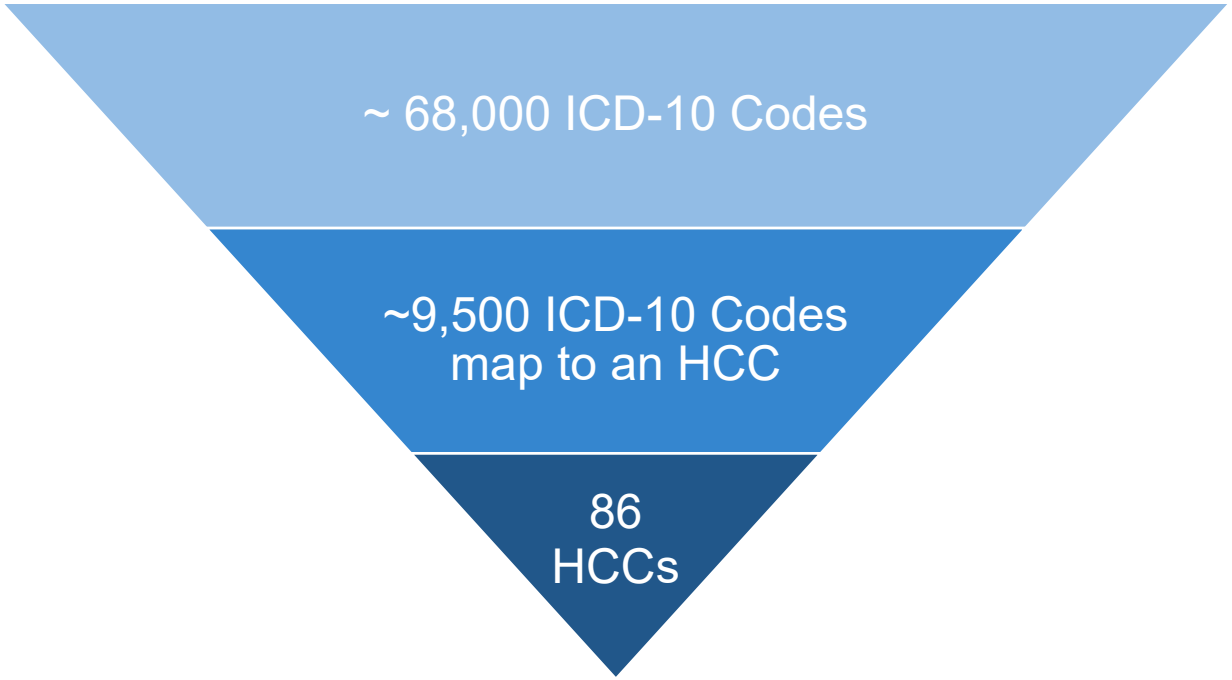
Definition of risk adjustment

- Risk adjustment is a statistical process that considers the underlying **health status** and **health spending** of the enrollees in an insurance plan when looking at their **healthcare** outcomes or **healthcare** costs.
- **Risk adjustment data** is pulled from diagnosis data reported from claims and medical record documentation from physician offices, as well as hospital inpatient and outpatient settings.
- In plain English: Risk adjustment is a way to predict patient healthcare needs and costs by using the patient's diagnoses.

Risk Adjustable Populations

Hierarchical condition category (HCC)

- HCCs are a grouping of clinically related diagnoses with similar cost implications.
- Only those diagnoses that map to an HCC are used to calculate risk scores.
- Every year, a new model is released with new diagnosis codes to HCC mappings.



Calculating the risk score

Every patient is assigned a risk score.

Example: A 74-year-old female diagnosed with Type 2 diabetes mellitus with hyperglycemia (E1165) and chronic obstructive pulmonary disease, unspecified (J449).

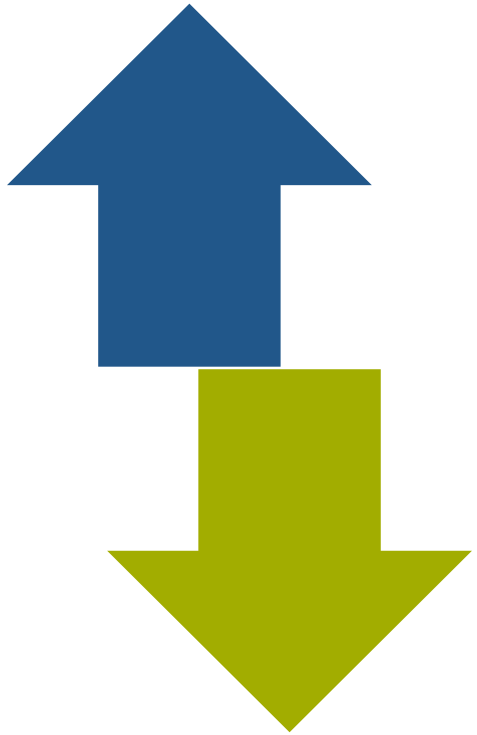
*Factors related to age, sex, disabled status, original entitlement reason, and Medicaid status are what make up demographics for a Medicare Advantage member.

Interpreting the risk score

Higher risk scores =
patients with greater-than-average disease burden

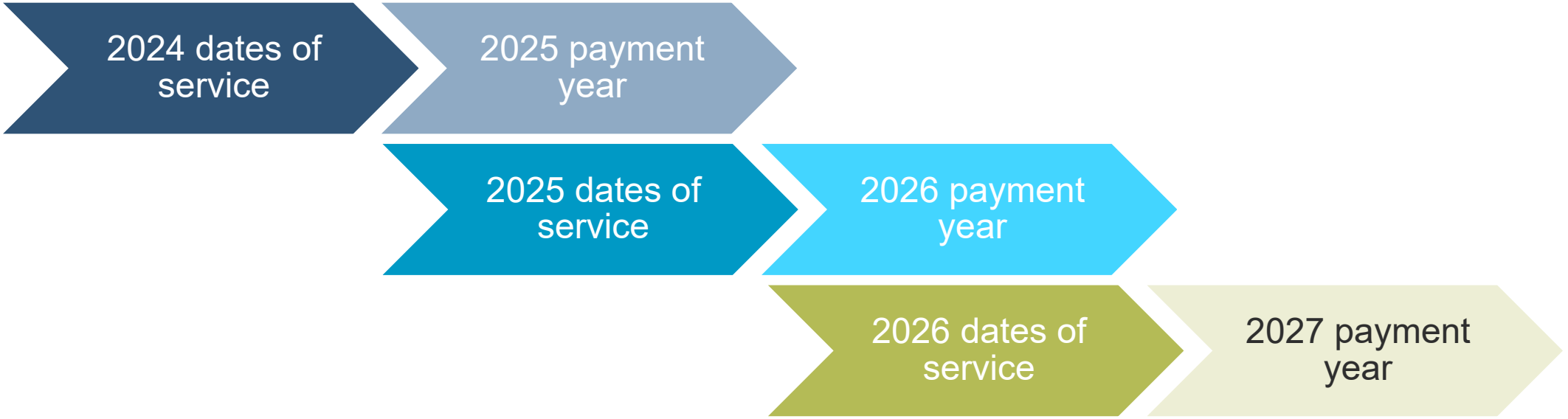
Lower risk scores =
healthier patients, but may also incorrectly indicate overall health due to:

- Inadequate or incomplete chart documentation
- Inaccurate or incomplete diagnosis coding



Risk model overview | MA model

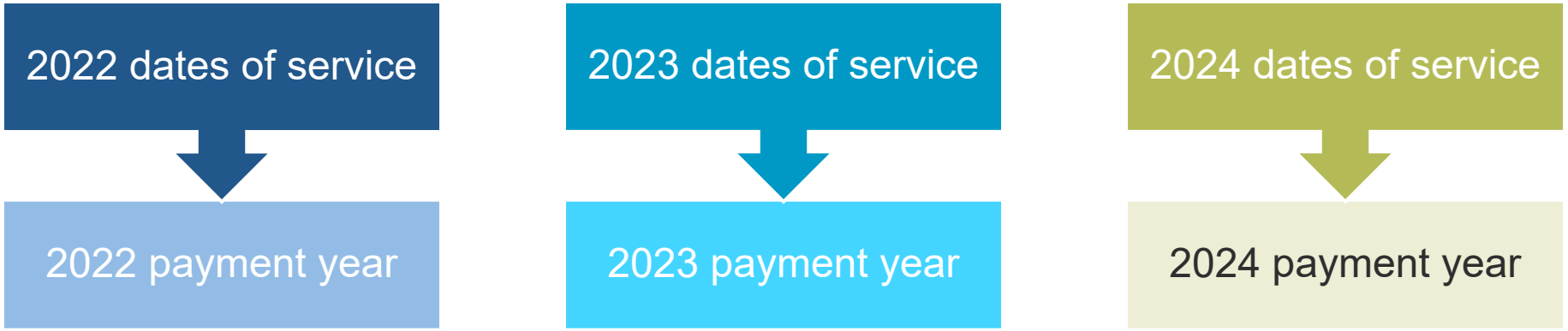
Prospective model



CMS/OHA requires chronic conditions to be reported annually for payment. (Patient risk scores are reset each year.)

Risk model overview | commercial model

Concurrent model



- ***CMS requires chronic conditions to be reported annually for payment. (Patient risk scores are reset each year.)***
- Individual and small-group members on ACA plans

Risk adjustment terms/definitions

Payment year – The enrollment year. Example: PY2021 CMS is paying for health plan members enrolled in 2021.

Base year – The dates of service used for a payment year. Example: PY2024 has a base year of 2023.

Stayers – 12 months of enrollment in base year, all 12 with PacificSource.

New members – 12 months of enrollment in base year, not all with PacificSource.

New enrollees – Does not have 12 months of Medicare Advantage (MA) enrollment in the base year, only has a demographic component of their risk score.

ESRD – End stage renal disease. A different model is used to calculate these patients' risk scores than the rest of the MA population.

Hospice – Hospice patients receive a risk score of zero. Hospice is not funded through risk adjustment, thus risk scores are zeroed out.

Risk adjustment success – tips and tricks

- Risk adjustment scores reset every year. Providers must document and code active diagnoses annually, even chronic conditions.
- The annual wellness visit is a good opportunity to capture all appropriate diagnoses.
- Preventive screenings, such as screening of risk factors for depression, functional status, and fall risk can aid in identifying additional diagnoses that contribute to a patient's risk.
- Document and code to the highest level of specificity to give an accurate picture of each patient's health status.
- Telehealth visits must include both audio and video to be risk adjustable.
- Use MEAT principles: a diagnosis should be (M)onitored, (E)valuated, (A)ssessed, or (T)reated (see the next slide).

Reference: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html

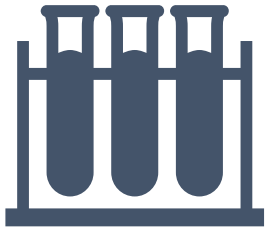
Understanding MEAT

Monitor

Signs/symptoms

Disease progression/regression

Review of previous labs or other tests



Evaluate

Test results

Medication effectiveness

Response to treatment

Physical exam findings

Assess/address

Discussion, review records

Counseling

Ordering of new labs /tests

Treat

Medications Reconciliation

Surgical/other therapeutic interventions

Referral to specialist for treatment/consultation

Questions

Risk Adjustment and the Optum IOA Tool 2025 FAQ

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Does a clinic need to use the Optum In-Office Assessment (IOA) tool to be successful with risk adjustment?

Optum is a great way to begin risk adjustment work and start to understand the importance of hierarchical condition category (HCC) recapture and coding to specificity. However, a clinic can choose not to use the Optum IOA tool and make full use of any internal EHR tools like Best Practice Advisory (BPAs) or software that pushes information from PacificSource into their Electronic Medical Record (EMR).

What are some best practices for risk adjustment work?

- Implementing pre-visit planning and post-visit review to identify HCC gaps
- Scheduling patients who do not have upcoming appointments
- Designating a provider champion who understands the value of HCC recapture
- Facilitating leadership buy-in and provider accountability
- Facilitating contract alignment and considering financial incentives for providers
- Tracking BPA use (if available in your EMR) and providing feedback
- Offering HCC coder staff training and coder feedback to providers prior to billing

Can clinics amend notes and resubmit claims for recent visits to capture HCC diagnoses? If so, what is the process?

The Centers for Medicare and Medicaid Services (CMS) allows amendments to a chart note within a reasonable amount of time after the original date of service. **Industry standard to amend a chart is 30 days after the visit date.** Claims may be resubmitted after the original submission. Defer to your billing office to submit a corrected claim.

When reviewing a suggested HCC diagnosis that does not apply to the member (either because the condition has resolved or the diagnosis is incorrect), what is the process for notifying PacificSource to request the removal of this gap from the list?

Clinics can email this information to RiskAdjustmentAnalytics@PacificSource.com in one of the following ways:

A. Send the Member ID, HCC, or diagnosis code along with an explanation

B. Send the HCC gap list Excel file back to us with the addition of a column that explains why the diagnosis is resolved or incorrect

Send the information in either format to RiskAdjustmentAnalytics@PacificSource.com.

Optum: We are working with Optum to remove HCCs that providers submit to us as not applicable or resolved. In the meantime, your providers can assess—**but not diagnose**—those conditions to get CGAP credit for the program to help meet the closure rate.

PacificSource's software seems to only allow a certain number of ICD codes, and ghost claims have to be submitted for additional diagnoses. Is there a way to change the number of codes your software accepts?

Your EMR or your claims clearinghouse may be limiting the number of codes. Please contact PopulationHealth@PacificSource.com for more help.

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Are the Hierarchical Condition Category (HCC) gaps in the Optum IOA tool the same as the HCC Medicare gap list sent to clinics?

The gaps are essentially the same, but there are slightly different calculations used to determine which gaps are listed. You can use either or both tools to capture HCCs. Optum provides a way to organize and document the work and capture additional HCCs.

PacificSource includes diagnoses that are captured, submitted, and accepted by CMS. Optum casts a wider net to include captured and submitted diagnoses from CMS where PacificSource was not the payor.

Optum payments and quality gap information for 2025

- Optum has made changes to thresholds across all *health plans* for 2025. This includes 100% HCC recapture for both Medicare and Commercial (ACA) as well as 80% for Medicare quality gap closure.
- Optum payments are made weekly via ACH within 45 days of submission
- **Medicare**
  - For 2025, PacificSource has set the following performance expectations that will continue in 2026:
    - 75% IOA return rate
    - 50% Comprehensive Gap Assessment Program (CGAP) criteria met (chart documentation supports recaptured HCCs)
  - Changes to the payment model have been made for 2025 to encourage improved quality documentation
  - Administrative fee (timely filing within 60 days of the visit): $25 ($10 late)
  - HCC recapture threshold of 100% met: $75
  - Quality gaps closure rate of 80% met: $50
- **Commercial (ACA)**
  - Administrative fee (timely filing within 60 days of the visit): $25 ($10 late)
  - HCC recapture threshold of 100% met: $75

Medicare quality gaps for 2025

- Advance care planning
- Breast cancer screening
- Colorectal cancer screening
- Controlling high blood pressure—any reading
- Glycemic status assessment for patients with diabetes (≤9.0%)—any reading (revised—formerly A1C control)
- Eye exam for patients for diabetes
- Kidney health evaluation for patients with diabetes
- Care of older adults—functional status assessment, pain assessment
- Osteoporosis management for women who have had a fracture
- Medication adherence for patients with hypertension, diabetes, and cholesterol
- Statin therapy for patients with cardiovascular disease
- Statin use in persons with diabetes

Commercial (ACA) quality gaps for 2025

- Breast cancer screening
- Colorectal cancer screening
- Cervical cancer screening
- Controlling high blood pressure—any reading
- Glycemic status assessment for patients with diabetes (≤8.0%)—any reading (revised—formerly A1C control)
- Eye exam for patients for diabetes
- Kidney health evaluation for patients with diabetes
- Statin therapy for patients with diabetes
- BMI percentile documentation
- Nutrition counseling
- Physical activity counseling

Questions?

Contact the Population Health team at:
PopulationHealth@PacificSource.com

2025 Common Hierarchical Condition Categories (HCC) ICD-10 Codes

PacificSource

Clear, supportive documentation is critical for accurate coding in risk adjustment.

1. Document and code all conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management.
2. The encounter note must be complete, legible, and include the provider signature and credentials.
3. Code to the highest level of specificity and certainty documented in the encounter.

Endocrine, Nutritional, and Metabolic Disease (E00-E89)		
Diabetes mellitus (DM)	Type 1	Type 2
Use additional code *to identify insulin use.*		Z79.4
Diabetes mellitus without complications	E10.9	E11.9
Complete documentation must include type, control, and complications affecting body system(s) if applicable.		
Diabetes mellitus with hyperglycemia	E10.65	E11.65
When documentation specifies diabetes mellitus as "poorly controlled", "inadequately controlled," or "out of control", diabetes mellitus with hyperglycemia should be coded. Uncontrolled diabetes indicates that the patient's blood sugar is not at an acceptable level, because it is either too high or too low; therefore, there is no default code for "uncontrolled".		
Diabetes mellitus with diabetic nephropathy	E10.21	E11.21
When both diabetic nephropathy and chronic kidney disease (CKD) are documented, code only diabetic CKD, as it is more specific.		
Diabetes mellitus with diabetic chronic kidney disease	E10.22	E11.22
Use additional code *to identify CKD stage.*	N18.1-N18.6	N18.1-N18.6
Diabetes mellitus with unspecified diabetic retinopathy	E10.31-	E11.31-
Diabetes mellitus with diabetic cataract	E10.36	E11.36
Diabetes mellitus with diabetic neuropathy	E10.40	E11.40
Diabetes mellitus with diabetic polyneuropathy	E10.42	E11.42
Diabetes mellitus with diabetic peripheral angiopathy without gangrene	E10.51	E11.51
Diabetes mellitus with foot ulcer	E10.621	E11.621
Use additional code *to identify site of ulcer.*	L97.4-, L97.5-	L97.4-, L97.5-
Assign as many codes from categories E08-E13 as needed to identify all the diabetic complications documented.		
Morbid (severe) obesity due to excess calories	E66.01	
Use additional code *to identify BMI, if known.*	Z68.-	
Document and evaluate for morbid obesity in patients with BMI ≥ 40. BMI codes are never intended to be used as stand-alone codes; providers must document a clinically significant weight-related condition to capture **Z68** codes.		
Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)		
Unspecified dementia, unspecified severity, without behavioral disturbance		F03.90
Unspecified dementia, unspecified severity, with behavioral disturbance		F03.91-
Bipolar disorder, unspecified		F31.9
Major depressive disorder, single episode, moderate		F32.1
Major depressive disorder, single episode, severe, without psychotic features		F32.2
Major depressive disorder, single episode, severe, with psychotic features		F32.3
Major depressive disorder, recurrent, moderate		F33.1
Major depressive disorder, recurrent, severe, without psychotic features		F33.2
Major depressive disorder, recurrent, severe, with psychotic features		F33.3
Complete documentation requires the following: 1. Episode (single or recurrent), 2. Degree/severity (mild, moderate, severe with psychotic symptoms, severe without psychotic features), 3. Status (partial or full remission).		
Disease of the Nervous System (G00-G99)		
Alzheimer's disease	G30.-	
Must be confirmed by the providers' documentation to capture. Alzheimer's codes must be paired with an additional code from category **F02** as a manifestation of Alzheimer's. The physician does not have to mention dementia to code it.		
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909	
Do not assign **R56.9** when a patient has had a seizure disorder or recurrent seizures. When a seizure disorder or recurrent seizures are documented, use appropriate code from Category **G40**.		
Disease of the Circulatory System (I00-I99)		
Essential (primary) hypertension		I10
The classification presumes a causal relationship between hypertension, heart, and kidney involvement, unless the documentation clearly states the conditions are unrelated.		
Hypertensive heart disease with heart failure		I11.0
Use additional code to identify type of heart failure.		I50.-
Hypertensive heart disease without heart failure		I11.9
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease		I12.0
Use additional code to identify stage of CKD.		N18.5-N18.6

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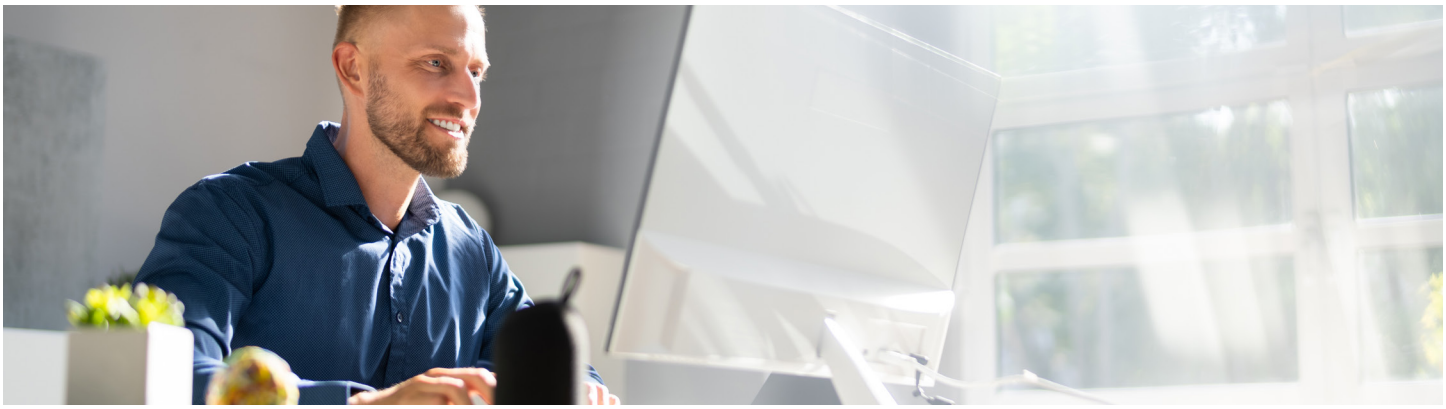
Disease of the Circulatory System (I00-I99) *cont.*	
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I12.9
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure with stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease	I13.10
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure and with stage 5 chronic kidney disease, or end stage renal disease	I13.11
Use additional code to identify stage of CKD.	N18.5-N18.6
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage kidney disease	I13.2
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.5, N18.6
Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	I25.110
Paroxysmal atrial fibrillation	I48.0
Longstanding persistent atrial fibrillation	I48.11
Other persistent atrial fibrillation	I48.19
Chronic atrial fibrillation, unspecified	I48.20
Permanent atrial fibrillation	I48.21
Unspecified atrial fibrillation	I48.91
Unspecified atrial flutter	I48.92
Sick sinus syndrome	I49.5
End stage heart failure	I50.84
Use additional code to identify the type of heart failure as systolic, diastolic, or combined, if known.	I50.2-I50.43
Heart failure, unspecified	I50.9
Diseases of the Respiratory System (J00-J99)	
Unspecified chronic bronchitis	J42
Emphysema, unspecified	J43.9
Chronic obstructive pulmonary disease with (acute) lower respiratory infection	J44.0
Use additional code to identify the infection.	
Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1
If COPD with acute exacerbation and COPD with lower respiratory infection are present: document and code both.	
Chronic obstructive pulmonary disease, unspecified	J44.9
Severe persistent asthma	J45.5-
Respiratory failure	J96.-
Diseases of the Digestive System (K00-K95)	
Crohn's disease, unspecified	K50.9-
Ulcerative colitis, unspecified	K51.9-
Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)	
Rheumatoid arthritis, unspecified	M06.9
If known, document and code with or without rheumatoid factor, specific joint impacted along with laterality.	M05-M06.8A
Systemic lupus erythematosus, unspecified	M32.9
Diseases of the Genitourinary System (N00-N99)	
Chronic kidney disease, stage 3 unspecified	N18.30
Chronic kidney disease, stage 3a	N18.31
Chronic kidney disease, stage 3b	N18.32
Chronic kidney disease, stage 4 (severe)	N18.4
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Use additional code to identify dialysis status.	Z99.2
Factors Influencing Health Status (Z00-Z99)	
Tracheostomy status	Z93.0
Gastrostomy status	Z93.1
Ileostomy status	Z93.2
Colostomy status	Z93.3
Unspecified cystostomy status	Z93.50
Heart transplant status	Z94.1
Lung transplant status	Z94.2
Liver transplant status	Z94.4



What to know about CMS-HCC Version 28

The new CMS-Hierarchical Condition Categories (HCC) risk adjustment model, Version 28, is the only model in use for 2025 and includes changes to the Medicare Advantage (MA) capitation rate and risk adjustment methodologies. These changes significantly impacted risk adjustment factor (RAF) scores.

What's changed:

- The names and numbers of HCC codes
- How HCCs are mapped[1]
- The coefficient of HCC values
- The removal of 2,294 diagnosis codes that map to an HCC for payment
- 29 new HCCs
- 268 new diagnosis codes that did not previously map to an HCC

Version 28 HCCs are calibrated to capture more complete and accurate data about the health status of patients with chronic conditions. This helps health plans and medical practices better understand their patients' health needs to provide them with the care they need.

Coding is key for HCCs

To mitigate the potential financial impact of the Version 28 HCC model changes, consider investing in staff training and education to ensure clinical documentation is clear and supportive, and coding practices are up-to-date and compliant. Also consider working with certified medical coders and auditors to perform internal reviews and identify areas for improvement.

As the CMS-HCC risk adjustment model continues to grow and change, it's important to stay on top of these changes. This will ensure your organization can continue to provide quality patient care and receive the necessary financial resources to do so.

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Contact
PopulationHealth@PacificSource.com
541-284-7653
TTY: 711. We accept all relay calls.

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[1] For the proposed list of HCC-to-ICD-10-CM mappings, visit CMS.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/RiskOtherModel-Related.

Removal of 2,000+ codes

Over 2,000 codes were removed from the model to enhance predictive ability by better reflecting current disease patterns, treatment methods, and costs, as well as coding practices. Some examples include malnutrition, peripheral vascular disease (PVD), and amputation status.

The table below from the CMS Rate Announcement provides additional information on the underlying diagnosis code counts for the V24 (2020) and the V28 (2024) model.

	V24 (2020) CMS-HCC Model	V28 (2024) CMS-HCC Model
FY22/23 ICD-10 codes—total	73,926*	73,926*
FY22/23 ICD-10 codes—mapped to payment HCCs	9,797 (13.3%)	7,770 (10.5%)
FY22/23 ICD-10 codes—mapped to nonpayment HCCs	64,129 (86.7%)	66,156 (89.5%)
Not in V24 Model but added to V28 Model	-	209
In V24 Model but no longer mapped to payment in V28 Model	-	2,236
• No longer mapped—ICD-10 clinical updates	-	2,161 (96.6%)
• No longer mapped—Principle-10 focused updates related to discretionary coding	-	75 (3.4%)
HCCs—total	204	266
HCCs—payment	86 (42.2%)	115 (43.2%)
HCCs—nonpayment	118 (57.8%)	151 (56.8%)

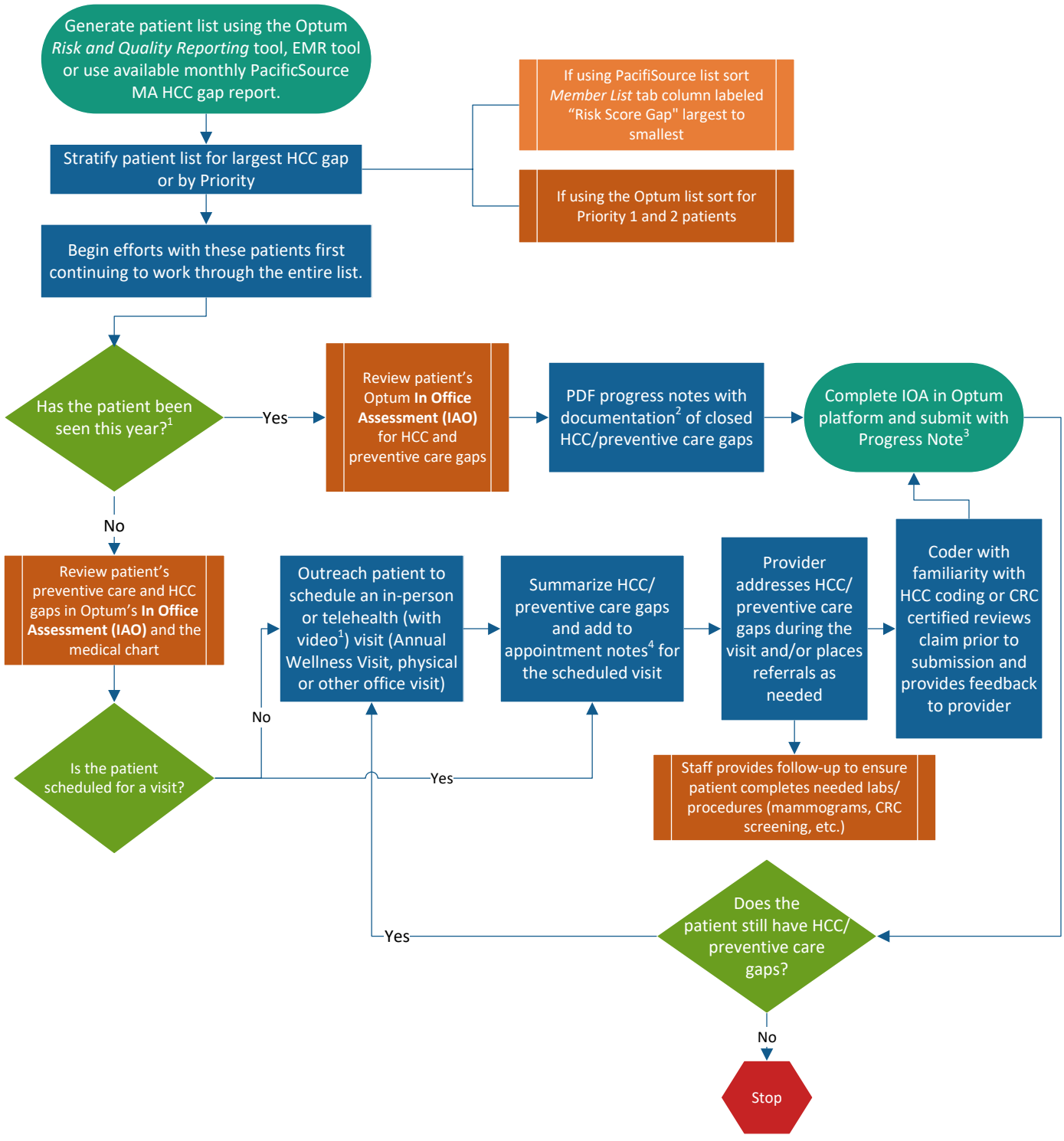
* The total number of ICD-10 diagnosis codes varies by fiscal year.

Resources

1. AACP Editorial Staff. (2023, May 2). *What is risk adjustment?* American Academy of Professional Coders. AAPC.com/resources/what-is-risk-adjustment
2. Centers for Medicare and Medicaid Services. (2023, March 31). *Fact Sheet: 2024 Medicare Advantage and Part D Rate Announcement.* Centers for Medicare and Medicaid Services. CMS.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement
3. Goel, A. J., Curran, E. R., & O'Brien, K. (2023, April 5). *CMS Finalizes Risk Adjustment Model in 2024 Rate Announcement for Medicare Advantage and Part D.* Insights. MWE.com/insights/cms-finalizes-risk-adjustment-model-in-2024-rate-announcement-for-medicare-advantage-and-part-d/
4. Stearns, M., James, M., & Rykaczewski, K. (2023, February 27). *How CMS-HCC Version 28 will impact risk adjustment factor (RAF) scores.* Wolters Kluwer. WoltersKluwer.com/en/expert-insights/how-cms-hcc-version-28-will-impact-risk-adjustment-factor-raf-scores#:~:text=CMS%20made%20significant%20changes%20to,An%20expanded%20number%20of%20HCCs

Risk Adjustment - Closing HCC Gaps – Sample Workflow Using the Optum Program - 2025

The Optum program allows our clinic partners to identify their Medicare Advantage (and ACA) covered patients with HCC and preventive care gaps that need to be addressed by the provider. Where possible, centralized management of the program for clinics is recommended to accurately track that each patient has been outreached and completed a visit with their provider. Clinic partners are encouraged to use existing Electronic Medical Record (EMR) Best Practice Advisories to close HCC and preventive care gaps and population based tools to more efficiently identify patients with and without a visit scheduled when available.



[1]Patient visits must be in-person or if the visit is conducted via telehealth include a video component to be risk-adjustable
[2]Complete Progress Note must be submitted including diagnosis, notes addressing gaps, DOS, type of visit, and electronic signature
[3]In-Office Assessments must be returned within 60 days for the full administrative fee - all returns must be submitted by 1/31/2026
[4]Different tools are available based on EMR capabilities to get this information in front of the provider for an upcoming visit – Use the tool that work best for your practice. EMR tools that place diagnoses in front of providers at the time of the visit can be very successful in recapturing HCC diagnosis and require less manual work.

Risk Adjustment Documentation and Coding

Part I: Introduction and Coding for Diabetes and Neoplasm

PacificSource

12/24

Agenda

Introduction

- The concept of support
- Understanding MEAT

Diabetes documentation and coding

- Overview
- Diabetes types
- Diabetes control
- Diabetes complications
- Diabetes MEAT examples

Neoplasm documentation and coding

- Overview
- Neoplasm best practices
- Neoplasm status
- Neoplasm MEAT examples

The concept of support

- Code all documented conditions that *coexist at the time of the encounter/visit **and** require or affect patient care, treatment, or management.*
  (ICD-10 CM outpatient coding guidelines)
- Per CMS medical reviewer guidance: "*MA Organization is required to submit medical records to support all CMS-Hierarchical Condition Categories (HCCs) in the sampled beneficiaries' risk scores for the payment year.*"

The concept of support

- Coding professionals should not assign codes based solely on diagnoses noted in the history, problem list, and/or a medication list. It is the provider's responsibility to document that the chronic condition *affected care and management* of the patient for that encounter.
  (AHA CC, Q3 2021)
- **MEAT** was created by health plans to support coders in abstracting conditions that impact a patient's health status.

Understanding MEAT

Monitor

Signs/symptoms

Disease progression/ regression

Review of previous labs or other tests

Evaluate

Test results

Medication effectiveness

Response to treatment

Physical exam findings

Assess/Address

Discussion, review records

Counseling

Ordering of new labs/ tests

Treat

Medication reconciliation

Surgical/other therapeutic interventions

Referral to specialist for treatment/consultation

Diabetes documentation and coding

Diabetes documentation and coding

- Diabetes is a chronic condition that is often miscoded.
- Complete documentation must include:
  - Type

    If not documented, the default per ICD-10 CM guidelines is type 2
  - Control

    No default code assignment for uncontrolled in ICD-10 CM Index
  - Complications affecting body system(s)

    Best practice is to always document causal relationships

Diabetes types

ICD-10 CDM Category	Description	Note
E08-	Diabetes mellitus due to underlying condition	Code first the underlying condition. Use additional code to identify insulin use.
E09.-	Drug or chemical-induced diabetes mellitus	Code first poisoning due to drug or toxic, if applicable. Use additional code for adverse effect, if applicable. Use additional code to identify insulin use.
E10.-	Type 1 diabetes mellitus	No additional code needed to identify insulin use.
E11.-	Type 2 diabetes mellitus	Use additional code to identify insulin use.
E13.-	Other specified diabetes mellitus	Use additional code to identify insulin use.

Diabetes control

Control	Documentation	ICD 10-CM
Uncontrolled – No default code. Assign E11.9, without complications, if no further specified.	Explicitly specified as hyperglycemia	E11.65
	Explicitly specified as hypoglycemia	E11.649
Poorly controlled	Alphabetic index directs to “with hyperglycemia”	E11.65
Inadequately controlled	Alphabetic index directs to “with hyperglycemia”	E11.65
Out of control	Alphabetic index directs to “with hyperglycemia”	E11.65

Diabetes complications

- Use as many codes from categories E08–E13 as necessary to capture all diabetic complications, as they illustrate the need for different care management.
- The classification presumes a causal relationship between diabetes and any condition listed under the term “with” in the ICD-10 CM Alphabetic Index.
  - These conditions should be coded as related **unless** the provider clearly documented that they are unrelated.

Diabetes complications

- For conditions not specifically linked by these relational terms in the classification, provider documentation must establish causal relationships.
  - Examples: Diabetic, due to diabetes, secondary to diabetes

Diabetes complications: Examples

Body system	Complications with presumed link	ICD-10 CM	Note
Kidney	Chronic kidney disease (CKD)	E11.22	Use additional code for CKD stage. Use additional code for dialysis status, if applicable.
Eye(s)	Cataract	E11.36	
Nervous	Neuropathy	E11.40	
Skin	Foot ulcer	E11.621	Use additional code for ulcer site and severity (L97.4-, L97.5-).

Diabetes MEAT examples

Monitor	• **Type 1 diabetes** Well controlled. A1C 6.1; patient is snacking less and following a healthy diet.
Evaluate	• **Type 2 diabetes with polyneuropathy** Controlled on Amaryl. Decreased sensation noted over both lower extremities.
Assess/Address	• **Type 2 diabetes with hyperglycemia** Uncontrolled. Recheck A1C today. Patient was counseled on the importance of diabetes control.
Treat	• **Type 2 diabetes** Continue current medication. Ophthalmology referral for due yearly eye exam.

Neoplasm documentation and coding

Neoplasm documentation and coding

- Neoplasm coding, especially malignant, significantly affects patient outcomes and healthcare priorities.
- Clear and detailed documentation includes:
  - Anatomical location
    Laterality if applicable
  - Behavior
    Benign, malignant, in situ, uncertain, unspecified, metastasized
  - Status
    Active vs. historical, in remission, in relapse
  - Complications
    Neoplasm-related and treatment-related

Neoplasm coding best practices

- When terms like “mass,” “lump,” “tumor,” or “growth” are documented, start in the Alphabetic Index and look up the exact words from documentation. Never code these conditions using the Neoplasm Table.
- Know the difference between uncertain vs. unspecified neoplasm: An uncertain neoplasm has been examined microscopically, but its nature could not be ascertained. An unspecified neoplasm has an unknown etiology because no microscopy examination has been performed or documented.

Neoplasm coding best practices

- Metastatic or secondary neoplasm: Documentation should clearly reflect the primary site and secondary site(s). Code accordingly.

Neoplasm status

Active	Historical
Newly diagnosed: Developing treatment plan, reviewing pathology finding	Cancer excised with no further treatment
Ongoing treatment: Chemotherapy, radiation therapy, surgical intervention	No evidence of malignancy (NED)
Refusal of therapeutic treatment	Under surveillance for recurrence
Watchful waiting: Risks outweigh benefits	Adjuvant therapy specified for *prophylactic* purposes

Neoplasm MEAT examples

Monitor	• **History of prostate cancer** No reported new symptoms, continue monitoring PSA
Evaluate	• **Malignant neoplasm of upper-inner quadrant of right female breast** Biopsy done 10/20; results show stage 3 breast cancer
Assess/Address	• **Stage 4 malignant neoplasm of right main bronchus with liver metastasis** Patient counseled on treatment options but refused to proceed. Discussed palliative care options
Treat	• **Prostate Cancer** Receiving radiation therapy; referral to a new urologist

Questions?

Risk Adjustment Documentation and Coding

Part II: Coding for Obesity and Major Depressive Disorder

PacificSource

Agenda

Obesity documentation and coding

- Overview
- Body Mass Index
- Obesity MEAT examples

Major depressive disorder documentation and coding

- Overview
- Coding tips
- Major depressive disorder MEAT examples

Obesity documentation and coding

Obesity documentation and coding

- Weight-related diagnoses are often under-coded, although they are always considered clinically significant and reportable when documented in the medical record.
- To capture a weight-related condition, clinical documentation must:
  - **Support the presence of the condition.** Diagnosis documented in the history of present illness (HPI), physical exam (PE), and/or assessment and plan (A/P) sections.
  - **Outline the provider's plan for management of the condition**. Discussion of the patient's weight condition and a plan of care for it. Examples include referral to a dietitian, counseling on weight loss, nutritional counseling, lifestyle counseling, dietary changes, increased physical activity, and behavior modifications.

Obesity documentation and coding

- Not all weight-related diagnoses are treated equally under the risk adjustment model. For example, overweight and obese diagnoses do not affect risk adjustment payment. Morbid obesity, however, affects risk adjustment calculations and is weighted highly in risk and resource utilization.
- Complete documentation and accurate coding are critical for proper risk adjustment reimbursement. This includes:
  - **Severity:** Obese, overweight, morbid obesity
  - **Contributing factors:** Excess calories, drug-induced
  - **Comorbidities:** Coronary heart disease, atherosclerotic diseases (PVD/PAD), Type 2 diabetes, sleep apnea/respiratory problems (e.g., chronic obstructive pulmonary disease)
- Class 3 obesity is synonymous with morbid obesity, which is classified to code **E66.01**. For Class 1 and Class 2 obesity, query the provider to determine the type or etiology of the obesity if the documentation does not specify this information (AHA CC Q2 2022, p. 9).
- Effective October 1, 2024, use the appropriate code from category E66.8- to code obesity by class.

Body Mass Index (BMI)

- Use additional code for Body Mass Index (BMI)
  - BMI over 40 kg/m2 carry value in risk adjustment.
  - BMI codes were never intended to be used as stand-alone codes. The provider must document a clinically significant, weight-related condition (such as morbid obesity, obesity, overweight, underweight, malnutrition, cachexia, eating disorders, or abnormal weight gain/loss) to capture a code for BMI (AHA CC, Q4 2018, p. 77).

Body Mass Index (BMI)

- Use additional code for Body Mass Index (BMI)
  - BMI code assignment may be based on medical record documentation from clinicians who are not the patient's provider (healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record). However, the associated diagnosis must be documented by the treating provider (ICD-10 Guidelines I.B.14).
  - Coders cannot make the calculation to get an undocumented BMI.
  - Coders cannot imply a weight-related diagnosis based on BMI value.

Obesity MEAT examples

Monitor	• **Morbid obesity due to excess calories** • During last visit, we asked patient to count calories/day, and today, they reported back more than 2,000 calories/day with snacking a lot between meals.
Evaluate	• **Obesity with Type 2 diabetes mellitus** • A1C elevated; increased abdominal fat noticed in physical exam; encouraged physical activity.
Assess/Address	• **Morbid obesity due to excess calories** • BMI 42. Counseled on importance of dietary changes to achieve target weight goal.
Treat	• **Morbid obesity due to excess calories** • Referral to dietitian.

Major depressive disorder documentation and coding

Major depressive disorder documentation and coding

- Depression is a common mental health disorder. Approximately 30% of patients report symptoms of depression to their primary care providers. However, fewer than 10% of these patients have major depression (AHA CC, Q4 2021, p. 9).
- Effective October 1, 2021, a code was created to identify depression unspecified: **F32.A**.
  - Previously in ICD-10-CM, the default for depression not otherwise specified (NOS) was code **F32.9**, *Major depressive disorder, single episode, unspecified*. However, this code did not separately capture the actual occurrence of depression not further specified, and statistically inflated the incidence of major depressive disorder.

Major depressive disorder documentation and coding

- Coders cannot code mental health disorders from problem lists or past medical history.
- Coders cannot assume diagnoses based on medications list or screening tools (PHQ-9). Providers must reiterate the condition with complete clinical documentation.

Major depressive disorder documentation

Complete clinical documentation is critical for accurate coding and must include the following:

- Episode
  - Single
  - Recurrent
- Severity/degree
  - Mild, moderate, severe with psychotic symptoms, severe without psychotic features
- Status
  - Current, partial remission, or full remission

Depression coding tips

- Bipolar disorder and recurrent major depressive disorder
  - Assign code **F31.9**, *Bipolar disorder, unspecified*. Bipolar disorder includes both depression and mania, and it is more important to capture the bipolar disorder. Therefore, a code for depression would not be reported separately *(AHA CC, Q1 2020, p.23).*

Depression coding tips

- Depression with anxiety
  - The classification does not assume a linkage between depression and anxiety. Unless there is a linkage in the documentation to indicate a single disorder, these conditions should be coded separately *(AHA CC, Q1 2021, p. 10).*
    - ✓ If the provider does indicate a relationship between the two conditions (anxiety depression, or mixed anxiety and depressive disorder, also known as MADD), it would be appropriate to assign code **F41.8**, *Other specified anxiety disorders*.

Major depressive disorder MEAT examples

Monitor	• **Major depressive disorder, single episode, moderate** • Patient presents with feelings of sadness and hopelessness most days.
Evaluate	• **Major depressive disorder, recurrent, moderate** • Patient is very irritable and looks very tired during physical exam. Increase Paxil dosage.
Assess/Address	• **Major depressive disorder, recurrent, in partial remission** • Collaborate with therapist as needed. Reinforcement to keep taking medications consistently. Safety reviewed.
Treat	• **Major depressive disorder, recurrent, in partial remission** • Continue therapy. Continue Fluoxetine current dose.

Questions?

Risk Adjustment Documentation and Coding

Part III: Coding for Circulatory Disorders

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Agenda

- Coding atrial fibrillation
- Coding heart failure
- Coding cerebral infarction

Atrial Fibrillation Documentation & Coding

Atrial fibrillation definition and types

Definition

Cardiac dysrhythmia is a disturbance in heart rhythm, including rate, regularity, and sequence of atrial and/or ventricular contractions. Atrial fibrillation is the most common dysrhythmia. It occurs when the two upper chambers of the heart lose their normal rate and rhythm, and beat chaotically, increasing the risk of blood clots forming in the heart as well as thromboembolic stroke. Atrial fibrillation is typically treated by electrical or pharmacological cardioversion.

Types

- **I48.0,** *Paroxysmal atrial fibrillation* – Occurs when a rapid, erratic heart rate begins suddenly and then stops on its own. Episodes may last minutes, hours, or days.
- **I48.11,** *Longstanding persistent atrial fibrillation* – Does not resolve on its own and has lasted for more than a year. Repeat electrical cardioversion and antiarrhythmic drugs are required.
- **I48.19,** *Other persistent atrial fibrillation* – Does not terminate within seven days. It cannot get back to its regular rhythm on its own.
- **I48.20,** *Chronic atrial fibrillation, unspecified* – May refer to any persistent, longstanding persistent, or permanent atrial fibrillation. It is only coded based on the provider's documentation.
- **I48.21,** *Permanent atrial fibrillation* – Resistant to treatment and cannot be converted to a normal rate and rhythm, even with medication and attempts at electrical cardioversion, or where cardioversion is contraindicated.

Atrial fibrillation coding tips

- **Chronic atrial fibrillation**

  The use of one of the more specific descriptive terms, when documented, is preferred over the use of the nonspecific term “chronic atrial fibrillation.”

  Example: Assign I48.19, *Persistent atrial fibrillation* for a documentation of chronic persistent atrial fibrillation. Chronic atrial fibrillation is a nonspecific term that could be referring to paroxysmal, persistent, long-standing persistent, or permanent atrial fibrillation. Since code I48.20 is nonspecific, code I48.19 is a more appropriate code assignment (*AHA CC 2019 Q2 p3*).

- **Chronic atrial fibrillation with rapid ventricular response**

  Assign code **I48.20,** *Chronic atrial fibrillation*, for chronic AF with RVR. The RVR is not coded separately. Chronic atrial fibrillation with rapid ventricular response (RVR) indicates problems with rate control, not paroxysmal atrial fibrillation (*AHA CC 2018 Q3 p6*).

- **History of atrial fibrillation on anticoagulant therapy**

  Query the provider for clarification of whether the patient has a history of atrial fibrillation that has resolved, or whether the atrial fibrillation is a chronic condition, currently maintained on long-term anticoagulation (*AHA CC 2013 Q4 p101*).

Heart Failure Documentation & Coding

Heart failure overview

Congestive heart failure (CHF) is the inability of the heart to pump blood efficiently, thus compromising circulation and causing *systemic complications* due to congestion and edema of fluids in the tissues.

Ejection fraction (EF) indicates the amount of blood that is pumped out from the ventricle to the body during systole (the phase in which the heart muscle contracts).

CHF includes two types: systolic and diastolic; patients may have components of both.

Systolic heart failure	Diastolic heart failure
Dilated, weak heart, and/or thin ventricular wall	Thickened myocardium/hypertrophic ventricle
Impaired ventricular pumping function	Impaired filling with blood
Ejection fraction (EF) less than 40% (“reduced” EF)	Ejection fraction (EF) preserved
Code **I50.2-**: • Heart failure with reduced ejection fraction (HFrEF) (mid-range or mildly) • Heart failure with low ejection fraction • Heart failure with reduced systolic function	Code **I50.3-**: • Heart failure with preserved ejection fraction (HFpEF) • Heart failure with a recovered EF • Heart failure with normal ejection fraction

Heart failure coding tips

- **Decompensated/exacerbated**
  - These terms indicate that there has been a flare-up (acute phase) of a chronic condition (*AHA CC 2008 Q3 p9*).
  - *Example*: Assign code **I50.23**, *Acute or chronic systolic heart failure*, for decompensated systolic heart failure.
- **Heart failure with dysfunction**
  - When the provider has linked either diastolic or systolic dysfunction with acute or chronic heart failure, it should be coded as “acute/chronic diastolic or systolic heart failure.”
  - If there is no provider documentation linking the two conditions, assign code **I50.9,** *Heart failure, unspecified* (AHA CC 2017 Q1 p46).

Heart failure coding tips, continued

- **Heart failure with hypertension**
  - Assign code **I11.0**, *Hypertensive heart disease with heart failure*, along with the appropriate code from category **I50.-**, *Heart failure*, for CHF in a patient with hypertension.
  - The classification presumes a causal relationship between hypertension and heart involvement, unless the provider documents that the conditions are unrelated (*ICD-10 CM C.9.a.1*).
- **End stage heart failure**
  - The American College of Cardiology and the American Heart Association classify heart failure in stages. End stage heart failure falls into stage D of this classification.
  - Use additional code to identify the type of heart failure as systolic, diastolic, or combined, if known (*AHA CC 2017 Q4 p15*).

Heart failure MEAT/supporting documentation

Monitor	• Signs and symptoms such as shortness of breath (SOB) or dyspnea, edema in extremities, fatigue, weakness
Evaluate	• Findings in the physical exam (PE), such as presence or absence of swelling in ankles, abnormal lung sounds, or heart sounds • Reviewing lab values (B-type natriuretic peptic (BNP)) and imaging (echocardiography, stress test, coronary angiogram)
Assess/Address	• Ordering labs and/or imaging • Discussing cardiac surgery • Counseling on heart-healthy diet and physical activity
Treat	• Medications reconciliation • Specialist referrals

Cerebral Infarction Documentation & Coding

Cerebral infarction overview

- Cerebral infarction can result from a blocked blood vessel due to a thrombus, embolus, or a constriction or narrowing of an artery in the head or neck (stenosis).
  - A **thrombus** is a mass of platelets, fibrin, and other blood components that form within the precerebral or cerebral vessels that supply blood to the brain.
  - An **embolism** is a clot or thrombus that travels from a remote site to another site; in this case, the embolus travels to the precerebral or cerebral arteries.
- Thrombi and emboli can obstruct the cerebral arteries, causing damage from the lack of blood supply reaching the brain.
- Cerebral infarction is classified based on:
  - **Type of occlusion**: thrombosis, embolism, or stenosis
  - **Site of the occlusion**, which requires identification of the specific precerebral or cerebral artery.
  - **Laterality:** does not apply to the basilar artery, because it is a single blood vessel that joins the vertebral arteries and is located at the base of the skull.

Cerebral infarction coding tips

- Acute stroke (Category **I63.-**), also known as cerebral infarction or CVA, should be coded only during the initial episode of care.
- Do not code diagnoses documented as probably, suspected, likely, questionable, possible, still to be ruled out, or other similar terms indicating uncertainty in emergency room (ER) and outpatient settings.
- When transient ischemic attack (TIA), also known as “mini stroke,” is diagnosed, use code **G45.9.**
- For post-discharge and follow-up visits, do not code for the cerebral infarction as active/current. Assign:
  - **Z86.73,** *Personal history of transient ischemic attack and cerebral infarction without residual deficits*, if the patient is seen in the outpatient setting and shows no residual deficits ***or*** if a diagnosis of a TIA was made and has been resolved.
  - Category **I69.-,** *sequela of cerebrovascular disease* if the patient has residual deficits from a stroke. Complete documentation includes:
    - Cause and effect relationship of CVA and deficits
    - Specific late effect, such as hemiparesis/hemiplegia, cognitive deficits, dysphagia, or ataxia
    - Laterality, if applicable, and whether the affected side is dominant or nondominant

Questions?

Risk Adjustment Documentation and Coding

Part IV: Coding for Seizures, Epilepsy, and Dementia

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Agenda

Seizures and epilepsy

- Overview
- Documentation
- Coding tips

Dementia

- Overview
- Documentation
- Coding tips
- Quick reference

Seizures and epilepsy documentation and coding

Seizures and epilepsy

Overview

A **seizure** is an event caused by the disruption of the brain's normal electrical activity that results in altered consciousness or other neurological and behavioral manifestations. It is caused by clearly identifiable external factors that may be resolved or reversed such as injury, high fever, or substance abuse.

Epilepsy is a chronic brain disorder characterized by recurrent transient disturbances of the cerebral function. These recurrent (two or more) seizures on more than one occasion are not provoked by a clearly identifiable external factor. Epilepsy may be secondary to prior trauma, hemorrhage, anoxia, neoplasms, or congenital defects.

Signs and symptoms include:

- Momentary interruption of activity, staring, and mental blankness
- More severe: Complete loss of consciousness, sudden momentary loss or contracture of muscle tone, rolling eyes, stiffness, violent jerking movements, and incontinence

Look for documentation of any of these signs and symptoms in the medical record.

Seizures and epilepsy

Documentation

Complete documentation for accurate ICD-10 CM code selection must include:

Seizure

- **Type**
  - Febrile: Simple or complex
  - Post-traumatic

Epilepsy

- **Type**
  - Generalized: Surges of abnormal nerve discharges throughout the cortex of the brain, at the same time
  - Focal/partial localization-related: Start in one part of the brain and spread to others
- **Control:** Intractable or not intractable
  - Intractable epilepsy should only be coded if it is documented. Documentation of recurrence does not substantiate intractable epilepsy because all seizures in an epileptic patient are recurrent.
    - Equivalent terms include **pharmacologically resistant**, **treatment resistant**, **refractory** (medically), and **poorly controlled**
- **Complications:** With or without status epilepticus
  - Status epilepticus is a series of seizures at intervals too brief to allow consciousness between attacks and can be a life-threatening event.

Seizures and epilepsy

Coding tips

Code selection

- To select the appropriate ICD-10 CM code, based on provider documentation, first locate the term in the alphabetical index, and then verify the code in the Tabular List (Excludes 1, Excludes 2, Inclusion terms, Use additional code, Code first…) (Official Coding Guidelines I.B.1.)
- Coding Seizure:

  Seizure(s) **–** see also Convulsions R56.9
  - disorder **–** see also Epilepsy G40.909
  - epileptic **–** see Epilepsy
  - recurrent G40.909

Temporal lobe epilepsy

Assign code G40.109, Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus, for temporal lobe epilepsy. Temporal lobe epilepsy is the most common form of focal epilepsy (American Hospital Association (AHA) Coding Clinic (CC) Advisor, Q3 2023, page 4).

Dementia documentation and coding

Dementia
Overview

Dementia is a progressive disease characterized by a general decline in cognitive abilities that impacts a person's ability to perform everyday activities. This typically involves problems with memory, thinking, behavior, and motor control. Dementia is generally due to an underlying disorder such as cerebrovascular disease or Alzheimer's disease, although the specific underlying condition cannot always be determined.

Types

- **F01.-** Vascular dementia – result of infarction of the brain due to vascular disease, including:
  - Arteriosclerotic dementia
  - Major neurocognitive disorder due to vascular disease
  - Multi-infarct dementia
- **F02.-** Dementia in other diseases classified elsewhere, such as:
  - Alzheimer's disease – G30.-
  - Multiple sclerosis – G35
  - Parkinson's disease – G20
  - Systemic lupus erythematosus (SLE) (M32.-)
  - Traumatic brain injury S06.-
- **F03.-** Unspecified dementia – when the cause of the dementia is unknown

Dementia
Documentation

The ICD-10-CM classifies dementia (categories F01, F02, and F03) based on:

- **Etiology**
- **Severity**
  - Requires the provider's clinical judgment. Codes should be assigned only based on provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification. If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity.
  - Progression of dementia moves through three stages of cognitive impairment:
    1. **Mild** dementia includes patients who are no longer fully independent and require occasional daily assistance with activities.
    2. **Moderate** dementia involves an extensive functional impact on everyday life with impairment in basic activities. Patients are no longer independent and require frequent assistance with daily living activities.
    3. **Severe** dementia indicates a complete dependency due to severe functional impact on daily life with impairments in basic activities, including basic self-care.
- **Behavioral and psychological symptoms of dementia** can be grouped into three broad categories:
  - Behavioral disturbances
  - Psychotic disorders
  - Mood (affective) disorders

Dementia
Coding tips

Dementia and epilepsy

Should coding professionals assume a link between dementia and epilepsy?

When the health record documentation does not specify the underlying cause of the dementia or support epilepsy in or due to dementia, query the provider to clarify the underlying cause since dementia may be due to epilepsy or epilepsy may be due to the dementia.

If the provider cannot issue clarification of the cause of the dementia, assign code F03.90, Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and code G40.909, Epilepsy, unspecified, not intractable, without status epilepticus, for a diagnosis of dementia and epilepsy (AHA CC Advisor, Q2 2024, page 8).

Dementia and Alzheimer's disease

Dementia is an inherent part of Alzheimer's disease. Therefore, the provider does not need to separately document it. Assign code G30.9, Alzheimer's disease, unspecified, followed by code F02.80, Dementia in other diseases classified elsewhere, without behavioral disturbance (AHA CC Advisor, Q1 2017, page 43).

Dementia

Quick reference: Vascular dementia (F01.-)

This quick reference is a tool to support coders in locating the most specific ICD-10 CM code for dementia based on the provider's documentation of type, severity, and associated symptoms, if applicable.

Symptoms	Severity			
	Unspecified	Mild	Moderate	Severe
Without symptoms	F01.50	F01.A0	F01.B0	F01.C0
With agitation Restlessness, rocking, pacing, exit-seeking, profanity, shouting, threatening, anger, aggression, combativeness, or violence	F01.511	F01.A11	F01.B11	F01.C11
With other behavioral disturbance Sleep disturbance, social disinhibition, or sexual disinhibition Use additional code for wandering Z91.83	F01.518	F01.A18	F01.B18	F01.C18
With psychotic disturbance Hallucinations, paranoia, suspiciousness, or delusional state	F01.52	F01.A2	F01.B2	F01.C2
With mood disturbance Depression, apathy, or anhedonia	F01.53	F01.A3	F01.B3	F01.C3
With anxiety	F01.54	F01.A4	F01.B4	F01.C4

Dementia

Quick reference: Dementia in other diseases classified elsewhere (F02.-)

This quick reference is a tool to support coders in locating the most specific ICD-10 CM code for dementia based on the provider's documentation of type, severity, and associated symptoms, if applicable.

Symptoms	Severity			
	Unspecified	Mild	Moderate	Severe
Without symptoms	F02.80	F02.A0	F02.B0	F02.C0
With agitation Restlessness, rocking, pacing, exit-seeking, profanity, shouting, threatening, anger, aggression, combativeness, or violence	F02.811	F02.A11	F02.B11	F02.C11
With other behavioral disturbance Sleep disturbance, social disinhibition, or sexual disinhibition Use additional code for wandering Z91.83	F02.818	F02.A18	F02.B18	F02.C18
With psychotic disturbance Hallucinations, paranoia, suspiciousness, or delusional state	F02.82	F02.A2	F02.B2	F02.C2
With mood disturbance Depression, apathy, or anhedonia	F02.83	F02.A3	F02.B3	F02.C3
With anxiety	F02.84	F02.A4	F02.B4	F02.C4

Dementia

Quick reference: Unspecified dementia (F03.-)

This quick reference is a tool to support coders in locating the most specific ICD-10 CM code for dementia based on the provider's documentation of type, severity, and associated symptoms, if applicable.

Symptoms	Severity			
	Unspecified	Mild	Moderate	Severe
Without symptoms	F03.90	F03.A0	F03.B0	F03.C0
With agitation Restlessness, rocking, pacing, exit-seeking, profanity, shouting, threatening, anger, aggression, combativeness, or violence	F03.911	F03.A11	F03.B11	F03.C11
With other behavioral disturbance Sleep disturbance, social disinhibition, or sexual disinhibition Use additional code for wandering Z91.83	F03.918	F03.A18	F03.B18	F03.C18
With psychotic disturbance Hallucinations, paranoia, suspiciousness, or delusional state	F03.92	F03.A2	F03.B2	F03.C2
With mood disturbance Depression, apathy, or anhedonia	F03.93	F03.A3	F03.B3	F03.C3
With anxiety	F03.94	F03.A4	F03.B4	F03.C4

References

2024 ICD-10-CM Official Guidelines for Coding and Reporting

CMS.gov/medicare/coding-billing/icd-10-codes

American Hospital Association Coding Clinic Advisor
CodingClinicAdvisor.com/

Questions?

Risk Adjustment Topics

- Transitioning from Model V24 to V28
- Provider Query

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Agenda

Transitioning from Model V24 to V28

- Tell the patient story
- Background
- Main updates
- Risk score changes
- Ensuring accurate coding of chronic conditions
- Higher specificity opportunities
- Quick summary
- Commonly dropped ICD-10-CM codes

Provider query

- Query
- Compliant query
- Compliant query examples

Transitioning from Model V24 to V28

Transitioning from Model V24 to V28

Tell the patient story

Accurate risk adjustment data is based on complete documentation and compliant coding.

- Enhance documentation by providing clinical relevance of conditions reported.

- Adhere to official coding guidelines and resources.

- Participate in continuous education and training on documentation and coding best practices.

Transitioning from Model V24 to V28

Background

Underlying data

- Previous versions of the Centers for Medicare & Medicaid Services (CMS)-Hierarchical Condition Category (HCC) model used ICD-9 codes to create the HCCs. The new CMS-HCC model will reflect a reclassification by which CMS, in consultation with a panel of outside clinicians, rebuilt the condition categories to reflect diagnosis coding under the ICD-10-CM diagnosis classification system.
- According to CMS, this calibration results in more appropriate relative weights for the HCCs in the model because they reflect more recent utilization, coding, and expenditure patterns.
- In plain English, CMS transitioned from building the model based on ICD-9 experience (2015 and earlier) to building the 2024 model based on ICD-10-CM experience.

Transitioning from Model V24 to V28

Background

Principle 10

- CMS reviewed conditions that focused on Principle 10, where coding in Medicare Advantage was highest relative to Medicare Fee-For-Service, in collaboration with clinical experts for evaluation against the model principles because they believe that this coding differential indicates conditions where there may be discretionary coding variation.
- **Example:** Malnutrition. Comorbid condition impacting inpatient stays but is missed in billing.

Transitioning from Model V24 to V28

Main updates

HCC constraints

Hold the coefficients of the HCCs equal. (Each HCC now carries the same weight.)

- In V28, Diabetes HCCs are now HCCs 36, 37, and 38.
- In V28, Congestive Heart Failure HCCs are HCCs 224, 225, and 226.

HCC removals

- HCC 47 Protein-Calorie Malnutrition
- HCC 230 Angina Pectoris
- HCC 265 Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication

Transitioning from Model V24 to V28

Risk score changes

Top prevalent conditions	V24	V28	Change
Diabetes with chronic complications	0.302	0.166	0.136
Diabetes without complication	0.105	0.166	0.061
Specified heart arrhythmias	0.268	0.299	0.031
Chronic obstructive pulmonary disease	0.335	0.319	0.016
Morbid obesity	0.250	0.186	0.064
Cardio-respiratory failure and shock	0.282	0.370	0.088

Transitioning from Model V24 to V28

Ensuring accurate coding of chronic conditions

Diabetes

- **Type:** If not documented, the default type per ICD-10 CM guidelines is Type 2.
- **Control:** With hyperglycemia, with hypoglycemia
- **Complications** affecting body system(s): Explicitly document these causal relations by using terms such as “diabetic,” “due to,” and “secondary to.”

Chronic obstructive pulmonary disease

- **Status and plan:** Even if the condition is controlled and stable on medications, it must be assessed and reported annually.

Morbid obesity

- Support the **presence of the condition:** Diagnosis documented in the history of present illness (HPI), physical exam (PE), and/or assessment and plan (A/P) sections.
- Outline the provider’s **plan for management** of the condition.
- Use additional code for **BMI value** with a weight-related diagnosis.

Transitioning from Model V24 to V28

Higher specificity opportunities

Depression

- **Episode:** Single or recurrent
- **Severity/degree:** Mild, moderate, severe with psychotic symptoms, severe without psychotic features
- **Status:** Partial remission or full remission

Asthma

- **Type:** Intermittent, persistent, exercise-induced bronchospasm, cough variant, other or unspecified
- **Severity:** Categorized as mild, moderate, or severe
- **Status asthmaticus** presence: A severe, intractable episode of asthma that is unresponsive to normal therapeutic measures

Cancer

- **Anatomical location** with **laterality,** if applicable
- **Behavior:** Benign, malignant, in situ, uncertain, unspecified, metastasized
- **Status:** Active vs. historical, in remission, in relapse
- **Complications:** Neoplasm-related and treatment-related

Transitioning from Model V24 to V28

Quick summary

	V24 (2020) CMS-HCC Model	V28 (2024) CMS-HCC Model
Total FY22/23 ICD-10 codes	**73,926***	**73,926***
Total FY22/23 ICD-10 codes—mapped to payment HCCs	9,797 (13.3%)	7,770 (10.5%)
Total FY22/23 ICD-10 codes—mapped to nonpayment HCCs	64,129 (86.7%)	66,156 (89.5%)
Not in V24 but added to V28	-	209
In V24but no longer mapped to payment in V28	-	**2,236**
• No longer mapped—ICD-10 clinical updates	-	2,161 (96.6%)
• No longer mapped—Principle 10-focused updates related to discretionary coding	-	75 (3.4%)
HCCs—total	**204**	**266**
HCCs—payment	86 (42.2%)	115 (43.2%)
HCCs—nonpayment	118 (57.8%)	151 (56.8%)

*The total number of ICD-10 diagnosis codes varies by fiscal year.

Transitioning from Model V24 to V28

Commonly dropped ICD-10-CM codes

HCC	ICD-10-CM
HCC 108: Vascular disease	I739: Peripheral vascular disease, unspecified
	I700: Atherosclerosis of aorta
	I77810: Thoracic aortic ectasia
HCC 135: Acute renal failure	N179: Acute kidney failure, unspecified
HCC 96: Specified heart arrhythmias	I471: Supraventricular tachycardia
HCC 48: Coagulation defects and other specified hematological disorders	D696: Thrombocytopenia, unspecified
HCC 59: Major depressive, bipolar, and paranoid disorders	F339: Major depressive disorder, recurrent, unspecified
	F330: Major depressive disorder, recurrent, mild
	F3341: Major depressive disorder, recurrent, in partial remission

Provider query

Provider query

Query

A communication tool or process used to clarify documentation in the health record for documentation integrity and accuracy of diagnosis/procedure/service code(s) assignment for an individual encounter in any healthcare setting.

When to query

- To resolve conflicting documentation
- To establish clinically supported acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code
- To establish the relevance of a condition documented as a “history of” to determine if the condition is active
- To establish/confirm a cause-and-effect relationship between medical conditions

When not to query

- When there is sufficient documentation to assign a valid code and no indicators that the code can be specified to a higher degree
- If the provider clearly cannot offer clarification based on the present health record documentation

Provider query

Compliant query

Titles of queries should be **nonleading** in nature and not include impactful information.

- A clear, concise, and nonleading query statement that is specific to the necessity of the query (e.g., “Please clarify the diagnoses,” “Can a diagnosis be provided?”)

Contain applicable **clinical indicators** sourced from the medical record

- Diagnostic findings such as laboratory and imaging
- Relevant prior visits if the documentation is clinically pertinent to the present encounter
- Ancillary professional documentation and assessments

Provide **multiple choice answer** options that are supported by the clinical indicators as well as an option of “other” (or similar terminology) to allow the provider to customize their response.

- To include “Unable to determine” for yes/no queries

Provider education is an important component of query efforts.

Provider query

Compliant query examples

Congestive Heart Failure Specificity

"Congestive heart failure" was listed in the Assessment section on progress note dated 09/16.

"Chronic systolic congestive heart failure" was documented in past medical history and noted on progress note dated 08/20.

Clinical Indicators: Echo done on 09/10 indicates ejection fraction of 35% and systolic dysfunction.

Please further specify the diagnosis of heart failure:

- Chronic systolic congestive heart failure
- Acute or chronic systolic congestive heart failure
- Other explanation of clinical findings (please specify) _____

References

- CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,* CMS.gov/files/document/2024-advance-notice-pdf.pdf
- AHIMA, *Guidelines for Achieving a Compliant Query Practice*, AHIMA.org/media/51ufzhgl/20221212_acdis_practice-brief.pdf

Questions?