ULTIMATE
HEALTH PLANS

MRA PROVIDER

MEDICAL REFERENCE POCKET GUIDE

Credits:

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The "Evaluation and Management Services Guide" issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

"Clear and concise medical record documentation is critical to providing patients with quality care and is required for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation helps physicians and other healthcare professionals evaluate and plan the patient's immediate treatment and monitor the patient's healthcare over time." January 2022.

- Each patient visit should be treated as a separate event, with enough information recorded to justify the medical decisions made.
- The main reason for the visit should be the first thing coded. This should be the diagnosis, condition, or problem that is primarily responsible for the visit.
- The chosen code must be supported by the medical records and follow the correct coding guidelines.
- Chronic diseases that are being treated on an ongoing basis can be coded and reported each time the patient receives care for them.
- All conditions that exist at the time of the visit and affect the patient's care should be coded. Conditions that have been treated and no longer exist should not be coded.
- If a patient's personal or family health history affects their current care, it can be coded as a secondary factor.
- If a diagnosis hasn't been confirmed, it's acceptable to code the symptoms or signs the patient is experiencing.
- Diagnoses that are uncertain or unconfirmed, such as "probable" or "suspected" conditions, should not be coded. Instead, the symptoms or other reasons for the visit should be coded.
- If a provider identifies an incidental finding that they decide to include in the patient's care plan, it should be coded and linked to an appropriate assessment and plan.

- Legibility: Medical records should always be readable to ensure that diagnoses and treatments can be verified.
- Patient Information: Each page should at least have the patient's name and date of birth.
- Page Numbering: Every page should be numbered and include the date of service for consistency.
- Provider Signature: Records should have the healthcare provider's signature (handwritten or electronic) along with their printed name and credentials.
- Dates and Timelines: These should be reported with as much detail as possible. This includes documenting details of hospital visits, discharge medications, etc.
- Current vs. Historical Diagnoses: Use terms like "current" or "chronic" for ongoing conditions and "history of" for conditions that are no longer active. Use "in remission" for chronic conditions that have been treated but not fully cured.
- Consistency: Ensure that the information in the record is consistent, especially when using electronic health record (EHR) templates.
- Specificity: Avoid vague descriptions like "other" or "unspecified". Always describe the final diagnosis with as much detail as possible.
- Confirmed vs. Uncertain Diagnoses: Avoid terms that imply uncertainty for confirmed conditions. If a diagnosis hasn't been confirmed, document the signs or symptoms instead.

- ICD 10: This is a code that is 3-7 characters long. The first character is an alphabet letter, the next two are numeric, and the last four can be either alphabetic or numeric. When multiple diagnoses correspond to a group, we use the character "X" in the ICD 10 code for grouping purposes. For the most specific diagnosis, refer to the most current CMS - ICD 10 Mappings, which can be downloaded from the CMS website.
- Code Description: This is the name of the ICD 10 code or group. If the ICD 10 code in the table has an "X", it represents a group of diagnoses under this code. For the most specific code for a condition, refer to the most current CMS - ICD 10 mapping.
- HCC: This stands for Hierarchical Condition Categories, a risk adjustment model used by CMS to calculate risk scores for Medicare beneficiaries. These scores represent the expected medical costs of a Medicare Advantage member in the coming year. CMS updates these HCC groups annually.
    - HCC codes need to be accurately recorded at least annually. This is essential for appropriate payment from the Centers for Medicare & Medicaid Services (CMS). Please note, these codes reset at the end of each calendar year, so it's crucial to document them again for each new year. This is a key step in correctly managing the risk adjustment process.
- Documentation: This column provides the documentation guidelines that should be followed when using the codes. If a specific code is mentioned for a particular HCC, it's because that code requires specific information.

Chapter Name	HCC V24	HCC V28
Diabetes	17;18;19	36; 37; 38
Cardiovascular	85	222; 224; 225; 226; 227; 267
Angina	87;88	229; N/A
Specified Heart Arrythmias	96	238
Vascular Disorders	108	94; 264; 267
Respiratory Disorders	84; 110; 111; 112; 114; 115	213; 277; 278; 279; 280; 282; 283
Amputations	189	409
Hepatic Disorders	27; 28; 29	63; 64; 65; 68
Morbid Obesity	22	48
Schizophrenia	57	151
MDD/Bipolar	59	152; 154; 155
Personality/Eating Disorders	60	153
Substance Use Disorders	54; 55; 56	135; 136; 137; 138; 139
Ophthalmological Disorders	122; 124	298; 300
Skin Disorders	157; 158; 159; 161	379; 380; 381; 382; 383
Neurological Disorders	70; 71; 72; 73; 74; 75; 76; 77; 78; 79; 103;104	180; 181; 182; 190; 191; 192; 193; 195; 196; 197; 198; 199; 200; 201; 253; 254
Dementia	51; 52	125; 126; 127
Cancers/Neoplasms	8; 9; 10; 11; 12	17; 18; 19; 20; 21; 22; 23

Diabetes

HCC V24	HCC V28
HCC 17: Diabetes with Acute Complications	HCC 36: Diabetes with Severe Acute Complications
HCC 18: Diabetes with Chronic Complications	HCC 37: Diabetes with Chronic Complications
	HCC 38: Diabetic with Glycemic, Unspecified, or No Complications
HCC 19: Diabetes without Complication	HCC 38: Diabetic with Glycemic, Unspecified, or No Complications

Disclaimer

- E11.XX Group codes were used to exemplify Diabetes with/without complication, appropriate diabetes ICD 10 codes (E08.-; E09.-; E10.-; E11.-; E13.-) should be used for specific diabetic patients.

Diabetes with Chronic Complications [Kidney Complications]

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ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	**18**	**37**
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	**18**	**37**
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	**18**	**37**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- **E11.21: Type 2 diabetes mellitus with diabetic nephropathy:** Document altered MAU/CR ratio results. Possible causes include:
  - Intracapillary glomerulosclerosis
  - Intracapillary glomerulonephrosis
  - Kimmelstiel-Wilson disease
- **E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease:** Utilize this code with CKD stages 2, 3, 4, 5, and ESRD. Remember to:
  - Always use an additional code to identify the stage of chronic kidney disease (N18.2 - N18.6).
  - To validate CKD stage diagnosis codes accurately, ensure you have at least two eGFR lab results within a 90-day timeframe.
  - In case both CKD, stage 5 and ESRD are present, only report N18.6: ESRD and Z99.2: Dependence on renal dialysis.
- **E11.29: Type 2 diabetes mellitus with other diabetic kidney complication:** Use this code for other diabetic kidney complications such as renal tubular degeneration.
- Additional step:
- **Consult Guidelines:** Refer to the American Kidney Association guidelines to establish the diagnosis.

N18.2	CKD Stage 2, mild	60-90 ml/min/1.73 m2
N18.30	CKD Stage 3, unspecified	unspecified
N18.31	CKD Stage 3a, moderate	45 – 59 ml/min/1.73 m2
N18.32	CKD Stage 3b, moderate	30 – 44 ml/min/1.73 m2
N18.4	CKD Stage 4, severe	15 – 29 ml/min/1.73 m2
N18.5	CKD Stage 5, kidney failure	< 15 ml/min/1.73 m2
N18.6	End Stage Renal Disease	< 15 ml/min/1.73 m2, requires chronic dialysis or transplant

Proliferative Diabetic Retinopathy and Vitreous Hemorrhage

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.31X	Type 2 diabetes mellitus with unspecified diabetic retinopathy	**18**	**37**
E11.32XX	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy	**18**	**37**
E11.33XX	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy	**18**	**37**
E11.34XX	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy	**18**	**37**
E11.35XX	Type 2 diabetes mellitus with proliferative diabetic retinopathy	**18**	**37**
		122	**298**
E11.36	Type 2 diabetes mellitus with diabetic cataract	**18**	**37**
E11.37XX	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment	**18**	**37**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consultation notes: Review the notes from the Ophthalmology consult to determine the precise ICD 10 code. Always reference the eye exam when documenting in the Assessment/Plan.
- **E11.36: Type 2 diabetes mellitus with diabetic cataract:** There's an assumed causal relationship unless the provider states the cause is different. If age-related cataract diagnosis is seen in the eye note, the provider must document that the cataracts are related to diabetes if applicable. Consider cataracts as resolved and delete once they are removed.
- **E11.39: Type 2 diabetes mellitus with other diabetic ophthalmic complication:** Make sure to use the "Code Also" feature for complications. For example, H42: Glaucoma in diseases classified elsewhere.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	**18**	**37**
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	**18**	**37**
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	**18**	**37**
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy	**18**	**37**
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy	**18**	**37**
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication	**18**	**37**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Symptoms and Clinical Findings: Always document symptoms and clinical findings in the physical exam, annual foot exam, or podiatry evaluation. Note whether they are present or improving with active medication.
- **E11.43: Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy:** This includes Diabetic Gastroparesis and any other autonomic manifestations.
- ICD 10 Guidelines Exclusions: The use of G63 along with E08-E13.4X codes is EXCLUDED according to the ICD 10 guidelines.

Diabetes with Chronic Complications [Vascular Complications]

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	18	37
		108	N/A
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	18	37
		106	263
E11.59	Type 2 diabetes mellitus with other circulatory complications	18	37

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical Findings: Record findings from the physical exam that are pertinent to the vascular complications, when applicable.
- Care Plan: Document the plan of care associated with the diagnosis. This could include medication, lifestyle changes, or surgical interventions.
- Imaging Studies: Include relevant imaging studies that report circulatory findings appropriate for each code. This could be Ultrasounds, CT scans, or MRIs.
- Specialist Consult Notes: Review and utilize notes from specialist consultations to pinpoint the specific description and current status of the disease, thereby assigning the most appropriate code.

Diabetes with Chronic Complications [Other Complications]

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy	**18**	**37**
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy	**18**	**37**
E11.620	Type 2 diabetes mellitus with diabetic dermatitis	**18**	**37**
E11.621	Type 2 diabetes mellitus with foot ulcer	**18**	**37**
		161	**383**
E11.622	Type 2 diabetes mellitus with other skin ulcer	**18**	**37**
		161	**383**
E11.628	Type 2 diabetes mellitus with other skin complications	**18**	**37**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical Findings: Document the relevant findings from the physical exam that relate to the chronic complications.
- Care Plan: Record the care plan associated with the diagnosis. This may include medications, lifestyle modifications, and other therapeutic interventions.
- Specialist Consult Notes: Review notes from specialist consultations, specifically Podiatry in this case, to find the specific description and current status of the disease. Use this information to assign the most appropriate code.

Diabetes with Chronic Complications [Other Complications]

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.630	Type 2 diabetes mellitus with periodontal disease	**18**	**37**
E11.638	Type 2 diabetes mellitus with other oral complications	**18**	**37**
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	**18**	**38**
E11.65	Type 2 diabetes mellitus with hyperglycemia	**18**	**38**
E11.69	Type 2 diabetes mellitus with other specified complications	**18**	**37**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Oral Complications: Record symptoms and clinical findings in the patient's history of present illness (HPI) and physical examination (PE). Best practices recommend requesting specialist consultation notes and documenting accordingly.
- E11.649: Type 2 diabetes mellitus with hypoglycemia without coma: Provide reports of blood sugar levels and any treatments administered.
- E11.65: Type 2 diabetes mellitus with hyperglycemia: Document Blood Sugar Levels and/or HbA1C levels and the patient's treatment regimen. ** Refer to ADA guidelines*
- E11.69: Type 2 diabetes mellitus with other specified complications: In addition to coding the disease, also include the specific complication code.

Diabetes without Complication

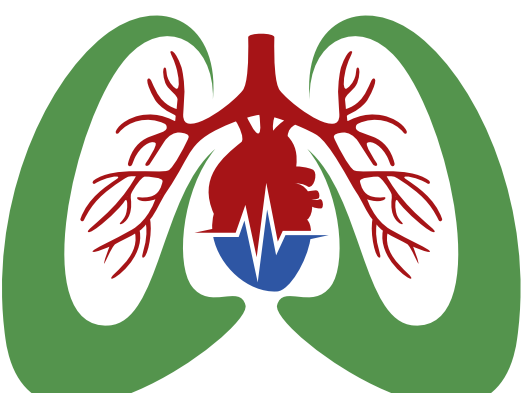
ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E11.9	Type 2 diabetes mellitus without complications	**19**	**38**
Z79.4	Long term (current) use of insulin	**19**	**38**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- E11.9: Type 2 diabetes mellitus without complications: This code should only be used for newly diagnosed diabetic patients until a complication is identified, after which it should be deleted to maintain record accuracy.
- Thoroughly examine patient records before using the code for Diabetes without complications to ensure you're reporting with the highest level of specificity.
- If complications are well-documented and supported, use the specific codes assigned to each complication.
- Z79.4: Long term (current) use of insulin: This code is applicable for diabetic patients on long-term insulin treatment. However, it shouldn't be used for episodes of acute hyperglycemia or for patients with Type I Diabetes (E10.XX).

HCC V24	HCC V28
HCC 85: Congestive Heart Failure	HCC 222: End-Stage Heart Failure
	HCC 224: Acute on Chronic Heart Failure
	HCC 225: Acute Heart Failure (Excludes Acute on Chronic)
	HCC 226: Heart Failure, Except End-Stage and Acute
	HCC 227: Cardiomyopathy/ Myocarditis
	HCC 267: Deep Vein Thrombosis and Pulmonary Embolism



Congestive heart failure

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
A36.81	Diphtheritic cardiomyopathy	**85**	**227**
B33.24	Viral cardiomyopathy	**85**	**227**
I09.81	Rheumatic heart failure	**85**	**226**
I11.0	Hypertensive heart disease with heart failure	**85**	**226**
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	**85**	**226**
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	**85**	**226**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the cardiology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Specific Conditions:
  - I09.81: For Rheumatic Heart Failure, also use an applicable I50.XX code to identify the type of heart failure.
  - I11.0: For Hypertensive Heart Disease with Heart Failure, also use an applicable I50.XX code.
  - I13.X: For Hypertensive Heart and Chronic Kidney Disease with Heart Failure, also use applicable I50.XX and N18.X codes.
- Medication reconciliation: Maintain an updated list of active prescriptions by performing regular medication reconciliation with the cardiology specialist.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I27.0	Primary pulmonary hypertension	85	226
I27.1	Kyphoscoliotic heart disease	85	226
I27.2X	Other specified pulmonary heart diseases	85	226
I27.81	Cor pulmonale (chronic)	85	226
I27.83	Eisenmenger's syndrome	85	226
I27.89	Other specified pulmonary heart diseases	85	226
I28.X	Other diseases of pulmonary vessels	85	226
I42.X	Cardiomyopathy	85	227
I42.7	Cardiomyopathy due to drug and external agent	85	N/A
I43	Cardiomyopathy in diseases classified elsewhere	85	227
I51.4	Myocarditis, unspecified	85	227
I51.5	Myocardial degeneration	85	227

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the cardiology and pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Echocardiogram review: Reports from echocardiogram tests should be documented and reviewed, as these can provide supportive evidence for the condition. For Secondary Pulmonary HTN, RVSP>35 (vary depending on specific client guidelines)
- Medication reconciliation: Maintain an updated list of active prescriptions by performing regular medication reconciliation with the cardiology and pulmonology specialists.

Congestive heart failure

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I50.1	Left ventricular failure, unspecified	85	226
I50.20	Unspecified systolic (congestive) heart failure	85	226
I50.21	Acute systolic (congestive) heart failure	85	225
I50.22	Chronic systolic (congestive) heart failure	85	226
I50.23	Acute on chronic systolic (congestive) heart failure	85	224
I50.30	Unspecified diastolic (congestive) heart failure	85	226
I50.31	Acute diastolic (congestive) heart failure	85	225
I50.32	Chronic diastolic (congestive) heart failure	85	226
I50.33	Acute on chronic diastolic (congestive) heart failure	85	224
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	85	226
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure	85	225
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	85	226
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	85	224

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the cardiology and pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Echocardiogram review: Reports from echocardiogram tests should be documented and reviewed, as these can provide supportive evidence for the condition. For Systolic HF: EF<50% (vary depending on specific client guidelines).
- Medication reconciliation: Maintain an updated list of active prescriptions by performing regular medication reconciliation with the cardiology and pulmonology specialists.

Congestive heart failure

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I50.810	Right heart failure, unspecified	85	226
I50.811	Acute right heart failure	85	225
I50.812	Chronic right heart failure	85	226
I50.813	Acute on chronic right heart failure	85	225
I50.814	Right heart failure due to left heart failure	85	226
I50.82	Biventricular heart failure	85	226
I50.83	High output heart failure	85	226
I50.84	End stage heart failure	85	222
I50.89	Other heart failure	85	226
I50.9	Heart failure, unspecified	85	226

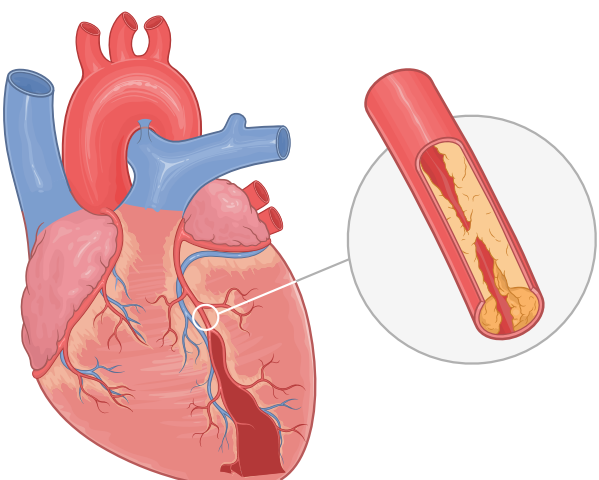
CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the cardiology and pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication reconciliation: Maintain an updated list of active prescriptions by performing regular medication reconciliation with the cardiology and pulmonology specialists.

Angina Pectoris

HCC V24	HCC V28
HCC 87: Unstable Angina and Other Acute Ischemic Heart Disease	HCC 229: Unstable Angina and Other Acute Ischemic Heart Disease
HCC 88: Angina Pectoris	N/A



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I20.0	Unstable Angina	87	229
I20.9	Angina Pectoris, Unspecified	88	N/A
I23.7	Postinfarction Angina	87	229
I23.8	Other current complications following acute myocardial infarction	87	229
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	87	229

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the cardiology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication reconciliation: Maintain an updated list of active prescriptions by performing regular medication reconciliation with the cardiology and pulmonology specialists.

- I23.7: Postinfarction Angina;
  - Angina within 30 days of acute MI event
  - Common after non-ST-elevation MI and fibrinolytic therapy
  - Associated with higher risk of adverse cardiac outcomes
  - Use code I23.7 for angina within first 4 weeks post-MI
  - Document timing of MI and onset of angina
  - Include I21.- code for the acute MI event

Specified Heart Arrhythmias

HCC V24	HCC V28
HCC 96: Specified Heart Arrhythmias	HCC 238: Specified Heart Arrhythmias

Specified Heart Arrhythmias

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I44.2	Atrioventricular block, complete	96	238
I47.X	Paroxysmal tachycardia	96	238
I48.XX	Atrial fibrillation and flutter	96	238
I49.2	Junctional premature depolarization	96	238
I49.5	Sick sinus syndrome	96	238

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- EKG/Echocardiogram Report: Include these reports as part of your documentation as they provide valuable information about the patient's heart health.
- Physical Exam: Document any clinical findings that are relevant to the episode of care.
- Specialist Consult Notes: Review the notes from the cardiology consultation to pinpoint the precise description and status of the disease, helping you to assign the most appropriate code.
- Medication Reconciliation: Update active prescriptions based on records from the cardiology specialist.

- Specific Codes:
  - I48.XX: If the patient has Atrial Fibrillation or Flutter with CHADVASC equal to 2 or higher, also code D68.69 for Other Thrombophilia and document any long-term Anticoagulant treatment for prevention. If the patient is not on this preventive treatment, document the reason. It is not required.
  - I44.2/I49.5: If applicable, also code Z95.0 for Presence of Cardiac Pacemaker.

Vascular Disease

HCC V24	HCC V28
HCC 108: Vascular Disease	HCC 264: Vascular Disease with Complications
	HCC 267: Deep Vein Thrombosis and Pulmonary Embolism
	HCC 94: Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I70.22X	Atherosclerosis of native arteries of extremities with rest pain	**108**	**264**
I70.32X	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain	**108**	**264**
I70.42X	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain	**108**	**264**
I70.52X	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain	**108**	**264**
I70.62X	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain	**108**	**264**
I70.72X	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain	**108**	**264**
I80.1X	Phlebitis and thrombophlebitis of femoral vein	**108**	**267**
I80.2XX	Phlebitis and thrombophlebitis of other and unspecified deep vessels of lower extremities	**108**	**267**
I82.0	Budd-Chiari Syndrome	**108**	**267**
I82.2211	Chronic embolism and thrombosis of superior vena cava	**108**	**267**
I82.2221	Chronic embolism and thrombosis of superior vena cava	**108**	**267**

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I82.2291	Chronic embolism and thrombosis of other thoracic veins	**108**	**267**
I82.3	Embolism and thrombosis of renal vein	**108**	**267**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical Findings in Physical Exam: Consistent records across all visits are vital for accurate coding.
  - Document vein or artery involvement, specifying if original or transplant
  - Note which side is affected: right, left, or both
  - Record any issues like leg pain during walking or continuous rest pain
- Specialist Consult Notes: Review the Vascular Specialist's consult notes to locate the precise description and status of the disease, to assign the most appropriate code.

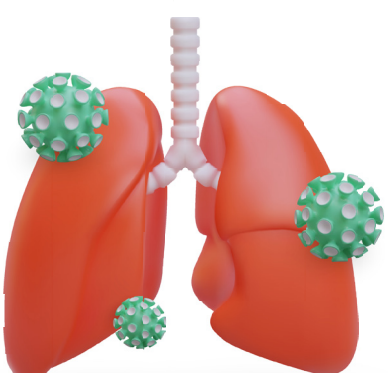
ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I82.5XX	Chronic embolism and thrombosis of deep veins of lower extremity	108	267
I82.72X	Chronic embolism and thrombosis of deep veins of upper extremity	108	267
I82.A2X	Chronic embolism and thrombosis of axillary vein	108	267
I82.B2X	Chronic embolism and thrombosis of subclavian vein	108	267
I82.C2X	Chronic embolism and thrombosis of internal jugular vein	108	267
M31.8	Other specified necrotizing vasculopathies	108	94
M31.9	Necrotizing vasculopathy, unspecified	108	94

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical Findings in Physical Exam: Consistent records across all visits are vital for accurate coding.
- Specialist Consult Notes: Review the Vascular Specialist's consult notes to locate the precise description and status of the disease, to assign the most appropriate code.
- Special Studies: Ensure to document special studies that support these conditions, including QuantaFlo, Arterial/Venous Ultrasound, Computed Tomography Angiography (CTA), or Magnetic Resonance Angiography (MRA).
- Medication Reconciliation: The medication reconciliation with the Vascular specialist should be performed to update active prescriptions. This ensures chronic thrombosis codes are not resolved.
    - In patient with Chronic embolism code also D68.69: Other thrombophilia when preventive long-term Anticoagulant/ Antiplatelet treatment is directed to treat the disease, and if patient is not on preventive Long-term Anticoagulant/Antiplate let treatment document reason.

HCC V24	HCC V28
HCC 84: Cardio-Respiratory Failure and Shock	HCC 213: Cardio-Respiratory Failure and Shock
HCC 110: Cystic Fibrosis	HCC 277: Cystic Fibrosis
HCC 111: Chronic Obstructive Pulmonary Disease	HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
HCC 112: Fibrosis of lung and other chronic lung disorders	HCC 278: Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
-	HCC 279: Severe Persistent Asthma
HCC 114: Aspiration and Specified Bacterial Pneumonias	HCC 282: Aspiration and Specified Bacterial Pneumonias
HCC 115: Pneumococcal Pneumonia, Empyema, Lung Abscess	HCC 283: Empyema, Lung Abscess



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia	**84**	**213**
J96.11	Chronic respiratory failure with hypoxia	**84**	**213**
J96.12	Chronic respiratory failure with hypercapnia	**84**	**213**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consultation notes from a Pulmonology specialist should be thoroughly reviewed to locate the exact description and the current status of the disease. This information will aid in assigning the most appropriate code.
- Document the care plan, specifically noting the requirement for continuous supplemental oxygen therapy (24/7 usage).
- When chronic respiratory failure is reported, also use the Z99.81 code to signify dependence on supplemental oxygen.

Cystic Fibrosis

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E84.0	Cystic fibrosis with pulmonary manifestations	**110**	**277**
E84.19	Cystic fibrosis with other intestinal manifestations	**110**	**277**
E84.8	Cystic fibrosis with other manifestations	**110**	**277**
E84.9	Cystic fibrosis, unspecified	**110**	**277**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Consistent recording of clinical findings from all patient visits helps maintain a comprehensive record.
- Specialist Consult Notes: Reviewing the detailed notes from a specialist consultation will help determine the exact description and current state of the disease, which is necessary to assign the most suitable code.
- Medication Reconciliation: An updated list of active prescriptions should be maintained through regular medication reconciliation with the specialist

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J41.X	Simple and mucopurulent chronic bronchitis	**111**	**280**
J42	Unspecified chronic bronchitis	**111**	**280**
J43.X	Emphysema	**111**	**280**
J44.X	Other chronic obstructive pulmonary disease	**111**	**280**
J82.81	Chronic eosinophilic pneumonia	**111**	**280**
J98.2	Interstitial emphysema	**111**	**280**
J98.3	Compensatory emphysema	**111**	**280**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Diagnostic Studies: Include provider's interpretation/validation of relevant diagnostic studies such as Pulmonary Function Test (PFT) [Gold Standard], Chest CT, and/or X-Rays in the specific office visit.
- Specialist Consult Notes: Review the detailed notes from a pulmonology consultation to determine the exact description and current state of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: An updated list of active prescriptions should be maintained through regular medication reconciliation with the pulmonology specialist.
- Coding for Specific Conditions:
  - For COPD with (acute) lower respiratory infection, code to identify the specific infection (J44.0).
  - For COPD with (acute) exacerbation (J44.1), be cautious to not assume exacerbation based on worsening of a concomitant respiratory disease or when COPD is described as end stage.
- Additional Codes: Use additional codes to identify Tobacco exposure, such as:
  - Z77.22: Exposure to environmental tobacco smoke
  - Z57.31: Occupational exposure to tobacco smoke
  - Z87.891: History of tobacco dependence
  - F17.X: Tobacco dependence
  - Z72.0: Tobacco use
- Mutual Exclusivity: Be aware of coding conflicts due to mutual exclusivity. For example, J44.- excludes notes for J41.- and J42.-, meaning that if one condition is coded, the others shouldn't be coded at the same time.

Fibrosis of Lung

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
B44.81	Allergic bronchopulmonary aspergillosis	112	280
D86.0	Sarcoidosis of lung	112	N/A
D86.2	Sarcoidosis of lung with sarcoidosis of lymph nodes	112	N/A
J47.X	Bronchiectasis	112	280
J60	Coalworker's pneumoconiosis	112	280
J61	Pneumoconiosis due to asbestos and other mineral fibers	112	280
J62.X	Pneumoconiosis due to dust containing silica	112	280
J63.X	Pneumoconiosis due to other inorganic dusts	112	280
J64	Unspecified pneumoconiosis	112	280

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Diagnostic Studies: Include relevant diagnostic studies such as Pulmonary Function Test (PFT), Chest CT, and/or X-Rays to validate the diagnosis.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.
- Additional Codes: Use additional codes to identify tobacco exposure, such as:
- Z77.22: Exposure to environmental tobacco smoke
- Z57.31: Occupational exposure to tobacco smoke
- Z87.891: History of tobacco dependence
- F17.X: Tobacco dependence
- Z72.0: Tobacco use

Fibrosis of Lung

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J65	Pneumoconiosis associated with tuberculosis	**112**	**280**
J66.X	Airway disease due to specific organic dust	**112**	**280**
J67.X	Hypersensitivity pneumonitis due to organic dust	**112**	**280**
J68.X	Respiratory conditions due to inhalation of chemicals, gases, fumes and vapors	**112**	**280**
J70.X	Respiratory conditions due to other external agents	**112**	**N/A**
J82.89	Other pulmonary eosinophilia, not elsewhere classified	**112**	**N/A**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Diagnostic Studies: Include relevant diagnostic studies such as Pulmonary Function Test (PFT), Chest CT, and/or X-Rays to validate the diagnosis.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.
- Coding for Specific Conditions:
  - For respiratory conditions due to inhalation of chemicals, gases, fumes, and vapors (J68.XX), code also (T51 – T65) to identify the cause and use an additional code to identify associated respiratory conditions such as Acute Respiratory Failure.
  - For respiratory conditions due to other external agents (J70.X), use an additional code to identify the external agents causing the condition, and if applicable, adverse effects to identify drugs and/or smoke inhalation.
- Additional Codes: Use additional codes to identify tobacco exposure, such as:
  - Z77.22: Exposure to environmental tobacco smoke
  - Z57.31: Occupational exposure to tobacco smoke
  - Z87.891: History of tobacco dependence
  - F17.X: Tobacco dependence
  - Z72.0: Tobacco use

Fibrosis of Lung

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J84.XXX	Other interstitial pulmonary diseases	112	280
J84.112	Idiopathic pulmonary fibrosis	112	278
J84.170	Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere	112	278
J99	Respiratory disorders in diseases classified elsewhere	112	280
M32.13	Lung involvement in systemic lupus erythematosus	112	280
M33.01	Juvenile dermatomyositis with respiratory involvement	112	280
M33.11	Other dermatomyositis with respiratory involvement	112	280
M33.21	Polymyositis with respiratory involvement	112	280
M33.91	Dermatopolymyositis, unspecified with respiratory involvement	112	280
M34.81	Systemic sclerosis with lung involvement	112	280
M35.02	Sjogren syndrome with lung involvement	112	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Diagnostic Studies: Include relevant diagnostic studies such as Pulmonary Function Test (PFT), Chest CT, and/or X-Rays to validate the diagnosis.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.
- J84.XXX: Other interstitial pulmonary diseases, Code first underlying disease, poisoning due to drugs or toxins and/or additional codes for adverse effect to identify drug when applicable.
- J99: Respiratory disorders in diseases classified elsewhere, Code first underlying disease to identify causing condition.
- J84.112: Idiopathic Pulmonary Fibrosis (IPF)
  - IPF is the most prevalent form of Pulmonary Fibrosis
  - Annually, approximately 50,000 new IPF cases are identified
  - Idiopathic causes account for 70-80% of Pulmonary Fibrosis instances
  - Common causes include autoimmune disorders, rare familial types, environmental exposure

Severe Persistent Asthma

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J45.50	Severe persistent asthma, uncomplicated	**N/A**	**279**
J45.51	Severe persistent asthma with (acute) exacerbation	**N/A**	**279**
J45.52	Severe persistent asthma with status asthmaticus	**N/A**	**279**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Consistent recording of clinical findings from all patient visits helps maintain a comprehensive record.
- Specialist Consult Notes: Reviewing the detailed notes from a specialist consultation will help determine the exact description and current state of the disease, which is necessary to assign the most suitable code.
- Medication Reconciliation: An updated list of active prescriptions should be maintained through regular medication reconciliation with the specialist

- 'Severe' classification requires near-daily episodes
- Exacerbations often present with ongoing daily symptoms

- For 'Severe Persistent Asthma' documentation, note:
    - Symptom frequency
    - Identifiable triggers
    - Prescribed medications
    - Impact of lifestyle and environmental factors

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J95.851	Ventilator associated pneumonia	**114**	**211**
A48.1	Legionnaires' disease	**114**	**282**
J15.0	Pneumonia due to Klebsiella pneumoniae	**114**	**282**
J15.1	Pneumonia due to Pseudomonas	**114**	**282**
J15.20	Pneumonia due to staphylococcus, unspecified	**114**	**282**
J152.11	Pneumonia due to Methicillin susceptible Staphylococcus aureus	**114**	**282**
J152.12	Pneumonia due to Methicillin resistant Staphylococcus aureus	**114**	**282**

CDI Tips

To accurately code for Legionnaire's disease, the following information should be properly documented to ensure the highest level of detail:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
J15.29	Pneumonia due to other staphylococcus	**114**	**282**
J15.5	Pneumonia due to Escherichia coli	**114**	**282**
J15.6	Pneumonia due to other Gram-negative bacteria	**114**	**282**
J15.8	Pneumonia due to other specified bacteria	**114**	**282**
J69.0	Pneumonitis due to inhalation of food and vomit	**114**	**282**
J69.1	Pneumonitis due to inhalation of oils and essences	**114**	**282**
J69.8	Pneumonitis due to inhalation of other solids and liquids	**114**	**282**

CDI Tips

To accurately code for Legionnaire's disease, the following information should be properly documented to ensure the highest level of detail:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.

Empyema and Lung Abscesses

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
B38.1	Chronic pulmonary coccidioidomycosis	**115**	**N/A**
B39.1	Chronic pulmonary histoplasmosis capsulati	**115**	**N/A**
B40.1	Chronic pulmonary blastomycosis	**115**	**N/A**
B41.0	Pulmonary paracoccidioidomycosis	**115**	**N/A**
J13	Pneumonia due to Streptococcus pneumoniae	**115**	**N/A**
J14	Pneumonia due to Hemophilus influenzae	**115**	**N/A**
J15.3	Pneumonia due to streptococcus, group B	**115**	**N/A**
J15.4	Pneumonia due to other strep-tococci	**115**	**N/A**
J18.1	Lobar pneumonia, unspecified organism	**115**	**N/A**

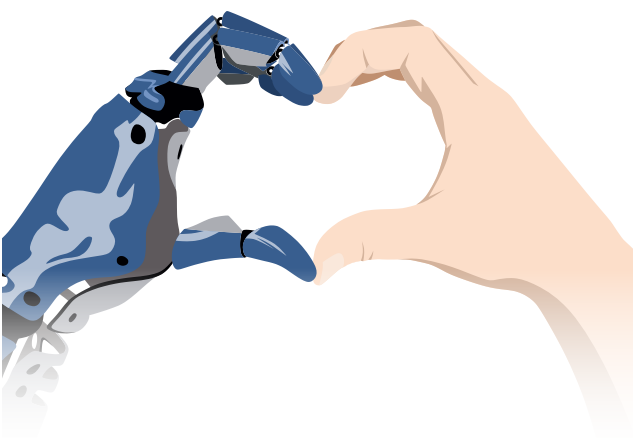
CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Physical Exam: Document clinical findings from all patient visits to maintain a consistent record.
- Diagnostic Studies: Include relevant diagnostic studies such as Pulmonary Function Test (PFT), Chest CT, X-Rays and/or Pathology reports to validate the diagnosis.
- Specialist Consult Notes: Review the notes from the pulmonology consultation to determine the precise description and status of the disease, assisting in assigning the most suitable code.
- Medication Reconciliation: Regular medication reconciliation with the pulmonology specialist should be done to maintain an updated list of active prescriptions.

Amputations

HCC V24	HCC V28
HCC 189: Amputation Status, Lower Limb/Amputation Complications	HCC 409: Amputation Status, Lower Limb/Amputation Complications



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
Z89.41X	Acquired absence of great toe	189	N/A
Z89.42X	Acquired absence of other toe(s)	189	N/A
Z89.43X	Acquired absence of foot	189	409
Z89.44X	Acquired absence of ankle	189	409
Z89.51X	Acquired absence of leg below knee	189	409
Z89.61X	Acquired absence of leg above knee	189	409
Z44.1XX	Encounter for fitting and adjustment of artificial leg	189	409
T87.3X	Neuroma of amputation stump	189	409
T87.4X	Infection of amputation stump	189	409
T87.5X	Necrosis of amputation stump	189	409
T87.8X	Other complications of amputation stump	189	409

CDI Tips

To properly code for Amputation Status, Lower Limb/Amputation Complications, documenting the following information will ensure that you are reporting to the maximum level of specificity:

- Physical Exam and Clinical Findings: Documenting the clinical findings in physical exam at all visits to maintain record consistency is crucial. This includes noting the site of amputation, whether it's a partial or complete amputation, and whether it's the right or left limb.
- Specialist Consult Notes: Consult notes from the patient's specialist should be reviewed to determine the specific description and status of the condition. This could be from a surgeon, orthopedic specialist, or a rehab specialist as appropriate.
- Z89.XXX: Acquired absence of limb codes group, INCLUDES:
    - Amputation status
    - Post procedural loss of limb
    - Post traumatic loss of limb
- Complication codes: If there are complications associated with the amputation, these should be coded separately using appropriate complication codes, such as T87.4 for infection, T87.5 for necrosis, etc.
- Remember to code any associated conditions or reasons for the amputation, such as diabetes or peripheral vascular disease.

Amputations Disease

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G54.6	Phantom limb syndrome with pain	189	409
G54.7	Phantom limb syndrome without pain	189	409
S48.XXXS	Traumatic amputation of shoulder and upper arm sequela	189	N/A
S58.XXXS	Traumatic amputation of elbow and forearm sequela	189	N/A
S68.XXXS	Traumatic amputation of wrist, hand and fingers sequela	189	N/A
S78.XXXD	Traumatic amputation of hip and thigh subsequent encounter	189	N/A
S78.XXXS	Traumatic amputation of hip and thigh sequela	189	N/A
S88.XXXD	Traumatic amputation of lower leg subsequent encounter	189	N/A
S88.XXXS	Traumatic amputation of lower leg sequela	189	N/A
S98.XXXD	Traumatic amputation of ankle and foot subsequent encounter	189	N/A
S98.XXXS	Traumatic amputation of ankle and foot sequela	189	N/A

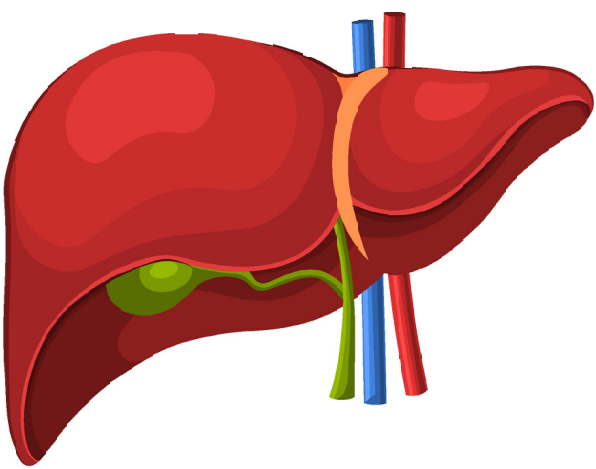
CDI Tips

To properly code for Amputation Status, Lower Limb/Amputation Complications, documenting the following information will ensure that you are reporting to the maximum level of specificity:

- Physical Exam and Clinical Findings: Documenting the clinical findings in physical exam at all visits to maintain record consistency is crucial. This includes noting the site of amputation, whether it's a partial or complete amputation, and whether it's the right or left limb.
- Specialist Consult Notes: Consult notes from the patient's specialist should be reviewed to determine the specific description and status of the condition. This could be from a surgeon, orthopedic specialist, or a rehab specialist as appropriate.
- Z89.XXX: Acquired absence of limb codes group, INCLUDES:
  - Amputation status
  - Post procedural loss of limb
  - Post traumatic loss of limb
- Complication codes: If there are complications associated with the amputation, these should be coded separately using appropriate complication codes, such as T87.4 for infection, T87.5 for necrosis, etc.
- Remember to code any associated conditions or reasons for the amputation, such as diabetes or peripheral vascular disease.

Liver Disorder

HCC V24	HCC V28
HCC 27: End-Stage Liver Disease	HCC 63: Chronic Liver Failure/End-Stage Liver Disorders
HCC 28: Cirrhosis of Liver	HCC 63: Chronic Liver Failure/End-Stage Liver Disorders
	HCC 64: Cirrhosis of Liver
	HCC 68: Cholangitis and Obstruction of Bile Duct Without Gallstones
HCC 29: Chronic Hepatitis	HCC 65: Chronic Hepatitis



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I85.00	Esophageal varices without bleeding	27	63
I85.01	Esophageal varices with bleeding	27	63
I85.10	Secondary esophageal varices without bleeding	27	63
I85.11	Secondary esophageal varices with bleeding	27	63
K72.10	Chronic hepatic failure without coma	27	63
K72.90	Hepatic failure, unspecified without coma	27	63
K76.6	Portal hypertension	27	63
K76.7	Hepatorenal syndrome	27	63
K76.81	Hepatopulmonary syndrome	27	63
K76.82	Hepatic Encephalopathy	27	63

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- If a patient is on long-term loop diuretic therapy, consider using the additional code E26.1, which signifies Secondary Hyperaldosteronism.
- Reference specialist consultation notes to ascertain the precise description and disease status, which will enable the assignment of the most appropriate code.
- I85.XX, representing Esophageal Varices, should be reported at EGD and/or CTA Abdomen.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
K70.30	Alcoholic cirrhosis of liver without ascites	28	64
K70.31	Alcoholic cirrhosis of liver with ascites	28	64
K70.40	Alcoholic hepatic failure without coma	28	63
K70.9	Alcoholic liver disease, unspecified	28	N/A
K74.3	Primary biliary cirrhosis	28	68
K74.4	Secondary biliary cirrhosis	28	64
K74.5	Biliary cirrhosis, unspecified	28	68
K74.60	Unspecified cirrhosis of liver	28	64
K74.69	Other cirrhosis of liver	28	64

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Understand that abdominal imaging studies are not diagnostic for cirrhosis. When these tests show abnormal results, a referral to a Gastroenterology specialist should be considered for further evaluation.
- Liver Biopsy and/or Elastography are diagnostic tools for hepatic cirrhosis and should be considered when necessary.
- Always incorporate an additional code that identifies the known cause of cirrhosis (Alcoholic, Infectious, Biliary) to provide a comprehensive medical picture.
- For patients on long-term loop diuretic therapy, it is appropriate to use the additional code E26.1, which signifies Secondary Hyperaldosteronism. This is applicable regardless of the presence or absence of ascites.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
B18.0	Chronic viral hepatitis B with delta-agent	29	65
B18.1	Chronic viral hepatitis B without delta-agent	29	65
B18.2	Chronic viral hepatitis C	29	65
B18.8	Other chronic viral hepatitis	29	65
B18.9	Chronic viral hepatitis, unspecified	29	65
K73.0	Chronic persistent hepatitis, not elsewhere classified	29	65
K73.1	Chronic lobular hepatitis, not elsewhere classified	29	65
K73.2	Chronic active hepatitis, not elsewhere classified	29	65
K73.8	Other chronic hepatitis, not elsewhere classified	29	65
K73.9	Chronic hepatitis, unspecified	29	65
K75.4	Autoimmune hepatitis	29	65

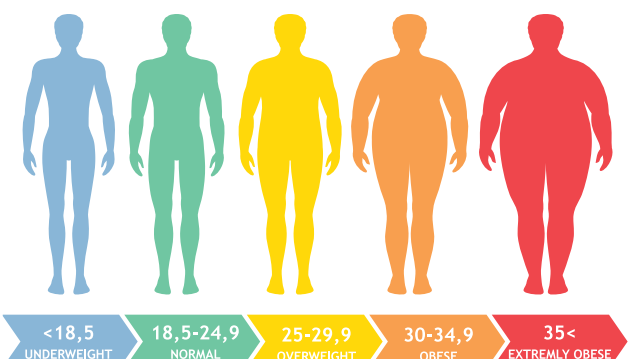
CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Confirmatory results of Hepatitis B or Hepatitis C screening tests, when establishing diagnosis.
- Any relevant clinical findings or ongoing treatment linked to the disease.
- Specify if the Delta Agent is involved in the case for Hepatitis B.
- Use of imaging studies or laboratory reports are encouraged for an extensive evaluation of liver function.
- Referrals to Gastroenterology or Hepatology specialists should be noted for advanced evaluation and treatment, if applicable.
- Upon successful treatment completion for Hepatitis C, marked by a negative HCV RNA test, the patient is deemed cured. The B18.2 code should then be resolved and switched to a personal history code.
- Use of 'Other', not classified elsewhere, and unspecified hepatitis codes should be l imited to cases where the cause of hepatitis remains unknown. Once the viral agent is identified, the diagnosis code should reflect the specific cause.
- For the K75.4 Autoimmune Hepatitis, the presence of positive autoantibodies tests is necessary for appropriate code support.

Morbid Obesity

HCC V24	HCC V28
HCC 22: Morbid Obesity	HCC 48: Morbid Obesity



Morbid Obesity

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E66.01	Morbid (severe) obesity due to excess calories	**22**	**48**
E66.2	Morbid (severe) obesity with alveolar hypoventilation	**22**	**48**
Z68.41	Body mass index [BMI] 40.0-44.9, adult	**22**	**48**
Z68.42	Body mass index [BMI] 45.0-49.9, adult	**22**	**48**
Z68.43	Body mass index [BMI] 50.0-59.9, adult	**22**	**48**
Z68.44	Body mass index [BMI] 60.0-69.9, adult	**22**	**48**
Z68.45	Body mass index [BMI] 70 or greater, adult	**22**	**48**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- A BMI greater than 40.
- A BMI greater than 35 plus an applicable comorbidity such as:
    - Uncontrolled Hypertension
    - Diabetes
    - Chronic Obstructive Pulmonary Disease
    - Coronary artery disease with or without angina
    - Congestive Heart Failure
    - Peripheral Vascular Disease
    - Sleep Apnea
    - Old Myocardial Infarction/Angina Pectoris
    - Note: The comorbidity must be properly documented, supported, and linked to morbid obesity to meet this criteria.
- Z68.XX Codes for BMI should only be assigned as a secondary code when there is an associated, reportable diagnosis (such as Obesity).

Schizophrenia

HCC V24	HCC V28
HCC 57: Schizophrenia	HCC 151: Schizophrenia

Schizophrenia

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F20.0	Paranoid schizophrenia	**57**	**151**
F20.1	Disorganized schizophrenia	**57**	**151**
F20.2	Catatonic schizophrenia	**57**	**151**
F20.3	Undifferentiated schizophrenia	**57**	**151**
F20.5	Residual schizophrenia	**57**	**151**
F20.81	Schizophreniform disorder	**57**	**151**
F20.89	Other schizophrenia	**57**	**151**
F20.9	Schizophrenia, unspecified	**57**	**151**
F25.0	Schizoaffective disorder, bipolar type	**57**	**151**
F25.1	Schizoaffective disorder, depressive type	**57**	**151**
F25.8	Other schizoaffective disorders	**57**	**151**
F25.9	Schizoaffective disorder, unspecified	**57**	**151**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Review consultation notes from the Specialist (Psychiatry), to ascertain the specific description and current status of the disease. This information will guide the assignment of the most appropriate code.
- Continually update and monitor the care plan in collaboration with the specialist. This ongoing assessment ensures the provision of optimal quality care to the patient.

MDD/Bipolar

HCC V24	HCC V28
HCC 59: Major Depressive, Bipolar, and Paranoid Disorders	HCC 152: Psychosis, Except Schizophrenia
	HCC 154: Bipolar Disorders without Psychosis
	HCC 155: Major Depression, Moderate or Severe, without Psychosis

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F22	Delusional disorders	59	152
F24	Shared psychotic disorder	59	152
F30.2	Manic episode, severe with psychotic symptoms	59	152
F30.1X	Manic episode without psychotic symptoms	59	154
F30.3	Manic episode in partial remission	59	154
F30.8	Other manic episodes	59	154
F30.9	Manic episode, unspecified	59	154
F30.4	Manic episode in full remission	59	N/A
T14.91XA	Suicide attempt, initial encounter	59	155

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Implement a depression screening test at least annually to monitor the condition's progress and response to treatment.
- Review consultation notes from the Specialist (Psychiatry) to identify the disease's specific description and current status. This information will help assign the most appropriate code and keep the care plan current.
- Pay attention to the coding exclusions within F30.XX – F31.XX – F32.X – F33.XX. These codes cannot or should not be used simultaneously. For example, depression codes shouldn't be used with bipolar disorder codes. Instead, use specific codes for mania, hypomania, or depression within bipolar disorder.
- Refer to the DSM-5 guidelines for diagnostic criteria related to depressive, bipolar, and paranoid disorders.
- For assessing self-harm intentions, review hospital records and/or psychiatry consult notes to maintain record consistency. If a patient responds positively to PHQ9 questions 3-5-9, please document a suicide assessment in the relevant care episodes.
- Describe any sequela of self-harm, if present, and document a personal history of suicidal behavior (Z91.51) if applicable.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F31.2	Bipolar disorder, current episode manic severe with psychotic features	59	152
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	59	152
F31.0	Bipolar disorder, current episode hypomanic	59	154
F31.1X	Bipolar disorder, current episode manic without psychotic features	59	154
F31.3X	Bipolar disorder, current episode depressed, mild or moderate severity	59	154
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	59	154
F31.60	Bipolar disorder, current episode mixed, unspecified	59	154
F31.61	Bipolar disorder, current episode mixed, mild	59	154
F31.62	Bipolar disorder, current episode mixed, moderate	59	154
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	59	154
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	59	152

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Implement a depression screening test at least annually to monitor the condition's progress and response to treatment.
- Review consultation notes from the Specialist (Psychiatry) to identify the disease's specific description and current status. This information will help assign the most appropriate code and keep the care plan current.
- Pay attention to the coding exclusions within F30.XX – F31.XX – F32.X – F33.XX. These codes cannot or should not be used simultaneously. For example, depression codes shouldn't be used with bipolar disorder codes. Instead, use specific codes for mania, hypomania, or depression within bipolar disorder.
- Refer to the DSM-5 guidelines for diagnostic criteria related to depressive, bipolar, and paranoid disorders.
- For assessing self-harm intentions, review hospital records and/or psychiatry consult notes to maintain record consistency. If a patient responds positively to PHQ9 questions 3-5-9, please document a suicide assessment in the relevant care episodes.
- Describe any sequela of self-harm, if present, and document a personal history of suicidal behavior (Z91.51) if applicable.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	59	154
F31.73	Bipolar disorder, in partial remission, most recent episode manic	59	154
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	59	154
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	59	154
F31.81	Bipolar II disorder	59	154
F31.89	Other bipolar disorder	59	154
F31.9	Bipolar disorder, unspecified	59	154
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified	59	N/A
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic	59	N/A
F31.74	Bipolar disorder, in full remission, most recent episode manic	59	N/A
F31.76	Bipolar disorder, in full remission, most recent episode depressed	59	N/A
F31.78	Bipolar disorder, in full remission, most recent episode mixed	59	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Implement a depression screening test at least annually to monitor the condition's progress and response to treatment.
- Review consultation notes from the Specialist (Psychiatry) to identify the disease's specific description and current status. This information will help assign the most appropriate code and keep the care plan current.
- Pay attention to the coding exclusions within F30.XX – F31.XX – F32.X – F33.XX. These codes cannot or should not be used simultaneously. For example, depression codes shouldn't be used with bipolar disorder codes. Instead, use specific codes for mania, hypomania, or depression within bipolar disorder.
- Refer to the DSM-5 guidelines for diagnostic criteria related to depressive, bipolar, and paranoid disorders.
- For assessing self-harm intentions, review hospital records and/or psychiatry consult notes to maintain record consistency. If a patient responds positively to PHQ9 questions 3-5-9, please document a suicide assessment in the relevant care episodes.
- Describe any sequela of self-harm, if present, and document a personal history of suicidal behavior (Z91.51) if applicable.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F32.3	Major depressive disorder, single episode, severe with psychotic features	59	152
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	59	152
F32.1	Major depressive disorder, single episode, moderate	59	155
F32.2	Major depressive disorder, single episode, severe without psychotic features	59	155
F33.1	Major depressive disorder, recurrent, moderate	59	155
F33.2	Major depressive disorder, recurrent severe without psychotic features	59	155
F32.0	Major depressive disorder, single episode, mild	59	N/A
F32.4	Major depressive disorder, single episode, in partial remission	59	N/A
F32.5	Major depressive disorder, single episode, in full remission	59	N/A
F33.0	Major depressive disorder, recurrent, mild	59	N/A
F33.40	Major depressive disorder, recurrent, in remission, unspecified	59	N/A
F33.41	Major depressive disorder, recurrent, in partial remission	59	N/A
F33.42	Major depressive disorder, recurrent, in full remission	59	N/A
F33.8	Other recurrent depressive disorders	59	N/A
F33.9	Major depressive disorder, recurrent, unspecified	59	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Implement a depression screening test at least annually to monitor the condition's progress and response to treatment.
- Review consultation notes from the Specialist (Psychiatry) to identify the disease's specific description and current status. This information will help assign the most appropriate code and keep the care plan current.
- Pay attention to the coding exclusions within F30.XX – F31.XX – F32.X – F33.XX. These codes cannot or should not be used simultaneously. For example, depression codes shouldn't be used with bipolar disorder codes. Instead, use specific codes for mania, hypomania, or depression within bipolar disorder.
- Refer to the DSM-5 guidelines for diagnostic criteria related to depressive, bipolar, and paranoid disorders.
- For assessing self-harm intentions, review hospital records and/or psychiatry consult notes to maintain record consistency. If a patient responds positively to PHQ9 questions 3-5-9, please document a suicide assessment in the relevant care episodes.
- Describe any sequela of self-harm, if present, and document a personal history of suicidal behavior (Z91.51) if applicable.

HCC V24	HCC V28
HCC 60: Personality Disorders	HCC 153: Personality Disorders; Anorexia/Bulimia Nervosa

Personality Disorders

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F21	Schizotypal disorder	60	153
F44.0	Dissociative amnesia	60	153
F44.1	Dissociative fugue	60	153
F44.81	Dissociative identity disorder	60	153
F48.1	Depersonalization-derealization syndrome	60	153
F60.XX	Specific personality disorders	60	153
F50.00	Anorexia nervosa, unspecified	N/A	153
F50.01	Anorexia nervosa, restricting type	N/A	153
F50.02	Anorexia nervosa, binge eating/ purging type	N/A	153
F50.2	Bulimia nervosa	N/A	153

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Review consultation notes from the Specialist (Psychiatry), to ascertain the specific description and status of the disease. This information will guide the assignment of the most appropriate code.
- Continually update and monitor the care plan in collaboration with the specialist. This ongoing assessment ensures the provision of optimal quality care to the patient.

- For Eating Disorders:
- Code Anorexia Nervosa with F50.01 (restricting type) or F50.02 (binge eating/ purging type) based on patient behavior.
- For Bulimia Nervosa, use F50.2, documenting binge eating followed by purging activities like vomiting or laxative use.
- Note eating patterns, food restriction methods, and purging behaviors in patient records.
- Record patient's body image perception and psychological assessments.
- Include weight, BMI, and health status;
- Detail patient history, emotional well-being, and family history of eating disorders.
- Outline treatment plans, counseling, dietary management, and medications.
- Provide patient education on anorexia and bulimia and their health impacts.
- Plan and document follow-up visits and ongoing monitoring of the condition.

SUD/Dependencies

HCC V24	HCC V28
HCC 54: Substance Use with Psychotic Complications	HCC 135: Drug Use with Psychotic Complications
	HCC 136: Alcohol Use with Psychotic Complications
HCC 55: Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	HCC 137: Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
	HCC 139: Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications
HCC 56: Substance Use Disorder, Mild, Except Alcohol and Cannabis	HCC 138: Drug Use Disorder, Mild, Uncomplicated, Except Cannabis

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F10.131	Alcohol abuse with withdrawal delirium	54	136
F10.132	Alcohol abuse with withdrawal with perceptual disturbance	54	136
F10.15X	Alcohol abuse with alcohol-induced psychotic disorder	54	136
F10.231	Alcohol dependence with withdrawal delirium	54	136
F10.232	Alcohol dependence with withdrawal with perceptual disturbance	54	136
F10.25X	Alcohol dependence with alcohol-induced psychotic disorder	54	136
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder	54	136
F10.27	Alcohol dependence with alcohol-induced persisting dementia	54	136
F10.931	Alcohol use, unspecified with withdrawal delirium	54	136
F10.932	Alcohol use, unspecified with withdrawal with perceptual disturbance	54	136
F10.95X	Alcohol use, unspecified with alcohol-induced psychotic disorder	54	136
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder	54	136
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia	54	136

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F11.15X	Opioid abuse with opioid-induced psychotic disorder	54	135
F11.25X	Opioid dependence with opioid-induced psychotic disorder	54	135
F11.95X	Opioid use, unspecified with opioid-induced psychotic disorder	54	135
F12.15X	Cannabis abuse with psychotic disorder	54	135
F12.25X	Cannabis dependence with psychotic disorder	54	135
F12.95X	Cannabis use, unspecified with psychotic disorder	54	135
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium	54	135
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance	54	135
F13.15X	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder	54	135
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium	54	135
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance	54	135
F13.25X	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder	54	135

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	54	135
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia	54	135
F13931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium	54	135
F13932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances	54	135
F13.95X	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder	54	135
F13.96	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	54	135
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia	54	135
F1415X	Cocaine abuse with cocaine-induced psychotic disorder	54	135
F14.25X	Cocaine dependence with cocaine-induced psychotic disorder	54	135
F14.95X	Cocaine use, unspecified with cocaine-induced psychotic disorder	54	135

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F10.12X	Alcohol abuse with intoxication	55	N/A
F10.130	Alcohol abuse with withdrawal, uncomplicated	55	139
F10.139	Alcohol abuse with withdrawal, unspecified	55	139
F10.14	Alcohol abuse with alcohol-induced mood disorder	55	139
F10.18X	Alcohol abuse with other alcohol-induced disorders	55	139
F10.19	Alcohol abuse with unspecified alcohol-induced disorder	55	N/A
F10.2X	Alcohol dependence	55	139
F10.22X	Alcohol dependence with intoxication	55	139
F10.230	Alcohol dependence with withdrawal uncomplicated	55	139
F10.239	Alcohol dependence with withdrawal unspecified	55	139
F10.24	Alcohol dependence with alcohol-induced mood disorder	55	139
F10.28X	Alcohol dependence with other alcohol-induced disorders	55	139
F10.29	Alcohol dependence with unspecified alcohol-induced disorder	55	139

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- The presence of a Substance use disorder should be noted in the patient's social history with an annual status update to maintain record consistency, in line with the DSM V criteria.
- Detailed descriptions of the clinical characteristics of the substance use disorder and any accompanying complications, especially when they are relevant to the patient's episode of care.
- Consultation notes from the specialist should be thoroughly reviewed to extract the most specific description and current status of the disease, which will aid in assigning the most accurate code.
- Document any counseling provided, including the duration of each session when it is relevant to the episode of care.
- If rehabilitation therapy was considered or discussed as a part of the patient's plan of care, the details and outcome of such a discussion should be included in the documentation.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F10.92X	Alcohol use, unspecified with intoxication	55	N/A
F10.930	Alcohol use, unspecified with withdrawal uncomplicated	55	139
F10.939	Alcohol use, unspecified with withdrawal unspecified	55	139
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder	55	139
F10.98X	Alcohol use, unspecified with other alcohol-induced disorders	55	139
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder	55	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- The presence of a Substance use disorder should be noted in the patient's social history with an annual status update to maintain record consistency, in line with the DSM V criteria.
- Detailed descriptions of the clinical characteristics of the substance use disorder and any accompanying complications, especially when they are relevant to the patient's episode of care.
- Consultation notes from the specialist should be thoroughly reviewed to extract the most specific description and current status of the disease, which will aid in assigning the most accurate code.
- Document any counseling provided, including the duration of each session when it is relevant to the episode of care.
- If rehabilitation therapy was considered or discussed as a part of the patient's plan of care, the details and outcome of such a discussion should be included in the documentation.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F11.12X	Opioid abuse with intoxication	55	137
F11.13	Opioid abuse with withdrawal	55	137
F11.14	Opioid abuse with opioid-induced mood disorder	55	137
F11.18X	Opioid abuse with other opioid-induced disorder	55	137
F11.19	Opioid abuse with unspecified opioid-induced disorder	55	137
F11.2X	Opioid dependence	55	137
F11.22X	Opioid dependence with intoxication	55	137
F11.23	Opioid dependence with withdrawal	55	137
F11.24	Opioid dependence with opioid-induced mood disorder	55	137
F11.28X	Opioid dependence with other opioid-induced disorder	55	137
F11.29	Opioid dependence with unspecified opioid-induced disorder	55	137

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F11.92X	Opioid use, unspecified with intoxication	**55**	**137**
F11.93	Opioid use, unspecified with withdrawal	**55**	**137**
F11.94	Opioid use, unspecified with opioid-induced mood disorder	**55**	**137**
F11.98X	Opioid use, unspecified with other specified opioid-induced disorder	**55**	**137**
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder	**55**	**137**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F12.12X	Cannabis abuse with intoxication	55	N/A
F12.13	Cannabis abuse with withdrawal	55	137
F12.18X	Cannabis abuse with other cannabis-induced disorder	55	137
F12.19	Cannabis abuse with unspecified cannabis-induced disorder	55	N/A
F12.2X	Cannabis dependence	55	137
F12.22X	Cannabis dependence with intoxication	55	137
F12.23	Cannabis dependence with withdrawal	55	137
F12.28X	Cannabis dependence with other cannabis-induced disorder	55	137
F12.92X	Cannabis use, unspecified with intoxication	55	137
F12.93	Cannabis use, unspecified with withdrawal	55	137
F12.98X	Cannabis use, unspecified with other cannabis-induced disorder	55	137
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder	55	137

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F13.12X	Sedative, hypnotic or anxiolytic abuse with intoxication	55	N/A
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated	55	137
F13.139	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified	55	137
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder	55	N/A
F13.18X	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorders	55	137
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	55	137
F13.2X	Sedative, hypnotic or anxiolytic-related dependence	55	137
F13.22X	Sedative, hypnotic or anxiolytic dependence with intoxication	55	137
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	55	137
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified	55	137
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder	55	137
F13.28X	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorders	55	137

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder	55	N/A
F13.92X	Sedative, hypnotic or anxiolytic use, unspecified with intoxication	55	137
F13.930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated	55	137
F13.939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified	55	N/A
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder	55	137
F13.98X	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorders	55	137
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder	55	137

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Substance use disorder should be consistently updated on an annual basis in the patient's social history. The status update should adhere to the DSM V criteria.
- Document the specific clinical characteristics of the substance use disorder that exhibits psychotic complications, relevant to the patient's episode of care.
- Detailed description of the psychotic complications and the corresponding treatment plan or plan of care.
- Consultation notes from the specialist (such as a Psychiatrist) should be reviewed to obtain the most specific description and current status of the disease, for the purpose of assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F11.10	Opioid abuse, uncomplicated	**56**	**138**
F11.11	Opioid abuse, in remission	**56**	**138**
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	**56**	**138**
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission	**56**	**138**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- A record of Substance use disorder should be included in the patient's social history, with an annual update to ensure record consistency, following the guidelines provided by the DSM V Criteria.
- Include a detailed description of the clinical characteristics of the mild substance use disorder when it's relevant to the patient's care episode.
- Documentation should also contain information on counseling sessions provided to the patient, noting the duration when it's pertinent to the episode of care.

HCC V24	HCC V28
HCC 122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	HCC 298: Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage
HCC 124: Exudative Macular Degeneration	HCC 300: Exudative Macular Degeneration

Ophthalmological Disorders

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E08.35XX	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy	**122**	**298**
E10.35XX	Type 1 diabetes mellitus with proliferative diabetic retinopathy	**122**	**298**
E11.35XX	Type 2 diabetes mellitus with proliferative diabetic retinopathy	**122**	**298**
E13.35.XX	Other specified diabetes mellitus with proliferative diabetic retinopathy	**122**	**298**
H43.1X	Vitreous hemorrhage	**122**	**298**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Eye Exam Notes: Review the Ophthalmologist's consultation notes to locate the specific description and status of the disease, to assign the most appropriate code. This should include details about the exact nature of the retinopathy, extent of hemorrhage, affected eye(s), and the treatment plan.
- Medical History: It is crucial to document the history of diabetes mellitus, as the retinopathy is associated with this condition. If not already coded, use E08-E13 with the appropriate fourth and fifth characters to indicate the type of diabetes and whether it is controlled or uncontrolled.
- Medication Reconciliation: Ensure to perform a medication reconciliation to update active prescriptions, especially those related to diabetes control and any specific treatments for the retinopathy or hemorrhage.

Ophthalmological Disorders

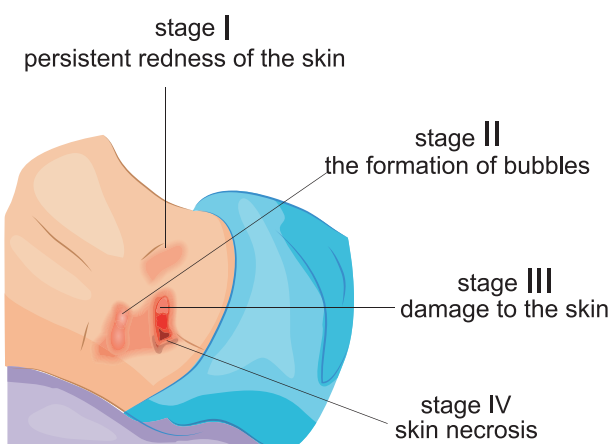
ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
H35.32XX	Exudative age-related macular degeneration	**124**	**300**

CDI Tips

To properly code for Exudative macular degeneration, make sure the following information is documented to provide the maximum level of specificity:

- Eye Exam Notes: Review the Ophthalmologist's consultation notes to locate the specific description and status of the disease, to assign the most appropriate code.

HCC V24	HCC V28
HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	HCC 379: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss	HCC 381: Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC 159: Pressure Ulcer of Skin with Partial Thickness Skin Loss	HCC 382: Pressure Ulcer of Skin with Partial Thickness Skin Loss
HCC 161: Chronic Ulcer of Skin, Except Pressure	HCC 380: Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle
	HCC 383: Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle



- **To accurately code for Bone/Joint/Muscle Infections/Necrosis, comprehensive documentation is essential, including:**

    - Site and laterality of the condition
    - Stage of the disease, specifically indicating whether there's partial or complete thickness skin loss and if there's muscular-bone involvement
    - Detailed measurements of the affected area
    - Information on undermining, sinus tracts or tunneling, recorded in centimeters
    - Wound-base description, including the presence of granulation, necrotic tissue, eschar, slough, or new epithelial tissue
    - Absence or presence of drainage, with details on the amount, color, consistency, and odor
    - Description of wound edges, which should include characteristics of the area up to 4 cm from the edge of the wound; this should be measured in centimeters and describe attributes such as color (light pink, deep red, purple) and texture (macerated, calloused)
    - Whether an odor is present or absent
    - Associated pain and related interventions
    - The current status of the condition

- **Diagnostic Tools that may be utilized include:**

    - Medical history and physical examination
    - Skin or wound culture if infection is suspected
    - Skin biopsy
    - Diagnostic testing related to underlying conditions
    - Evaluation of nutritional status

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
L89.XX4	Pressure ulcer stage 4	**157**	**379**
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4	**157**	**379**
L89.94	Pressure ulcer of unspecified site, stage 4	**157**	**379**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings that detail the specific characteristics of the pressure ulcer.
- Review consultation notes from a Wound Care Specialist, as these can offer precise descriptions and status updates of the condition to help assign the most appropriate code.
- Perform medication reconciliation with specialist records to ensure active prescriptions are up to date and accurately represented in the coding.
- If gangrene is associated with the pressure ulcer, it should be coded first using the appropriate code (I96).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
L89.XX0	Pressure ulcer, unstageable	**158**	**381**
L89.XX3	Pressure ulcer, stage 3	**158**	**381**
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3	**158**	**381**
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable	**158**	**381**
L89.93	Pressure ulcer of unspecified site, stage 3	**158**	**381**
L89.95	Pressure ulcer of unspecified site, unstageable	**158**	**381**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Detailed clinical findings that outline the distinct attributes of the pressure ulcer.
- Carefully review consultation notes from a specialist in wound care. These notes can provide a detailed description and status of the condition, assisting in assigning the most appropriate code.
- Conduct a medication reconciliation using the specialist's records to ensure all active prescriptions are currently updated in the patient's record.
- If gangrene is associated with the pressure ulcer, the coding for gangrene (I96) should be documented first.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
L89.XX2	Pressure ulcer, stage 2	**159**	**382**
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2	**159**	**382**
L89.92	Pressure ulcer of unspecified site, stage 2	**159**	**382**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clear clinical findings that depict the features of the pressure ulcer.
- Thoroughly review consultation records from a wound care specialist to find the precise description and current status of the condition. This will aid in determining the most appropriate code.
- Execute a medication reconciliation using the specialist's records to update the patient's active prescriptions accurately.
- Should there be any associated gangrene, remember to first document its code (I96).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E08.621	Diabetes mellitus due to underlying condition with foot ulcer	**161**	**383**
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer	**161**	**383**
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer	**161**	**383**
E10.621	Type 1 diabetes mellitus with foot ulcer	**161**	**383**
E10.622	Type 1 diabetes mellitus with other skin ulcer	**161**	**383**
E11.621	Type 2 diabetes mellitus with foot ulcer	**161**	**383**
E11.622	Type 2 diabetes mellitus with other skin ulcer	**161**	**383**
E13.621	Other specified diabetes mellitus with foot ulcer	**161**	**383**
E13.622	Other specified diabetes mellitus with other skin ulcer	**161**	**383**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Carefully described clinical findings illustrating the features of the ulcer.
- Thorough review of the specialist's (Wound care) consultation records to locate the specific description and current status of the condition. This information is crucial to assign the most suitable code.
- When using EXX.621, include an additional code to identify the site of the ulcer (Codes L97.4XX, L97.5XX).
- Similarly, for EXX.622, ensure to use an additional code to pinpoint the site of the ulcer (Codes L97.1 – L97.9, L98.41 – L98.49).
- Refrain from assigning a code for a diabetic ulcer when the ulcer has healed or to report a history of diabetic ulcers. Instead, code Z86.31: Personal history of diabetic foot ulcer can be assigned.
- Implement medication reconciliation in alignment with the specialist's records to keep the active prescriptions up to date

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I70.23X	Atherosclerosis of native arteries of the extremities	161	383
I70.24X	Atherosclerosis of native arteries of left leg with ulceration	161	383
I70.25	Atherosclerosis of native arteries of other extremities with ulceration	161	383
I70.33X	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration	161	383
I70.34X	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration	161	383
I70.35	Atherosclerosis of unspecified type of bypass graft(s) of other extremity with ulceration	161	383
I70.43X	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration	161	383
I70.44X	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration	161	383
I70.45	Atherosclerosis of autologous vein bypass graft(s) of other extremity with ulceration	161	383

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings providing a detailed description of the ulcer's characteristics.
- Consultation notes from the Specialist (Wound care, Vascular) should be thoroughly reviewed to find the exact description and status of the condition, enabling the assignment of the most fitting code.
- If applicable, utilize an additional code to identify a chronic total occlusion of an artery of an extremity (Code I70.92).
- An additional code may also be used to indicate the severity of the ulcer, if applicable.
- Regular medication reconciliation in accordance with the specialist's records is necessary to keep the list of active prescriptions updated.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I70.53X	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration	161	383
I70.54X	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration	161	383
I70.55	Atherosclerosis of nonautologous biological bypass graft(s) of other extremity with ulceration	161	383
I70.63X	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration	161	383
I70.64X	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration	161	383
I70.65	Atherosclerosis of nonbiological bypass graft(s) of other extremity with ulceration	161	383
I70.73X	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration	161	383
I70.74X	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration	161	383
I70.75	Atherosclerosis of other type of bypass graft(s) of other extremity with ulceration	161	383

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings providing a detailed description of the ulcer's characteristics.
- Consultation notes from the Specialist (Wound care, Vascular) should be thoroughly reviewed to find the exact description and status of the condition, enabling the assignment of the most fitting code.
- If applicable, utilize an additional code to identify a chronic total occlusion of an artery of an extremity (Code I70.92).
- An additional code may also be used to indicate the severity of the ulcer, if applicable.
- Regular medication reconciliation in accordance with the specialist's records is necessary to keep the list of active prescriptions updated.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
L97.XX1	Non-pressure chronic ulcer of lower limb, not elsewhere classified, limited to breakdown of skin	**161**	**383**
L97.XX2	Non-pressure chronic ulcer of lower limb, not elsewhere classified, with fat layer exposed	**161**	**383**
L97.XX8	Non-pressure chronic ulcer of lower limb, not elsewhere classified, with other specified severity	**161**	**383**
L97.XX9	Non-pressure chronic ulcer of lower limb, not elsewhere classified, with unspecified severity	**161**	**383**
L98.4X1	Non-pressure chronic ulcer of skin, not elsewhere classified, limited to breakdown of skin	**161**	**383**
L98.4X2	Non-pressure chronic ulcer of skin, not elsewhere classified, with fat layer exposed	**161**	**383**
L98.4X8	Non-pressure chronic ulcer of skin, not elsewhere classified, with other specified severity	**161**	**383**
L98.4X9	Non-pressure chronic ulcer of skin, not elsewhere classified, with unspecified severity	**161**	**383**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings describing the characteristics of the pressure ulcer should be clearly documented.
- Review Specialist (Wound care) consult notes to locate the specific description and current status of the condition in order to assign the most appropriate code.
- When coding, any associated underlying condition should be recorded first. These conditions could include gangrene (I96), atherosclerosis of lower extremities (I70.X), chronic venous hypertension (I87.31 – I87.33), diabetic ulcers, postphlebitic syndrome (I87.01X – I87.03X), postthrombotic syndrome (I87.01X – I87.03X), or varicous ulcers (I83.0 – I83.2).
- Assign a code from this category/subcategory for a non-pressure ulcer if it is documented as acute.
- Medication reconciliation with specialist records should be performed to ensure the list of active prescriptions is up to date.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
L97.XX3	Non-pressure chronic ulcer of lower limb, with necrosis of muscle	161	380
L97.XX4	Non-pressure chronic ulcer of lower limb, with necrosis of bone	161	380
L97.XX5	Non-pressure chronic ulcer of lower limb, with muscle involvement without evidence of necrosis	161	380
L97.XX6	Non-pressure chronic ulcer of lower limb, with bone involvement without evidence of necrosis	161	380
L98.4X3	Non-pressure chronic ulcer of skin, not elsewhere classified, with necrosis of muscle	161	380
L98.4X4	Non-pressure chronic ulcer of skin, not elsewhere classified, with necrosis of bone	161	380
L98.4X5	Non-pressure chronic ulcer of skin, not elsewhere classified, with muscle involvement without evidence of necrosis	161	380
L98.4X6	Non-pressure chronic ulcer of skin, not elsewhere classified, with bone involvement without evidence of necrosis	161	380

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings describing the characteristics of the pressure ulcer should be clearly documented.
- Review Specialist (Wound care) consult notes to locate the specific description and status of the condition to assign the most appropriate code.
- When coding, any associated underlying condition should be recorded first. These conditions could include gangrene (I96), atherosclerosis of lower extremities (I70.X), chronic venous hypertension (I87.31 – I87.33), diabetic ulcers, postphlebitic syndrome (I87.01X – I87.03X), postthrombotic syndrome (I87.01X – I87.03X), or varicous ulcers (I83.0 – I83.2).
- Medication reconciliation with specialist records should be performed to ensure the list of active prescriptions is up to date.

HCC V24	HCC V28
HCC 70: Quadriplegia	HCC 180: Quadriplegia
HCC 71: Paraplegia	HCC 181: Paraplegia
HCC 72: Spinal Cord Disorders/ Injuries	HCC 182: Spinal Cord Disorders/ Injuries
	HCC 190: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy
	HCC 200: Friedreich and Other Hereditary Ataxias; Huntington Disease
HCC 73: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	HCC 190: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy
HCC 74: Cerebral Palsy	HCC 191: Quadriplegic Cerebral Palsy
	HCC 192: Cerebral Palsy, Except Quadriplegic
HCC 75: Myasthenia Gravis/ Myoneural Disorders and Guillain-Barre Syndrome/ Inflammatory and Toxic Neuropathy	HCC 195: Myasthenia Gravis with (Acute) Exacerbation
	HCC 193: Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy
	HCC 196: Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders
HCC 76: Muscular Dystrophy	HCC 197: Muscular Dystrophy
HCC 77: Multiple Sclerosis	HCC 198: Multiple Sclerosis
HCC 78: Parkinson's and Huntington's Diseases	HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia
	HCC 200: Friedreich and Other Hereditary Ataxias; Huntington Disease
HCC 79: Seizure Disorders and Convulsions	HCC 201: Seizure Disorders and Convulsions
HCC 103: Hemiplegia/Hemiparesis	HCC 253: Hemiplegia/Hemiparesis
HCC 104: Monoplegia, Other Paralytic Syndromes	HCC 254: Monoplegia, Other Paralytic Syndromes

NEURO Disorders

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G82.5X	Quadriplegia	70	180
R53.2	Functional quadriplegia	70	180

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

NEURO Disorders

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G82.2X	Paraplegia	71	181

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
B00.82	Herpes simplex myelitis	**72**	**182**
B01.12	Varicella myelitis	**72**	**182**
B02.24	Postherpetic myelitis	**72**	**182**
G04.1	Tropical spastic paraplegia	**72**	**182**
G04.89	Other myelitis	**72**	**182**
G04.91	Myelitis, unspecified	**72**	**182**
G05.4	Myelitis in diseases classified elsewhere	**72**	**182**
G11.XX	Hereditary Ataxia	**72**	**190**
G12.XX	Spinal muscular atrophy and related syndromes	**72**	**200**
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere	**72**	**182**
G32.81	Cerebellar ataxia in diseases classified elsewhere	**72**	**182**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.
- If code description includes “in diseases classified elsewhere” code first the underlying condition

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G83.4	Cauda equina syndrome	72	182
G90.1	Familial dysautonomia [Riley-Day]	72	182
G95.XX	Other and unspecified diseases of spinal cord	72	182
G99.2	Myelopathy in diseases classified elsewhere	72	182

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.
- If code description includes “in diseases classified elsewhere” code first the underlying condition
- G99.2: Myelopathy in diseases classified elsewhere, code first the underlying condition

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G12.20	Motor neuron disease, unspecified	**73**	**190**
G12.21	Amyotrophic lateral sclerosis	**73**	**190**
G12.22	Progressive bulbar palsy	**73**	**190**
G12.23	Primary lateral sclerosis	**73**	**190**
G12.24	Familial motor neuron disease	**73**	**190**
G12.25	Progressive spinal muscle atrophy	**73**	**190**
G12.29	Other motor neuron disease	**73**	**190**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G80.0	Spastic quadriplegic cerebral palsy	**74**	**191**
G80.1	Spastic diplegic cerebral palsy	**74**	**192**
G80.2	Spastic hemiplegic cerebral palsy	**74**	**192**
G80.3	Athetoid cerebral palsy	**74**	**192**
G80.4	Ataxic cerebral palsy	**74**	**192**
G80.8	Other cerebral palsy	**74**	**192**
G80.9	Cerebral palsy, unspecified	**74**	**192**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
D86.82	Multiple cranial nerve palsies in sarcoidosis	75	N/A
G13.0	Paraneoplastic neuromyopathy and neuropathy	75	N/A
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease	75	N/A
G61.81	Chronic inflammatory demyelinating polyneuritis	75	193
G61.82	Multifocal motor neuropathy	75	193
G62.0	Drug-induced polyneuropathy	75	N/A
G62.1	Alcoholic polyneuropathy	75	N/A
G62.2	Polyneuropathy due to other toxic agents	75	N/A
G62.81	Critical illness polyneuropathy	75	N/A
G62.82	Radiation-induced polyneuropathy	75	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently record the clinical findings from all Physical Examinations to maintain record consistency.
- Review consultation notes from the relevant Specialist (Neurology) to ascertain the specific description and current status of the disease. This information is crucial for assigning the most appropriate code.
- Use additional codes to identify serum (G61.1), adverse drug reactions (G62.0), toxic agents (G62.2), or an external cause code to identify the cause (G62.82).
- For G62.1: Alcoholic polyneuropathy, use an additional code to identify the patient's alcohol dependence status (F10.2X).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G63	Polyneuropathy in diseases classified elsewhere	75	N/A

CDI Tips

To accurately code for these condition, ensure you are capturing these essential details to the greatest degree of specificity:

- Always record the clinical findings from every Physical Examination to maintain consistency in the records.
- Consultation notes from the relevant Specialist (Neurology, Neurosurgeon) should be reviewed to discern the specific description and current status of the disease. This information is vital for assigning the most appropriate code.
- It's important to first code the underlying conditions such as:
    - Amyloidosis
    - Endocrine diseases (excluding Diabetes)
    - Metabolic diseases (E70 – E88)
    - Neoplasms
    - Nutritional deficiencies

- **EXCLUDES:**
    - Diabetes Mellitus (E08-E13 with .42) and Prediabetes.
    - Diphtheria (A36.83)
    - Infectious mononucleosis complicated by polyneuropathy (B27.0 - B27.9 with 5th character 1)
    - Lyme disease (A69.22)
    - MUMPS (B26.84)
    - Postherpetic (B02.23)
    - Rheumatoid Arthritis (M05.5X)
    - Scleroderma (M34.83)
    - Systemic Lupus Erythematosus (M32.19)
    - Neuralgia NOS (M79.2)
    - Neuritis NOS (M79.2)
    - Peripheral neuritis in pregnancy (O26.82-)
    - Radiculitis NOS (M54.10)

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G65.X	Sequelae of inflammatory and toxic polyneuropathies	75	N/A
G70.XX	Myasthenia gravis and other myoneural disorders	75	196
G73.1	Lambert-Eaton syndrome in neoplastic disease	75	196
G73.3	Myasthenic syndromes in other diseases classified elsewhere	75	196
M05.5XX	Rheumatoid polyneuropathy with rheumatoid arthritis	75	N/A
M34.83	Systemic sclerosis with polyneuropathy	75	N/A

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings from each Physical Exam should be consistently recorded to maintain an accurate medical history.
- Review consultation notes from relevant specialists such as Neurologists or Rheumatologists to pinpoint the specific description and current state of the disease, which is essential for assigning the most suitable code.
- For G73.1: Lambert-Eaton syndrome in neoplastic disease, the underlying neoplasm should be coded first.
- In the case of G73.3: Myasthenic syndromes in other diseases classified elsewhere, the underlying condition like Neoplasm or Thyrotoxicosis should be coded first.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G71.0X	Muscular dystrophy	76	N/A
G71.11	Myotonic muscular dystrophy	76	196
G71.2XX	Congenital myopathies	76	196

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G35	Multiple sclerosis	77	198
G36.X	Other acute disseminated demyelination	77	198
G37.0	Diffuse sclerosis of central nervous system	77	198
G37.1	Central demyelination of corpus callosum	77	198
G37.2	Central pontine myelinolysis	77	198
G37.5	Concentric sclerosis [Balo] of central nervous system	77	198
G37.8	Other specified demyelinating diseases of central nervous system	77	198
G37.9	Demyelinating disease of central nervous system, unspecified	77	198

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G10	Huntington's disease	**78**	**200**
G20	Parkinson's disease	**78**	**199**
G21.3	Postencephalitic parkinsonism	**78**	**199**
G21.4	Vascular parkinsonism	**78**	**199**
G21.8	Other secondary parkinsonism	**78**	**199**
G21.9	Secondary parkinsonism, unspecified	**78**	**199**
G23.X	Other degenerative diseases of basal ganglia	**78**	**199**
G90.3	Multi-system degeneration of the autonomic nervous system	**78**	**199**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G40.XXX	Epilepsy and recurrent seizures	**79**	**201**
R56.XX	Convulsions, not elsewhere classified	**79**	**201**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Current treatment strategy should be clearly documented.
- The date of the most recent seizure episode should be recorded, including any associated complications if applicable.
- Documentation should note the recurrence or frequency of seizure episodes.
- Consultation notes from the neurologist or relevant specialist should be reviewed to determine the specific description and current state of the disorder, which will assist in assigning the most appropriate code.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G81.XX	Spastic/Flaccid/Unspecified Hemiplegia	103	253
I69.05X	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage	103	253
I69.15X	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage	103	253
I69.25X	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage	103	253
I69.35X	Hemiplegia and hemiparesis following cerebral infarction	103	253
I69.85X	Hemiplegia and hemiparesis following other cerebrovascular disease	103	253
I69.95X	Hemiplegia and hemiparesis following unspecified cerebrovascular disease	103	253

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
G83.0	Diplegia of upper limbs	104	254
G83.1X	Monoplegia of lower limb	104	254
G83.2X	Monoplegia of upper limb	104	254
G83.3X	Monoplegia, unspecified	104	254
G83.5	Locked-in state	104	254
G83.8X	Other specified paralytic syndromes	104	254
G83.9	Paralytic syndrome, unspecified	104	254
I69.03X	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage	104	254
I69.04X	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage	104	254
I69.06X	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage	104	254
I69.13X	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage	104	254
I69.14X	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage	104	254
I69.16X	Other paralytic syndrome following nontraumatic intracerebral hemorrhage	104	254

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Record clinical findings during the physical exam at every visit for consistency.
- Review consultation notes from a neurology specialist to find the specific description and the current status of the condition to assign the most suitable code.
- Make note of the patient's mobility status.
- If present, document any associated conditions such as bed sores, skin ulcers, or issues with urinary or fecal incontinence or retention.
- For maximum specificity, code according to the underlying disease, laterality, and side dominance.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I69.23X	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage	104	254
I69.24X	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage	104	254
I69.26X	Other paralytic syndrome following other nontraumatic intracranial hemorrhage	104	254
I69.33X	Monoplegia of upper limb following cerebral infarction	104	254
I69.34X	Monoplegia of lower limb following cerebral infarction	104	254
I69.36X	Other paralytic syndrome following cerebral infarction	104	254
I69.83X	Monoplegia of upper limb following other cerebrovascular disease	104	254
I69.84X	Monoplegia of lower limb following other cerebrovascular disease	104	254
I69.86X	Other paralytic syndrome following other cerebrovascular disease	104	254
I69.93X	Monoplegia of upper limb following unspecified cerebrovascular disease	104	254
I69.94X	Monoplegia of lower limb following unspecified cerebrovascular disease	104	254
I69.96X	Other paralytic syndrome following unspecified cerebrovascular disease	104	254

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Record clinical findings during the physical exam at every visit for consistency.
- Review consultation notes from a neurology specialist to find the specific description and the current status of the condition to assign the most suitable code.
- Make note of the patient's mobility status.
- If present, document any associated conditions such as bed sores, skin ulcers, or issues with urinary or fecal incontinence or retention.
- For maximum specificity, code according to the underlying disease, laterality, and side dominance.

Dementia

HCC V24	HCC V28
HCC 51: Dementia With Complications	HCC 125: Dementia, Severe HCC 126: Dementia, Moderate HCC 127: Dementia, Mild or Unspecified
HCC 52: Dementia Without Complication	

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F01.CXX	Vascular dementia, severe	51	125
F02.CXX	Dementia in other diseases classified elsewhere, severe	51	125
F03.CXX	Unspecified dementia, severe	51	125
F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	52	125
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	52	125
F03.C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	52	125

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings and behavioral disturbances when pertinent to episode of care.
- Review Specialist (Neurology) consult notes to locate the specific description and status of the disease to assign the most appropriate code.
- For specific conditions:
- F01.XXX: Vascular dementia - document imaging studies supporting a diagnosis of vascular dementia.
- F02.XX: Dementia in other diseases classified elsewhere - Code first the underlying physiological condition, such as:
- G30.9 - Alzheimer's disease
- G10 – Huntington's disease
- G20 – Parkinson's disease
- G31.83 - Dementia with Lewy bodies
- G31.09 - Frontotemporal dementia
- G40.XX - Epilepsy and recurrent seizures
- S06.XX - Traumatic brain injury
- And others.
- Also, remember to document:
- The stage and severity of dementia (early, middle, late, or unspecified).
- The presence and type of any behavioral disturbances (agitation, aggression, wandering).
- Any associated complications such as falls, fractures, or aspiration pneumonia.
- Whether the dementia is affecting the patient's ability to perform activities of daily living.

Dementia

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F01.BXX	Vascular dementia, moderate	**51**	**126**
F02.BXX	Dementia in other diseases classified elsewhere, moderate	**51**	**126**
F03.BXX	Unspecified dementia, moderate	**51**	**126**
F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**126**
F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**126**
F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**126**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings and behavioral disturbances when pertinent to episode of care.
- Review Specialist (Neurology) consult notes to locate the specific description and status of the disease to assign the most appropriate code.
- For specific conditions:
- F01.XXX: Vascular dementia - document imaging studies supporting a diagnosis of vascular dementia.
- F02.XX: Dementia in other diseases classified elsewhere - Code first the underlying physiological condition, such as:
- G30.9 - Alzheimer's disease
- G10 – Huntington's disease
- G20 – Parkinson's disease
- G31.83 - Dementia with Lewy bodies
- G31.09 - Frontotemporal dementia
- G40.XX - Epilepsy and recurrent seizures
- S06.XX - Traumatic brain injury
- And others.
- Also, remember to document:
- The stage and severity of dementia (early, middle, late, or unspecified).
- The presence and type of any behavioral disturbances (agitation, aggression, wandering).
- Any associated complications such as falls, fractures, or aspiration pneumonia.
- Whether the dementia is affecting the patient's ability to perform activities of daily living.

Dementia

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
F01.AXX	Vascular dementia, mild	**52**	**127**
F02.AXX	Dementia in other diseases classified elsewhere, mild	**52**	**127**
F03.AXX	Unspecified dementia, mild	**52**	**127**
F01.50	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
F02.80	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
F03.90	Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	**52**	**127**
G30.X	Alzheimer's disease	**52**	**127**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings and behavioral disturbances when pertinent to episode of care.
- Review Specialist (Neurology) consult notes to locate the specific description and status of the disease to assign the most appropriate code.
- For specific conditions:
- F01.XXX: Vascular dementia - document imaging studies supporting a diagnosis of vascular dementia.
- F02.XX: Dementia in other diseases classified elsewhere - Code first the underlying physiological condition, such as:
- G30.9 - Alzheimer's disease
- G10 – Huntington's disease
- G20 – Parkinson's disease
- G31.83 - Dementia with Lewy bodies
- G31.09 - Frontotemporal dementia
- G40.XX - Epilepsy and recurrent seizures
- S06.XX - Traumatic brain injury
- And others.
- Also, remember to document:
- The stage and severity of dementia (early, middle, late, or unspecified).
- The presence and type of any behavioral disturbances (agitation, aggression, wandering).
- Any associated complications such as falls, fractures, or aspiration pneumonia.
- Whether the dementia is affecting the patient's ability to perform activities of daily living.

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V
G31.01	Pick's disease	52	127
G31.09	Other frontotemporal neurocognitive disorder	52	127
G31.81	Alpers disease	52	127
G31.82	Leigh's disease	52	127
G31.83	Neurocognitive disorder with Lewy bodies	52	127
G91.X	Hydrocephalus	51	127
A81.XX	Atypical virus infections of CNS [diseases of CNS]	52	127
G93.7	Reye's syndrome	52	127
I67.3	Progressive vascular leukoencepha-lopathy	52	127

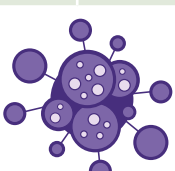
CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Clinical findings and cognitive assessment when pertinent to episode of care.
- Review Specialist (Neurology) consult notes to locate the specific description and status of the disease to assign the most appropriate code.

- For specific conditions:
    - G91.X: Hydrocephalus - document imaging studies and/or neurology notes supporting a diagnosis of hydrocephalus. Also, document the presence of a ventriculoperitoneal shunt if applicable.

HCC V24	HCC V28
HCC 8: Metastatic Cancer and Acute Leukemia	HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
	HCC 18: Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
	HCC 22: Bladder, Colorectal, and Other Cancers
HCC 9: Lung and Other Severe Cancers	HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
	HCC 19: Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
	HCC 20: Lung and Other Severe Cancers
	HCC 22: Bladder, Colorectal, and Other Cancers
HCC 10: Lymphoma and other cancers	HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
	HCC 18: Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
	HCC 19: Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
	HCC 20: Lung and Other Severe Cancers
	HCC 21: Lymphoma and Other Cancers
	HCC 22: Bladder, Colorectal, and Other Cancers
	HCC 23: Prostate, Breast, and Other Cancers and Tumors



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C77.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck	**8**	**18**
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes	**8**	**17**
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes	**8**	**18**
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes	**8**	**18**
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes	**8**	**18**
C78.XX	Secondary malignant neoplasm of respiratory and digestive organs	**8**	**17**
C79.0X	Secondary malignant neoplasm of kidney and renal pelvis	**8**	**17**
C79.1X	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	**8**	**18**
C79.3X	Secondary malignant neoplasm of brain and cerebral meninges	**8**	**17**
C79.4X	Secondary malignant neoplasm of other and unspecified parts of nervous system	**8**	**17**
C79.5X	Secondary malignant neoplasm of bone and bone marrow	**8**	**18**
C79.6X	Secondary malignant neoplasm of ovary	**8**	**18**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Review oncology records to confirm the anatomic site, behavior, laterality, and primary cancer type if possible.
- If the primary malignancy has been successfully treated and there is no further evidence of active disease, Code First: the secondary malignancy. Also, assign a code from category Z85.XX to denote the previous site of malignancy as a secondary code.
- Each time a code is used, document the treatment plan, which may include radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, or surgery. If a patient has completed treatment and there is no further evidence of disease, it is appropriate to assign a Personal History code (Z85.XX).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C79.7X	Secondary malignant neoplasm of adrenal gland	**8**	**17**
C79.89	Secondary malignant neoplasm of other specified sites	**8**	**18**
C79.9	Secondary malignant neoplasm of unspecified site	**8**	**19**
C7B.XX	Secondary neuroendocrine tumors	**8**	**17**
C80.0	Disseminated malignant neoplasm, unspecified	**8**	**18**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Review oncology records to confirm the anatomic site, behavior, laterality, and primary cancer type if possible.
- If the primary malignancy has been successfully treated and there is no further evidence of active disease, Code First: the secondary malignancy. Also, assign a code from category Z85.XX to denote the previous site of malignancy as a secondary code.
- Each time a code is used, document the treatment plan, which may include radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, or surgery. If a patient has completed treatment and there is no further evidence of disease, it is appropriate to assign a Personal History code (Z85.XX).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C91.XX	Lymphoid leukemia	8	18
C92.0X	Acute myeloblastic leukemia	8	17
C92.4X	Acute promyelocytic leukemia	8	22
C92.5X	Acute myelomonocytic leukemia	8	17
C92.6X	Acute myeloid leukemia with 11q23-abnormality	8	18
C92.AX	Acute myeloid leukemia with multilineage dysplasia	8	18
C93.XX	Acute monoblastic/monocytic leukemias	8	17
C94.XX	Acute erythroid/megakaryoblastic leukemias	8	17
C95.XX	Acute leukemia of unspecified cell type	8	18

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Review Hematology/Oncology records that validate the diagnosis.
- Document the current treatment regime as indicated in the specialist's note, when applicable.
- When using categories for acute leukemia, apply codes that specify whether the leukemia is in remission or not. If there's ambiguity regarding the leukemia's remission status in the documentation, seek updated specialist notes and continue using active disease codes pending confirmation.
- If applicable, document the status of a bone marrow transplant (Z99.84).
- Each time a code is used, document the treatment plan, which can include radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, or surgery. If a patient has finished treatment and there is no further evidence of disease, it is appropriate to use a Personal History code (Z85.XX).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C92.3X	Myeloid sarcoma	9	17
C45.X	Mesothelioma	9	19
C90.0X	Multiple myeloma	9	19
C90.1X	Plasma cell leukemia	9	19
C90.2X	Extramedullary plasmacytoma	9	19
C15.X	Malignant neoplasm of esophagus	9	20
C16.X	Malignant neoplasm of stomach	9	20
C17.X	Malignant neoplasm of small intestine	9	20
C22.X	Malignant neoplasm of liver and intrahepatic bile ducts	9	20
C23	Malignant neoplasm of gallbladder	9	20
C24.X	Malignant neoplasm of other and unspecified parts of biliary tract	9	20
C25.X	Malignant neoplasm of pancreas	9	20
C33	Malignant neoplasm of trachea	9	20
C34.XX	Malignant neoplasm of bronchus and lung	9	20
C38.4	Malignant neoplasm of pleura	9	20
C48.X	Malignant neoplasm of retroperitoneum and peritoneum	9	20
C92.2X	Atypical chronic myeloid leukemia, BCR/ABL-negative	9	20
C92.9X	Myeloid leukemia, unspecified	9	20
C92.ZX	Other myeloid leukemia	9	20
C93.1X	Chronic myelomonocytic leukemia	9	20
C93.3X	Juvenile myelomonocytic leukemia	9	20
C93.9X	Monocytic leukemia, unspecified	9	20
C93.ZX	Other monocytic leukemia	9	20
C94.3X	Mast cell leukemia	9	20
C94.8X	Other specified leukemias	9	20
C92.1X	Chronic myeloid leukemia, BCR/ABL-positive	9	22

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Cancer Behavior: It could be malignant, neuroendocrine, carcinoma in situ, benign, or unknown.
- Metastasis: First code the primary site and then the secondary cancer/metastatic site if applicable.
- Morphology: Note the histological type, stage, and grade.
- Anatomic Site: Identify the specific cancer location.
- Laterality: Indicate whether it's left, right, or bilateral.
- <u>Ensure to:</u>
- Review Hematology/Oncology Consult Notes: For the precise description and status of the severe cancer to assign the appropriate code.
- Continued Usage of Active/Current Diagnosis: Document in the Assessment/Plan if the patient is:
    - Currently undergoing treatment, such as surgery, radiotherapy, immunotherapy, targeted therapy, or chemotherapy. Reflect this in the Plan/Assessment of the office visit for proper validation of active diagnosis.
    - In current Adjuvant therapy status post excision of the neoplasm. Reflect this in the Plan/Assessment of the office visit for proper validation of active diagnosis.
    - Under active surveillance, i.e., the Oncologist has discussed various therapeutic options, and the patient/caregiver has refused any treatment. The provider keeps the patient under active surveillance to monitor the progress of the chronic disease.
- Assign the Right Code for Patients in Remission: Lymphoma and multiple myeloma patients in remission are still considered to have the disease and should be assigned their appropriate primary neoplasm code (C90-C96). However, Hodgkin's lymphomas, after a certain period in remission, are considered cured and should be coded as Z85.81: Personal history of Hodgkin's lymphoma.
- Include the treatment plan (radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, surgery). If the patient has completed treatment and there is no further evidence of disease, use a Personal History code (Z85.XX).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C40.XX - C41.XX	Malignant neoplasm of bone and articular cartilage	10	21
C46.XX	Kaposi's Sarcoma	10	21
C47.XX	Malignant neoplasm of peripheral nerves	10	21
C49.XX*	Malignant neoplasm of connective and soft tissue	10	21
C49.4	Malignant neoplasm of connective and soft tissue of abdomen	10	23
C49.AX	Gastrointestinal Stromal Tumor	10	23
C56.X - C57.XX	Malignant neoplasm of ovary and uterine adnexa	10	22
C58	Malignant neoplasm of placenta	10	22
C70.X - C72.XX	Malignant neoplasm of Central nervous system	10	20
C74.XX	Malignant neoplasm of adrenal gland	10	22
C75.1	Malignant neoplasm of pituitary gland	10	20
C75.2	Malignant neoplasm of craniopharyngeal duct	10	20
C75.3	Malignant neoplasm of pineal gland	10	20
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes	10	20
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified	10	18
C79.81	Secondary malignant neoplasm of breast	10	18
C79.82	Secondary malignant neoplasm of genital organs	10	18
C81.XX	Hodgkin lymphomas	10	21
C82.XX	Follicular lymphoma	10	21
C83.0X	Small cell B-cell lymphoma	10	21

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Site of Lymphoma: Specify the location of the lymphoma.
- Type of Lymphoma: Identify the specific kind of lymphoma.
- State of the Disease: Indicate if it's active or in remission.

- Consider the following specifics:
  - Multiple Sites of Lymphomas: When lymphoma is present in multiple sites, each site should be regarded as primary and reported with individual ICD-10 codes (multiple sites) as appropriate.
  - Coding for Lymphomas in Remission: Patients in remission from lymphomas are still considered to have the disease and should be assigned their appropriate primary neoplasm code (C81-C96). An exception is Hodgkin lymphomas, which after a certain time in remission, are considered cured and should be coded as Z85.81: Personal history of Hodgkin's lymphoma.

- Remember to:
  - Review Hematology/Oncology Consult Notes: Locate the specific description and status of the lymphoma to assign the most suitable code.
  - Code Metastasis: First code the primary site, then the secondary cancer/metastatic site if applicable.
  - Coding for Successfully Treated Primary Malignancy: If the primary malignancy has been successfully treated and there is no further evidence of active disease, Code First: the secondary malignancy and assign a personal history code from category Z85.XX to indicate the former site of malignancy as a secondary code.

- And finally:
  - Document Every Time a Code is Used: Include the plan of treatment (radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, surgery). If the patient has completed treatment and there is no further evidence of disease, use a Personal History code (Z85.XX).

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C83.XX	Non-follicular lymphoma (except: Small cell B-cell lymphoma)	10	21
C84.0X	Mycosis fungoides	10	20
C84.1X	Sézary disease	10	17
C84.4X	Peripheral T-cell lymphoma, not elsewhere classified	10	19
C84.6X	Anaplastic large cell lymphoma, ALK-positive	10	20
C84.7X	Anaplastic large cell lymphoma, ALK-negative	10	19
C84.9X	Mature T/NK-cell lymphomas, unspecified	10	20
C84.AX	Cutaneous T-cell lymphoma, unspecified	10	20
C84.ZX	Other mature T/NK-cell lymphomas	10	20
C85.XX	Other specified and unspecified types of non-Hodgkin lymphoma	10	21
C83.XX	Non-follicular lymphoma (except: Small cell B-cell lymphoma)	10	21
C84.0X	Mycosis fungoides	10	20
C84.1X	Sézary disease	10	17
C84.4X	Peripheral T-cell lymphoma, not elsewhere classified	10	19
C84.6X	Anaplastic large cell lymphoma, ALK-positive	10	20
C84.7X	Anaplastic large cell lymphoma, ALK-negative	10	19
C84.9X	Mature T/NK-cell lymphomas, unspecified	10	20
C84.AX	Cutaneous T-cell lymphoma, unspecified	10	20
C84.ZX	Other mature T/NK-cell lymphomas	10	20
C85.XX	Other specified and unspecified types of non-Hodgkin lymphoma	10	21

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C86.0	Extranodal NK/T-cell lymphoma, nasal type	10	20
C86.1	Hepatosplenic T-cell lymphoma	10	20
C86.2	Enteropathy-type (intestinal) T-cell lymphoma	10	20
C86.3	Subcutaneous panniculitis-like T-cell lymphoma	10	19
C86.4	Blastic NK-cell lymphoma	10	19
C86.5	Angioimmunoblastic T-cell lymphoma	10	19
C86.6	Primary cutaneous CD30-positive T-cell proliferations	10	20
C88.2	Heavy chain disease	10	21
C88.3	Immunoproliferative small intestinal disease	10	21
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]	10	21
C88.8	Other malignant immunoproliferative diseases	10	21
C88.9	Malignant immunoproliferative disease, unspecified	10	21
C90.3X	Solitary plasmocytoma	10	19
C91.1X	Chronic lymphocytic leukemia of B-cell type	10	22
C91.3X	Prolymphocytic leukemia of B-cell type	10	19
C91.4X	Hairy cell leukemia	10	22
C91.5X	Adult T-cell lymphoma/leukemia (HTLV-1-associated)	10	19
C91.6X	Prolymphocytic leukemia of T-cell type	10	19
C91.9X	Lymphoid leukemia, unspecified	10	22
C91.AX	Mature B-cell leukemia Burkitt-type	10	20
C91.ZX	Other lymphoid leukemia	10	22

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C95.1X	Chronic leukemia of unspecified cell type	**10**	**22**
C95.9X	Leukemia, unspecified	**10**	**22**
C96.XX	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue	**10**	**21**

CDI Tips

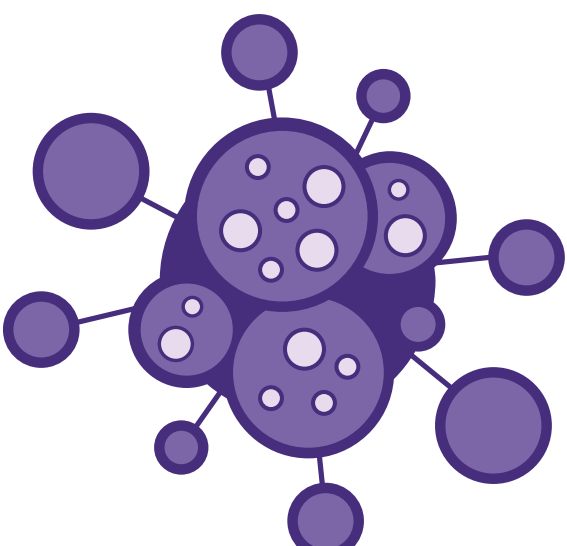
To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Lymphoma Location: The specific site of the lymphoma within the body.
- Lymphoma Type: The distinct type of lymphoma diagnosed.
- State of Condition: Indication of whether the lymphoma is active or in remission.

- <u>Specific points for Lymphomas:</u>
  - If multiple sites are involved in the lymphoma, each site should be treated as a primary site and be coded with an individual ICD-10 code (pertaining to multiple sites).
  - Patients with lymphoma in remission are still considered to have lymphoma and should be assigned the relevant primary neoplasm code (C81-C96), except in cases of Hodgkin lymphomas. After a specific duration of remission, Hodgkin lymphomas are considered cured and should be coded as Z85.81: Personal history of Hodgkin's lymphoma.

- <u>Further considerations:</u>
  - Hematology/Oncology consult notes should be thoroughly reviewed to find the detailed description and current status of the lymphoma, ensuring the most suitable code is assigned.
  - In situations where the primary malignancy has been successfully treated with no further signs of active disease, the secondary malignancy should be coded first. A personal history code from category Z85.XX should then be assigned to signify the previous site of malignancy.
  - Each time a code is applied, the treatment plan (involving radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, surgery) should be well-documented. If a patient has completed treatment and no active disease is present, it is proper to use a Personal History code (Z85.XX).

HCC V24	HCC V28
HCC 11: Colorectal, Bladder, and Other Cancers	HCC 20: Lung and Other Severe Cancers
	HCC 21: Lymphoma and Other Cancers
	HCC 22: Bladder, Colorectal, and Other Cancers
HCC 12: Breast, Prostate, and Other Cancers and Tumors	HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
	HCC 21: Lymphoma and Other Cancers
	HCC 23: Prostate, Breast, and Other Cancers and Tumors



ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C01 – C06.XX	Malignant neoplasms of oral cavity	11	21
C07 – C08.X	Malignant neoplasms of salivary glands	11	21
C09.X - C11.X	Malignant neoplasms of tonsils, epiglottis, oropharynx and nasopharynx	11	21
C12.X - C13.X	Malignant neoplasms of pyriform sinus and hypopharynx	11	21
C14.X	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx	11	21
C18.X - C21.X	Malignant neoplasms of large intestine, rectum and anus	11	22
C26.X	Malignant neoplasm of other and ill-defined digestive organs	11	22
C30.X - C31.X	Malignant neoplasms of nasal cavity, nasal sinuses and middle ear	11	21
C32.X	Malignant neoplasms of larynx	11	21
C37	Malignant neoplasm of thymus	11	21
C38.0	Malignant neoplasm of heart	11	20
C38.1	Malignant neoplasm of anterior mediastinum	11	21
C38.2	Malignant neoplasm of posterior mediastinum	11	21
C38.3	Malignant neoplasm of mediastinum, part unspecified	11	21
C38.8	Malignant neoplasm of overlapping sites of heart, mediastinum and pleura	11	21
C39.X	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs	11	21
C51.X - C57.X	Malignant neoplasms of female genital organs	11	22

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C64.X - C68.X	Malignant neoplasms of kidney and urinary organs	**11**	**22**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Disease Behavior: It could be malignant, neuroendocrine, carcinoma in situ, benign, or of unknown origin.
- Metastasis: Initially, code for the primary site and then for any secondary or meta static cancer sites if they exist.
- Morphology: Document the histological type, stage, and grade of the cancer.
- Anatomic Site: Precisely indicate where the cancer is located.
- Laterality: Specify if the cancer is on the left, right, or both sides.

- Additional important steps include:
  - Consult Note Review: Always check the Specialist/Oncology consult notes to gather detailed information on the disease's description and status, which aids in assigning the most accurate code.
  - Successful Primary Malignancy Treatment: If the primary malignancy has been successfully treated and there is no sign of active disease, Code First for the secondary malignancy. Also, use a personal history code from category Z85.XX to mark the initial site of the malignancy as a secondary code.**
  - Treatment Plan Documentation: Every time a code is used, record the plan of treatment which may include radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, or surgery. If the patient has finished the treatment and no further evidence of disease exists, use a Personal History code (Z85.XX).**

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
C43.XXX	Malignant melanomas *	12	23
C4A.XXX	Merkel Cell Carcinoma	12	21
C50.XXX	Malignant neoplasm of breast	12	23
C54.X - C55.X	Malignant neoplasm of uterus	12	23
C60.X	Malignant neoplasm of penis	12	23
C61	Malignant neoplasm of prostate	12	23
C62.XX - C63.XX	Malignant neoplasm of testis, epididymis, spermatic cord and scrotum	12	23
C69.XX	Malignant neoplasm of eye and adnexa	12	23
C73	Malignant neoplasm of Thyroid	12	23
C75.X	Malignant neoplasm of Parathyroid and paraganglia	12	23
C76.XX	Malignant neoplasm of other and ill-defined sites	12	23
C7A.XXX	Malignant carcinoid tumor and other malignant neuroendocrine tumors	12	21
C80.1	Malignant (primary) neoplasm, unspecified	12	23
C80.2	Malignant neoplasm associated with transplanted organ	12	23
D03.XXX	Melanoma in situ	12	23
D18.02	Hemangioma of intracranial structures	12	23
D32.X	Benign neoplasm of meninges	12	23
D33.X	Benign neoplasm of central nervous system	12	23
D35.X	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland	12	23
D42.X - D49.X	Neoplasm of uncertain behavior of meninges, central nervous system, pituitary gland, craniopharyngeal duct, pineal gland and paraganglia	12	23

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
E34.0	Carcinoid syndrome	**12**	**17**
Q85.XX	Neurofibromatosis, tuberous sclerosis and phakomatosis	**12**	**23**

CDI Tips

To accurately code for these group of conditions, ensure you are capturing these essential details to the greatest degree of specificity:

- Disease Behavior: It could be malignant, neuroendocrine, carcinoma in situ, benign, or of unknown origin.
- Metastasis: Initially, code for the primary site and then for any secondary or meta static cancer sites if they exist.
- Morphology: Document the histological type, stage, and grade of the cancer.
- Anatomic Site: Precisely indicate where the cancer is located.
- Laterality: Specify if the cancer is on the left, right, or both sides.

- Additional important steps include:
  - Consult Note Review: Always check the Specialist/Oncology consult notes to gather detailed information on the disease's description and status, which aids in assigning the most accurate code.
  - Successful Primary Malignancy Treatment: If the primary malignancy has been successfully treated and there is no sign of active disease, Code First for the secondary malignancy. Also, use a personal history code from category Z85.XX to mark the initial site of the malignancy as a secondary code.**
  - Treatment Plan Documentation: Every time a code is used, record the plan of treatment which may include radiotherapy, chemotherapy, immunotherapy, hormonal adjuvant therapy, or surgery. If the patient has finished the treatment and no further evidence of disease exists, use a Personal History code (Z85.XX).**

Old MI – History of Cerebral infarction

ICD 10	CODE DESCRIPTION	HCC-V24	HCC-V28
I25.2	Old Myocardial Infarction	n/a	n/a
Z86.73	Personal history of TIA and cerebral infarction without residual deficits	n/a	n/a
I69.30	Unspecified sequelae of cerebral infarction	n/a	n/a
I69.310 - I69.319	Cognitive deficits following cerebral infarction	n/a	n/a
I69.320 - I69.328	Speech and language deficits following cerebral infarction	n/a	n/a
I69.331 - I69.339	Monoplegia of upper limb following cerebral infarction	104	254
I69.341 - I69.349	Monoplegia of lower limb following cerebral infarction	104	254
I69.351 - I69.359	Hemiplegia and hemiparesis following cerebral infarction	103	253
I69.361 - I69.369	Other paralytic syndrome following cerebral infarction	104	254
I69.390 - I69.398	Other sequelae of cerebral infarction	n/a	n/a

CDI Tips

For past myocardial infarction (e.g., STEMI/NSTEMI), use I25.2: Old Myocardial Infarction. Note: Acute Myocardial Infarction (AMI) codes are valid for up to 28 days post-event. For patients with a history of cerebral infarction but no residual deficits, use Z86.73: Personal history of TIA and cerebral infarction without residual deficits.

For patients with previous cerebral infarction presenting with residual effects,

- Consistently note the clinical findings from Physical Examinations in all visits to maintain record consistency.
- Review consultation notes from the relevant Specialists (Neurology, Neurosurgery) to identify the specific description and current status of the condition. This information is crucial for assigning the most appropriate code.
- Document any associated conditions, such as bedsores, skin ulcers, urinary and/or fecal incontinence/retention, among others, and outline the appropriate plan of care.

NOTES

ULTIMATE
HEALTH PLANS

Good health is where you live.