2025

Provider MRA V28: Comprehensive Reference Guide

ULTIMATE HEALTH PLANS

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Transitioning from V24 to V28: CMS's Revised HCC Risk Adjustment Model Explained

Dear Valued Providers and Staff,

At Ultimate Health Plans, we continually strive to keep our network informed of changes that impact our shared commitment to delivering quality patient care. It is with this in mind that I write to you about the recent updates from the Centers for Medicare & Medicaid Services (CMS) regarding their HCC Risk Adjustment Model.

Understanding the Transition from V24 to V28: As we venture into 2025, CMS has presented a revised HCC risk adjustment model. If you recall, the 2020 version introduced the eight-model segments back in 2017-18, and condition count variables in 2020. The upcoming model still retains this structure. However, the transition will be phased over three years:

- **2025: 33% based on V28, with the remaining 67% on V24 (Based on DOS 2023)**
- **2025: The balance shifts to 67% based on V28, and 33% on V24 (Based on DOS 2025)**
- **2026 onward: 100% reliance on V28 (Based on DOS 2025 and subsequent years)**
  This phased transition is anticipated to result in a decrease in overall risk scores.

Important Note to Providers: During this transitional phase, we urge our Physicians and other care providers to continue utilizing codes previously risk adjusted under V24 model. Please do not discontinue using these codes as they still serve our members. Any new coding technique that we discuss during our one-on-one meeting will only add to your coding arsenal and will not take away any previously used codes. Such practice will ensure accurate risk adjustment calculations.

V28 Risk Adjustment - Key Changes Overview:

***Removed Conditions in V28: The following conditions have been excluded*:**

- AKI's (Acute Kidney Injury)
- Alcoholic Liver Disease
- Angina Pectoris
- Atherosclerosis of the Aorta, Renal Artery
- Atherosclerosis of Arteries of the Extremities with Intermittent Claudication
- Senile Degeneration…, "Cortical Atrophy"
- Complications of Specified Implanted Device or Graft
- Common Hematological Disorders
- Disorders of Immunity (D84.81, D84.821, D84.822, D84.89, D84.9)
- MDD (unspecified, mild, partial remission, full remission)
- Protein-Calorie Malnutrition and Cachexia
- Sacroiliitis, Spinal Enthesopathy, and Inflammatory Spondylopathy
- Secondary Polyneuropathy (inflammatory, alcoholic, drug-induced)
- SVT (Supraventricular tachycardia)

Added Conditions in V28: Newly included are:

- Benign Carcinoid Tumor (multiple sites)

- Other Benign Neuroendocrine Tumors
- Sarcoidosis of Skin
- Anorexia Nervosa / Bulimia Nervosa
- Postpolio Syndrome
- Severe Persistent Asthma
- Obstruction of Bile Duct
- Birth Trauma, Maternal Use of Drugs
- Newborn Problems and Disorders Specific to the Perinatal Period

Mapping to Non-Payment HCCs in V28: The 2,236 diagnosis codes excised by CMS for the new CMS- HCC v28 Model predominantly fall under six categories:

- **5% Subsequent Encounter (codes ending in D)**
- **40% Sequela (codes ending in S)**
- **8% Drug-induced**
- **16% Complication of Medical Care**
- **3% Principle 10 only**
- **28% Others**

Highlighting the Key Changes:

- **Demographics**: V28 introduces alterations in utilizing demographic data, aiming to enhance prediction accuracy regarding healthcare costs based on beneficiary details.
- **HCC Weights (coefficients)**: V28 has re-evaluated the significance of various HCCs, reflecting current healthcare trends and beneficiary requirements.
- **Number of HCCs**: The total count of HCCs differs between V28 and V24. Specifically:
    - V24 Model: 86 Payment HCCs with 9,797 ICD-10 codes mapped.
    - V28 Model: 115 Payment HCCs with 7,770 ICD-10 codes mapped.

Moreover, it's worth noting the mapping adjustments in ICD-10-CM codes to HCCs. For instance, diabetes codes that previously mapped to HCCs 17,19,18 in V24 now map to HCC 36,37, and 38 in V28. Additionally, CMS has applied constraints to certain HCCs, and even removed some, such as HCC 47 (Protein-Calorie Malnutrition), HCC 230 (Angina Pectoris), and HCC 265 (Atherosclerosis with Intermittent Claudication).

Your role, as healthcare providers, is pivotal in guiding preventive services, enabling timely identification and treatment of conditions. Accurate documentation not only benefits patient care but also augments analytics leading to improved health outcomes.
Our dedicated MRA Department is preparing educational resources regarding these updates. These will delve deeper into the effects of the V28 model on varied HCCs. Our shared objective is ensuring optimal patient care while effectively navigating these financial intricacies.

Anticipated Impact on Risk Scores: CMS highlighted that the transition's effect on risk scores would largely depend on the clinical characteristics of each plan's members. The cumulative updates, including data revisions and ICD-10 reclassifications, might lead to alterations in risk scores depending on the unique clinical combinations of a beneficiary or an entire plan's demographic.

For a more in-depth insight into these changes, please refer to the resources listed below.
In closing, let us reiterate our commitment to working collaboratively with you. Together, we can continue to enhance the quality of care we offer to our beneficiaries.

References available in Section 6: Reference

Navigating Vascular Disorders Classification: Unpacking the Transition from CMS v24 to v28 HCC Model for Enhanced Patient Care

Understanding the Transition
With the rollout of the CMS v28 Model, vascular disorders formerly under HCCs 107 and 108 in the CMS v24 Model have been restructured into HCCs 263, 264, and 267. This reclassification facilitates a clearer, more precise categorization of vascular disorders, ensuring a more streamlined approach to patient diagnosis and care.

Refinements in Classification
Relying on empirical data and clinician input, the v28 Model offers a nuanced approach to categorizing atherosclerosis cases, with particular attention to those presenting with rest pain, ulceration, or gangrene. Importantly, diagnosis codes previously labeled “other” or “unspecified” are now designated to non-payment HCCs.

Details of the New Model
Under CMS v24:

- HCC 106: Atherosclerosis of the Extremities with Ulceration or Gangrene
- HCC 107: Vascular Diseases with Complications
- HCC 108: Vascular Diseases without Complications

Transitioning to CMS v28:

- HCC 263: Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene
- HCC 264: Vascular Disease with Complications
- HCC 267: Deep Vein Thrombosis and Pulmonary Embolism

Essential Coding and Documentation Tips
To ensure accurate and effective coding:

1. **Specify Location**: Identify the affected artery or vein, noting whether it’s native or a transplant.
2. **Transplants Details**: Document transplant specifics, if applicable.
3. **Side Affected**: Record whether the right, left, or both sides are affected.
4. **Report Symptoms**: Detail all patient symptoms.
5. **Outline Care Approach**: List medications, dietary advice, exercise suggestions, and specialist referrals.

Newly Introduced Codes for Providers
Ensure to integrate the following crucial codes into your coding practices:

- I70221: Atherosclerosis of native arteries of extremities with rest pain, right leg
- I70222: Atherosclerosis of native arteries of extremities with rest pain, left leg
- I70223: Atherosclerosis of native arteries of extremities with rest pain, bilateral legs

Understanding Rest Pain in PAD Patients

Rest pain in PAD patients is crucial to identify and understand for accurate coding and effective treatment. This pain is not limited to claudication but extends to include numbness, tingling, and a burning sensation in the lower extremities during rest. Recognizing and documenting these symptoms are vital.

To facilitate accurate patient assessment and effective coding, consider asking the following questions:

1. **Do you experience numbness in your legs or feet when you are resting or sleeping?**
2. **Is there a tingling sensation in your lower extremities at rest?**
3. **Do you feel a burning sensation in your legs or feet when not moving?**
4. **Are these sensations accompanied by visible skin changes, such as paleness or coolness to the touch?**
5. **Do the numbness, tingling, and burning sensations alleviate or intensify with movement or exercise?**

These inquiries will guide patients to describe their symptoms more accurately, providing you with the necessary information to use the new I70221, I70222, and I70223 codes appropriately.

Conclusion

Understanding the nuances of PAD symptoms, especially the various manifestations of rest pain, is essential for accurate coding under the CMS v28 Model. Integrating the new codes into your practice will facilitate precise documentation and diagnosis, ultimately leading to more effective and personalized patient care. Ensure to incorporate these documentation and coding practices into your daily operations for optimal patient service and compliance with the new CMS guidelines.

References are available in Section 6: References

Fine-Tuning Pulmonary Fibrosis Coding: Transitioning to Precise Diagnosis with Code J84.112 for Idiopathic Pulmonary Fibrosis

Overview of Coding Refinement
In the intricate landscape of medical coding, specificity is paramount. The emergence of more detailed coding options necessitates a shift in coding behavior, particularly for conditions like Pulmonary Fibrosis. The spotlight of this communication is to guide providers in transitioning from the commonly used **J84.10: Pulmonary Fibrosis, unspecified**, to the more precise **J84.112: Idiopathic Pulmonary Fibrosis.**

Moving Towards Specificity: Understanding Idiopathic Pulmonary Fibrosis
Precision in coding is crucial for accurate diagnosis and treatment. While J84.10 has been a go-to code for cases of Pulmonary Fibrosis, the need for a more refined coding approach is evident. The code J84.112 is introduced to bring this needed specificity to cases of Pulmonary Fibrosis that are inherently idiopathic, offering a clear distinction for cases that previously might have been generalized or misclassified.

Why the Shift is Crucial
Accurate coding plays a pivotal role in patient care, research, and treatment protocol development. By utilizing J84.112, healthcare providers acknowledge the idiopathic nature of the pulmonary fibrosis, contributing to a more tailored approach to patient care and treatment planning. This change is not merely about compliance; it reflects a commitment to precise, individualized patient diagnosis and care.

Implication for Providers: Changing Coding Practice
The introduction of J84.112 requires a conscious shift in coding practices. Providers need to:

- **Exercise Discernment**: Recognize and differentiate idiopathic pulmonary fibrosis from other forms.
- **Engage in Continuous Learning**: Familiarize themselves with the characteristics and criteria of idiopathic cases.
- **Implement Practice-Wide Adoption**: Ensure that the entire practice is aligned in using the new code where applicable.

Enhancing Documentation Practices
To effectively implement the use of J84.112:

- **Detailed Patient History**: Document the patient's history meticulously, focusing on the onset and progression of symptoms.
- **Diagnostic Criteria**: Clearly note the diagnostic criteria met for idiopathic pulmonary fibrosis.
- **Treatment Plan**: Develop and record a detailed treatment plan that aligns with the idiopathic nature of the condition.

Conclusion: A Call for Precision in Coding
The transition from J84.10 to J84.112 represents more than a change in nomenclature. It is a call for enhanced precision and acknowledgment of the complexity of pulmonary conditions. This shift requires a conscious change in provider behavior, emphasizing the importance of specificity in coding for idiopathic pulmonary fibrosis. By adopting J84.112, providers not only align with compliance standards but also contribute to the nuanced understanding and management of idiopathic pulmonary fibrosis, ultimately fostering improved patient care and outcomes under the evolving medical guidelines and practices.

References available in Section 6: References

Deciphering Severe Persistent Asthma & COPD Classification: Insights into CMS v28 Model's Risk Adjustment for Improved Patient Diagnosis and Treatment

An Overview of the Transition
The advent of the CMS v28 Model brings noteworthy adjustments in risk stratification for Severe Persistent Asthma, aligning the classification system more closely with patient symptoms and care needs.

Severe Persistent Asthma: Risk-Adjusted Codes
Under the newly introduced v28 Model, codes for Severe Persistent Asthma have undergone significant transformation:

- J45.50: **Severe persistent asthma**, uncomplicated
- J45.51: **Severe persistent asthma** with (acute) exacerbation
- J45.52: **Severe persistent asthma** with status asthmaticus

Previously falling under non-payment HCCs with no risk adjustment, these codes now possess risk adjustment coefficients of .818 in the v28 Model, ensuring a more precise reflection of patient care requirements and provider service intensity.

COPD: A Common Coding Challenge
While the code J44.9 is frequently utilized for COPD, it's crucial for providers to exercise caution and discernment. Patients with a long-term history of asthma often showcase diminished reversibility of airway obstruction, subsequently manifesting COPD-like patterns during pulmonary function testing (PFT). Such overlap in clinical presentations might inadvertently lead to over-coding of COPD in patients primarily suffering from asthma.
A combination of PFT, Bronchial Hyperresponsiveness, atopy testing, and high-resolution CT scans serves as vital tools to accurately differentiate between COPD and asthma.

Asthma in Seniors: A Critical Consideration
Asthma affects over 10% of the senior population, as documented in the Journal of Allergy and Clinical Immunology Practice. Inherent to its nature, asthma exhibits a persistent course. A diagnosis of severe persistent asthma necessitates the patient experiencing symptoms on a daily or nearly daily basis without appropriate treatment.
During exacerbations, patients may continue to endure daily symptoms until effective treatment is administered, characteristic of severe persistent asthma.

Essential Documentation Practices for Severe Persistent Asthma
The meticulous documentation is pivotal for the accurate coding and treatment of severe persistent asthma. Providers should ensure to record:

1. **Symptom Frequency**: Clearly document the regularity of the patient's asthma symptoms.
2. **Identifying Triggers**: Note specific triggers that precipitate or exacerbate the patient's asthma.
3. **Medication**: List all medications the patient is currently taking or has been prescribed for asthma.
4. **Lifestyle & Environment**: Include relevant information about the patient's living conditions and lifestyle, as these factors can significantly influence asthma.

Conclusion and Focus

As we integrate the CMS v28 Model, a meticulous understanding and application of the revised coding system for Severe Persistent Asthma and COPD are imperative. Emphasizing the frequency of symptoms is particularly crucial for accurate coding of Severe Persistent Asthma. Providers should bear in mind that a patient must exhibit symptoms daily or nearly daily without treatment for a correct diagnosis and coding of severe persistent asthma. Employing comprehensive documentation practices, and leveraging diagnostic tools effectively, providers can ensure precise diagnosis, coding, and consequently, optimized patient care under the new CMS guidelines. This mindful approach not only enhances the quality of patient care but also aligns seamlessly with the compliance requisites of the CMS v28 Model.

References are available in Section 6: References

Section 5

Adapting to Angina Pectoris Coding Updates: Discerning between Non-Risk and Risk-Adjusted Codes in CMS Model v28

Introduction: Navigating the Shifts in Angina Pectoris Coding
With the unfolding of the CMS Model v28, providers are necessitated to align with the adjustments in coding practices for Angina Pectoris. This guiding communication endeavors to delineate the distinctive lines between non-risk adjusted codes and those that are risk-adjusted under the new framework, concentrating particularly on the code I23.7 for Postinfarction Angina.

Angina Pectoris: Now Non-Risk Adjusted
In the latest edition of the CMS Model, the following codes associated with Angina Pectoris are now designated as non-risk adjusted:

Angina Pectoris (removed)
I20.1: Angina Pectoris with documented Spasm
I20.2: Refractory Angina Pectoris
I20.8: Other Forms of Angina Pectoris
I20.9: Angina Pectoris, Unspecified
Unstable Angina
    I20.0: Unstable Angina (risk adjusted)
Postinfarction Angina (risk adjusted)
    I23.7: Postinfarction Angina

Given this categorization, providers must exercise meticulous attention and accuracy in documentation and coding, acknowledging that these codes no longer carry risk adjustment under the CMS Model v28.

Postinfarction Angina: Risk-Adjusted Coding
Contrastingly, the code I23.7: Postinfarction Angina remains within the realm of risk-adjusted codes. This code is crucial for instances where patients experience angina following an acute myocardial infarction (MI). Adopting the I23.7 code is integral for accurate risk adjustment, as it plays a pivotal role in reflecting the patient's health status and calibrating the care services accordingly.

Essential Documentation Guidance
To seamlessly navigate this transition, consider the following documentation tips:

- For codes now deemed non-risk adjusted, ensure to capture the full clinical picture, detailing the patient's symptoms, triggers, and treatment regimen.
- When utilizing I23.7, accurate timing of the postinfarction angina in relation to the MI is crucial. Documentation should meticulously reflect the onset and characteristics of the angina, providing a clear timeline post the initial MI.

Conclusion: Embracing Precision in the New Coding Landscape
The advent of the CMS Model v28 heralds a season of precision and adaptability in medical coding. Providers are called to meticulously discern between non-risk adjusted and risk-adjusted codes when dealing with Angina Pectoris. Emphasis must be placed on understanding that while most Angina Pectoris codes have shifted to a non-risk adjusted category, I23.7 retains its status as a risk-adjusted code, requiring careful application and documentation. Through precise coding practices and diligent adaptation to these changes, providers will not only uphold compliance but more importantly, enhance the caliber of patient care delivered under the refined guidelines of CMS Model v28.

References are available in Section 6: Reference

References

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1. Centers for Medicare & Medicaid Services. (2025). Announcement of Calendar Year (CY) 2025 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. [PDF file]. Retrieved from https://www.cms.gov/files/document/2025-announcement-pdf.pdf
2. AAPC. (n.d.). Get Ready for CMS HCC v28. [Webpage]. Retrieved from https://www.aapc.com/blog/88300-get-ready-for-cms-hcc-v28/
3. COPE Health Solutions. (n.d.). What Payers and Providers Should Know About Proposed Changes to Medicare Advantage. [Webpage]. Retrieved from https://copehealthsolutions.com/cblog/what-payers-and-providers-should-know-about-proposed-changes-to-medicare-advantage/
4. eMedLogix. (n.d.). CMS HCC Model Category v28 vs. v24: A Comprehensive Analysis. [Webpage]. Retrieved from https://www.emedlogix.com/post/cms-hcc-model-category-v28-vs-v24-a-comprehensive-analysis

Fine-Tuning Pulmonary Fibrosis Coding: Transitioning to Precise Diagnosis with Code J84.112 for Idiopathic Pulmonary Fibrosis

1. Krishna, R., Chapman, K., & Ullah, S. (2023). Idiopathic Pulmonary Fibrosis. In StatPearls [Internet]. StatPearls Publishing. Retrieved from https://pubmed.ncbi.nlm.nih.gov/28846333/
2. American Lung Association. (2022, November 17). Types, Causes, and Risk Factors: Pulmonary Fibrosis. Retrieved from https://www.lung.org/lung-health-diseases/lung-disease-lookup/pulmonary-fibrosis/introduction/types-causes-and-risk-factors.
3. Centers for Medicare & Medicaid Services. (March 31, 2023). [Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies]. https://www.cms.gov/files/document/2025-announcement-pdf.pdf
4. AAPC. (June 30, 2023). Get ready for CMS HCC v28. https://www.aapc.com/blog/88300-get-ready-for-cms-hcc-v28/

Adapting to Angina Pectoris Coding Updates: Discerning between Non-Risk and Risk-Adjusted Codes in CMS Model v28

1. Grasso, A. W., & Brener, S. J. (2010). Complications of Acute Myocardial Infarction. In Cleveland Clinic (Eds.), *Current Clinical Medicine* (2nd ed., pp. 72-80). W.B. Saunders. Available on ScienceDirect. Accessed on June 15, 2023.
2. Optum. (n.d.). EncoderPro.com Expert. Retrieved from https://www.encoderpro.com/epro/index.jsp. Accessed on June 15, 202

Navigating Vascular Disorders Classification: Unpacking the Transition from CMS v24 to v28 HCC Model for Enhanced Patient Care

1. Braunwald, E. (n.d.). *Heart Disease: A Textbook of Cardiovascular Medicine* (6th ed.). Retrieved from http://www.arritmiaonline.com.br/files/Braunwald---Heart-Disease---A-Textbook-of-Cardiovascular-Medicine-6th-ed.pdf.
2. Coastal Vascular Center. (n.d.). Rest Pain - Peripheral Arterial Disease (PAD). Retrieved from https://coastalvascular.net/peripheral-arterial-disease-pad/rest-pain.
3. Mount Sinai. (n.d.). Peripheral Artery Disease of the Legs. Retrieved from https://www.mountsinai.org/health-library/diseases-conditions/peripheral-artery-disease-legs.

Deciphering Severe Persistent Asthma & COPD Classification: Insights into CMS v28 Model's Risk Adjustment for Improved Patient Diagnosis and Treatment

1. "Asthma in the Elderly: Can We Distinguish It from COPD?". (2011). *J Allergy (Cairo)*, vol. 2011, pp. 843543. Published online June 30, 2011.
   Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138061/.

Notes


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