INFECTIOUS DISEASES (HCC 1)

HIV/AIDS: B20 (Patient has symptoms of an acquired immunodeficiency syndrome (AIDS) related condition **or** taking an antiretroviral medication, even in the absence AIDS related symptoms) ---Asymptomatic HIV Status: Z21 (Patient does not have symptoms of an AIDS related condition **and** not taking an antiretroviral medication)

MALIGNANT NEOPLASM (HCC 8-12)

Primary malignant neoplasm: C00_ to C96. _ (Diagnose as **active** if the patient is undergoing or awaiting treatment, watchful waiting, refuses treatment, or on adjuvant therapy not being prescribed as prophylactic treatment. Clearly document the method of treatment in the medical record) ---Secondary malignant neoplasm: C77_ to C80. _ (Diagnose by location of the metastasis) ---History of malignant neoplasm: Z85.00 to Z85.9 (Diagnose when treatment has been completed and there is no evidence of disease) ---Lymphoma and Leukemia: C81. _ to C96. _ (Document lymphomas and leukemias as "in remission" rather than "history of", when applicable)

DIABETES MELLITUS (Examples are for Type II Diabetes Mellitus) (HCC 18-19)

DM w/o complications: E11.9---DM w/cataracts: E11.36---DM w/ hyperglycemia: E11.65---DM w/ hypoglycemia: E11.649 (Avoid documenting uncontrolled, must specify hyper or hypoglycemia)---DM w/nephropathy: E11.21---DM w/chronic kidney disease: E11.22 (Code also for the stage of CKD N18.30-N18.6)---DM w/neuropathy: E11.40---DM w/polyneuropathy: E11.42---DM w/peripheral angiopathy: E11.51 (PVD, PAD, atherosclerosis of extremities)---DM w/retinopathy, unspecified: E11.319---DM w/proliferative retinopathy: E11.359---DM w/foot ulcer: E11.621 (Code also ulcer L97.4-L97.5)---DM w/ulcer E11.622 (Other than foot)---Long term (current) insulin use: Z79.4

MALNUTRITION (HCC 21)

Protein calorie malnutrition: E44.1---Cachexia: R64 (Document ASPEN criteria, at least two required)

MORBID OBESITY (HCC 22)

Morbid obesity due to excess calories: E66.01 (BMI ≥ 40 or BMI ≥ 35.0 – 39.9 plus documented comorbidity such as, DM, CAD, CHF, Sleep apnea, MDD, Severe HTN, Hyperlipidemia, severe osteoarthritis) (Must clearly state what the comorbidity is. Document "morbid obesity" in the physical exam) BMI 35 to 35.9: Z68.35---BMI 36 to 36.9: Z68.36---BMI 37 to 37.9: Z68.37---BMI 38 to 38.9: Z68.38---BMI 39 to 39.9: Z69.39---BMI 40 to 44.9: Z68.41---BMI 45 to 49.9: Z68.42---BMI 50 to 50.9: Z68.43---BMI 60 to 60.9: Z68.44---BMI 70 or greater: Z68.45

OTHER ENDOCRINE DISORDERS (HCC 23)

Secondary hyperparathyroidism of renal origin: N25.81 (Most instances are caused by chronic renal failure, CKD 5/ESRD. Clearly document the primary diagnosis causing the hyperparathyroidism when reporting this secondary diagnosis code) --- Primary hyperparathyroidism: E21.0---Secondary hyperaldosteronism: E26.1 (Most instances are related to heart failure, cirrhosis)

GASTROENTEROLOGY (HCC 27-29, 34, 35)

Alcoholic cirrhosis: K70.30---Alcoholic liver disease unspecified: K70.9 (Code also for current drinking status F10.20 or F10.21) ---Liver failure: K72.10---Cirrhosis of liver unspecified: K74.60---Chronic hepatitis C: B18.2---Chronic hepatitis B: B18.1---Chronic viral hepatitis: B18.9---Chronic hepatitis unspecified: K73.9--- Alcohol induced chronic pancreatitis: K86.0 (Code also for current drinking status F10.20 or F10.21)---Crohn's disease without complications: K50.90---Ulcerative colitis without complications: K51.90

RHEUMATOLOGY (HCC 40)

Inflammatory polyarthropathy: M06.4---Lupus/SLE: M32.9---Polymyalgia rheumatica: M35.3---Rheumatoid arthritis, unspecified: M06.9---Rheumatoid arthritis with rheumatoid factor: M05.9---Rheumatoid arthritis without rheumatoid factor: M06.00--- Sacroiliitis: M46.1---Spinal enthesopathy: M46.00---Sjogren/Sicca unspecified: M35.00

HEMATOLOGY (HCC 46-48)

Myelodysplastic syndrome: D46.9---Aplastic anemia: D61.9---Immunodeficiency due to drugs: D84.821 (Immunosuppressants, corticosteroids, chemotherapy) ---Immunodeficiency due to external causes: D84.222 (Exposure to radiation therapy, bone marrow transplant) ---Immunodeficiency due to conditions classified elsewhere: D84.81 (HIV, AIDS, certain cancers, and genetic disorders) --- Pancytopenia: D61.81_

DEMENTIA (HCC 51-52) ***THERE WERE 69 ADDITIONAL CODES ADDED IN 2023 FOR DEMENTIA SPECIFICITY!!***

Unspecified dementia, without behavioral disturbance: F03.90, F03.A0-F03.C0 --- Unspecified dementia, with behavioral disturbance: F03.911, F03.918, F03.92-F03.94, F03.A11, F03.A18, F03.A2-F03.A4, F03.B11, F03.B18, F03.B2-F03.B4, F03.C11, F03.C18, F03.C2-F03.C4 ---Dementia in other diseases classified elsewhere, without behavioral disturbance: F02.80, F02.A0-F02.C0---Dementia in other diseases classified elsewhere, with behavioral disturbance: F02.811, F02.818, F02.82-F02.84, F02.A11, F02.A18, F02.A2-F02.A4, F02.B11, F02.B18, F02.B2-F03.B4, F02.C11, F02.C18, F02.C2-F02.C4---Vascular dementia without behavioral disturbance: F01.50, F01.A0-F01.C0--- Vascular dementia with behavioral disturbance: F01.511, F01.518, F01.52-

F01.54, F01.A11, F01.A18, F01.A2-F01.A4, F01.B11, F01.B18, F01B2-F01.B4, F01.C11, F01.C18, F01.C2-F01.C4 (Code first the underlying physiological condition or sequelae of cerebrovascular disease)

PSYCHIATRY AND SUBSTANCE USE (HCC 57-59)

MDD single episode: F32._ (Specify severity or in remission)---MDD recurrent episode: F33._ (Specify severity or in remission – considered lifelong/chronic)---Schizophrenia: F20._---Bipolar: F31._---Alcohol dependence, uncomplicated: F10.20---Alcohol dependence, in remission: F10.21---Cannabis dependence, uncomplicated: F12.20---Cannabis dependence, in remission: F12.21 Opioid abuse, uncomplicated: F11.10---Opioid abuse, in remission: F11.11---Opioid dependence, uncomplicated: F11.20---Opioid dependence, in remission: F11.21---Benzodiazepine abuse, uncomplicated: F13.10---Benzodiazepine abuse, in remission: F13.11 Benzodiazepine dependence, uncomplicated: F13.20---Benzodiazepine dependence, in remission: F13.21---Methamphetamine abuse, uncomplicated: F15.10---Methamphetamine abuse, in remission: F15.11---Methamphetamine dependence, uncomplicated: F15.20---Methamphetamine dependence, in remission: F15.21

NEUROLOGY (HCC 70-79)

Quadriplegia: G82.50---Paraplegia: G82.20---Cerebral palsy unspecified: G80.9---Guillain-barre syndrome: G61.0---Chronic inflammatory demyelinating polyneuritis: G61.81---Myasthenia gravis: G70.00---Muscular Dystrophy: G71.0---Multiple Sclerosis: G35---Polyneuropathy in diseases classified elsewhere (Secondary polyneuropathy): G63 (Code first and link underlying disease, such as Pre–DM, ESRD, B12 deficiency)---Polyneuropathy due to Alcohol (Alcoholism): G62.1 (Code also for current drinking status F10.20 or F10.21) ---Polyneuropathy Due to Drugs (Such as Methotrexate or Chemo) (Be sure to document & link the cause of neuropathy): G62.0 and T36 – T50---Parkinson's disease: G20---Huntington's disease: G10--- Neurogenic orthostatic hypotension: G90.3--- Epilepsy: G40.909 ---Partial complex seizures: G40.209---Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus: G40.309---Unspecified convulsions: R56.9---Post-traumatic seizures: R56.1

RESPIRATORY (HCC 84,111,112)

COPD unspecified: J44.9---Chronic bronchitis: J42---Emphysema: J43.9---Smoker's cough: J41.0---Interstitial lung disease: J84.9--- Pulmonary fibrosis: J84.10---Bronchiectasis: J47.9---Chronic respiratory failure: J96.1_ (Code also for dependence on home oxygen, when applicable: Z99.81)

CARDIAC (HCC 85,88,96)

Heart Failure: I50. _ ---Pulmonary Hypertension: I27.2_ --- Cardiomyopathy: I42. ---CAD with Angina: I25.110-I25.112, I25.118-I25.119 ---Post infarction angina: I23.7---Angina without CAD: I20.0-120.2, I20.8-I20.9--- Acute MI: I21. _ (<4 week): --- Old MI: I25.2 (> 4 weeks): ---Ventricular Tachycardia: I47.20-I47.21, I47.29---Paroxysmal tachycardia: I47.9 --- Atrial Fibrillation: I48. _--- Sick Sinus Syndrome: I49.5 (Code both the SSS and pacemaker status Z95.0 when applicable) ---Complete AV Block: I44.2---SVT: I47.1

CEREBROVASCULAR ACCIDENT (HCC 103-104)

Late effect of CVA-hemiplegia/hemiparesis: I69.35_ --- Late effect of CVA-monoplegia upper limb: I69.33_ --- Late effect of CVA-monoplegia lower limb: I69.34_ (If no late effects, use "history of" CVA: Z86.73)

VASCULAR (HCC 106,107,108) ***THERE WERE 25 ADDITIONAL CODES ADDED IN 2023 FOR DISSECTION AND ANEURYSM SPECIFICITY!!***

Atherosclerosis of aorta: I70.0---Atherosclerosis of renal artery: I70.1---Dissection of thoracic aorta: I71.010-I71.012, I71.019--- Thoracic aortic aneurysm, without rupture: I71.20-I71.23--- Abdominal aortic aneurysm, without rupture: I71.40-I71.43--- Thoracoabdominal aortic aneurysm without rupture: I71.60-I71.63---Thoracic aortic ectasia: I77.810---Abdominal aortic ectasia: I77.811---PAD / PVD unspecified: I73.9---Atherosclerosis of lower extremities, without ulcer: I70.2_--- Atherosclerosis of lower extremities with ulcer: I70.23_, I70.24. --- Varicose veins of right lower extremity with ulcer: I83.01_---Varicose veins of left lower extremity with ulcer: I83.02_ --- Chronic DVT: I82.5_ (On long term treatment) --- Chronic PE (On long term treatment): I27.82

RENAL DISEASE (HCC 136-138)

CKD, stage 3a: N18.31 (GFR 59-45) ---CKD, stage 3b: N18.32 (GFR 44-30) ---CKD, stage 4: N18.4 (GFR 29-15)
CKD, stage 5: N18.5 (GFR Less than 15) ---ESRD: N18.6 (Code also dialysis status, when applicable Z99.2)

CHRONIC SKIN ULCER (HCC 161)

Thigh: L97.1_ --- Calf: L97.2_ --- Ankle: L97.3_ --- Heel and midfoot: L97.4_ --- Other part of foot: L97.5_ (Toes)

TRANSPLANT STATUS (HCC 186)

Bone marrow transplant status: Z94.81---Stem cells transplant status: Z94.84--- Kidney transplant status: Z94.0 (RxHCC)

AMPUTATION STATUS (HCC 189)

Great toe: Z89.41_ --- Other toes: Z89.42_ --- Foot: Z89.43_ --- Ankle: Z89.44_ --- Below knee: Z89.51_ --- Above knee: Z89.61_
Phantom limb syndrome with pain: G54.6 --- Phantom limb syndrome without pain: G54.7

ARTIFICIAL OPENINGS (HCC 188)

Gastrostomy status: Z93.1---Ileostomy status: Z93.2---Colostomy status: Z93.3---Cystostomy status: Z93.50---Tracheostomy: Z93.0---Other cystostomy status: Z93.59

LIST OF COMMON CPT CATEGORY II CODES

ADVANCED CARE PLANNING

1123F - Advance care planning discussed and documented – Advance care plan or surrogate decision-maker documented in medical record

1124F - Advance care planning discussed and documented in medical record – Patient didn't wish to or was unable to provide an advance care plan or name a surrogate decision-maker

1157F - Advance care plan or similar document in medical record

1158F - Advance care planning discussion documented

PAIN ASSESSMENT

1125F - Pain assessment – Pain documented

1126F - Pain assessment – No pain documented

MEDICATION REVIEW

1159F - Medication list documented

1160F - Medication review by prescribing care provider or clinical pharmacist documented

FUNCTIONAL STATUS ASSESSMENT

1170F - Functional status assessed

COLORECTAL CANCER SCREENING

3017F - Colorectal cancer screening results documented and reviewed

BREAST CANCER SCREENING

3014F - Screening mammography results documented and reviewed

ADULT BMI

3008F* - Body Mass Index (BMI) documented. **Use ICD 10 codes to indicate specific BMI scores.* Example: CPT II 3008F with ICD 10: Z68.41 (BMI 40.0-44.9, adult)

DIABETES-RETINAL EYE EXAM

2022F - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM).

2023F - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)

2024F - 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM).

2025F - 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)

2026F - Diabetic retinal screening with eye care professional. Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)

2033F - Diabetic retinal screening with eye care professional. Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)

3072F - Diabetic retinal screening negative

DIABETES-HbA1c TESTING

3044F - HbA1c level less than 7.0%

3046F - HbA1c level greater than 9.0%

3051F - HbA1c level greater than or equal to 7.0% and less than 8.0%

3052F - HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%*l*

DIABETES-NEPHROPATHY SCREENING

3060F - Positive microalbuminuria test result reviewed and documented

3061F - Negative microalbuminuria test result reviewed and documented

3062F - Positive macroalbuminuria test result reviewed and documented

3066F - Documentation for treatment of nephropathy

4010F - ACE inhibitor or ARB therapy prescribed or currently being taken

CONTROLLING HIGH BLOOD PRESSURE

3074F - Systolic less than 130
3075F - Systolic between 130 to 139
3077F - Systolic greater than/equal to 140
3078F - Diastolic less than 80
3079F - Diastolic between 80 to 89
3080F - Diastolic greater than/equal to 90

LOW-DENSITY LIPOPROTEIN CHOLESTROL (LDL-C) TEST

3048F - LDL-C <100 mg/dL
3049F - LDL-C 100-129 mg/dL
3050F - LDL-C ≥ 130 mg/dL

MEDICATION RECONCILIATION POST-DISCHARGE/TRANSITION OF CARE

1111F - Discharge medications reconciled with current medications in outpatient record

DOCUMENTATION GUIDELINES

* A condition only exists when it is documented **Diagnoses do not carry over from visit to visit or year to year
* Conditions can be coded when documentation states condition is being monitored and treated by a specialist ** Patient on Coumadin for atrial fibrillation; followed by Dr. X
* Document all co-existing conditions that affects the care, treatment, or management of the patient
* Document associated conditions or complications and the relationship to the underlying chronic condition. **Cirrhosis of liver secondary to alcoholism --- Diabetic retinopathy --- Foot ulcer associated with diabetes
* Only document diagnoses as history of or past medical history when they no longer exist or are not a current condition
* Document an evaluation/status and plan of care for all diagnoses that are pertinent to the medical decision making for the encounter
  * Evaluative/status examples: Stable --- Improved --- Tolerating meds --- Deteriorating --- Asymptomatic --- Increased pain
  * Plan of care examples: Monitor --- Refer --- Continue current meds --- Control diet --- Exercise --- Better compliance --- A procedure
  * Documentation examples: **CKD stage 3** with eGFR 50 on 12/8/21 and 53 on 4/16/22, stable. Continue lisinopril **--- Breast cancer** taking tamoxifen, tolerating meds, will continue to monitor **--- Aorta atherosclerosis**, asymptomatic. Continue atorvastatin **--- Benign HTN**, 138/85, improved. Continue losartan 50 mg once a day

CODING GUIDELINES

* A diagnosis can be coded as many times as the patient receives care and treatment for the condition ** Do not code for conditions that were previously treated and no longer exist
* Co-existing diagnoses can be coded when documentation states that the condition affects the care, treatment, or management of the patient ** Diabetic patient comes in for chronic kidney disease
* Do not code unconfirmed diagnoses ** Examples: Probable, possible, suspected, working diagnosis
* Be sure all diagnosis code(s) coded and billed are consistent with the medical record documentation