Medicare HCC Risk Adjustment Coding Guidelines

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CareOregon Risk Adjustment Coding Guidelines

Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. By risk adjusting plan payments, CMS can make appropriate and accurate payments for enrollees with differences in expected costs. Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee. Risk scores measure individual beneficiaries' relative risk and risk scores are used to adjust payments for each beneficiary's expected expenditures. By risk adjusting plan bids, CMS can use standardized bids as base payments to plans.

The individual's health conditions are identified by the International Classification of Diseases - 10 (ICD-10) diagnoses that are submitted by providers on incoming claims. The Centers for Medicare and Medicaid (CMS) currently work from two separate volumes for the purposes of plan payment. Per the latest 2024 Model Software/ICD-10 Mapping, there are currently 9,979 ICD 10 codes that map to 86 HCC for Volume 24 and 7,770 ICD 10 codes which map to 115 HCCs for volume 28. There will be a phased approach of using both volumes through 2026.

CMS requires documentation in the patient's medical record by a qualified health care provider to support the submitted diagnoses. Documentation must support the presence of the condition and clearly support the provider's assessment and plan for management of the condition.[i]

Any chronic condition(s) that are current and managed must be reported (and supported by the documentation for that date of service) at least once per calendar year to allow for adequate and correct payment to the health plan. Encounters must follow CMS guidelines for acceptable place of service, provider type, and correct documentation.[i]

The Official ICD-10 coding guidelines state that a condition must exist at the time of the encounter and affect the patient's care or be actively managed and documented through the History of Present Illness (HPI), the Physical Exam, and the medical decision making. Each reported diagnosis should be documented in an assessment and a plan of care. According to CMS a simple list of "assessed" conditions alone would not support the diagnoses reported without showing that the condition is current (active) at the time and/or evaluation and treatment for each condition.[i]

When conducting medical chart reviews or audits, all risk adjustment diagnosis codes submitted by an MA organization must be supported by medical record documentation.

Coding professionals must review the entire medical record for documentation to assign the appropriate ICD-10-CM diagnosis. This should include the clinical provider assessment or plan for management of specific condition. Most organizations use M.E.A.T., which is an acronym used to describe factors that support the ICD-10-CM code(s) chosen. Please see below for the acronym description and what they mean:

M = Monitor (signs, symptoms, disease progression, disease regression)

E = Evaluate (test results, medication effectiveness, response to treatment)

A = Assess/Address (ordering tests, discussion, review records, counseling)

T= Treat (medications, therapies, other modalities)[i]

Some common issues to be aware of when coding or auditing for support of reported diagnoses:

- Code to the highest level of specificity. This can affect support for the risk factor if unspecified or generic codes are used.
- Coding of "history" as current: anything that is not supported as active at the time of the face- to-face encounter, such as "resolved" or "history of" conditions, should not be reported.
- Conditions and manifestations need to be clearly linked with such terms as "due to" "because of" etc. According to ICD-10-CM, some conditions have a presumed cause and effect relationship such as hypertension and CKD (ICD-10-CM Section 1; 9. A.2.). Always code to the highest level of documented specificity.[i]

Purpose of Guidelines

These CareOregon Coding Guidelines are prepared to establish consistent coding and auditing practices. All CareOregon staff are to adhere to these guidelines, be critical, ask questions, and suggest additions for these guidelines. To provide Risk Adjustment guidelines with the relevant information required to perform Risk Adjustment medical record reviews. This guidance is drawn from CMS guidelines for ICD-10-CM coding for Medicare Advantage as well as the Official ICD-10-CM Guidelines for Coding and Reporting and the AHA Coding Clinic. These guidelines will be discussed quarterly by CareOregon's Coding Guidelines committee, and then reviewed and updated anually by the Risk Adjustment coding team.

Official Coding Guidelines

ICD-10-CM diagnosis Codes are 3- to 7-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations.[i] ICD-10-CM codes are used for inpatient, outpatient, and physician services. The risk adjustment model relies on the ICD-10-CM diagnosis codes to prospectively reimburse MA organizations based on the health status of their enrolled beneficiaries. Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-10-CM coding guidelines.[i] Therefore, CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines.

Coding Conventions

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.[ii]

ICD-10 Coding Guidelines Section I.A.1

Examples:

- Includes - Appears immediately under a three-character code title to further define, or give examples of, the content of the category.
- Excludes - ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use, but they are all similar in that they indicate that codes excluded from each other are independent of each other.

- **Excludes1** - It means “**NOT CODED HERE!**” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
- **Excludes2** - A type 2 Excludes note represents “Not included here.” An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

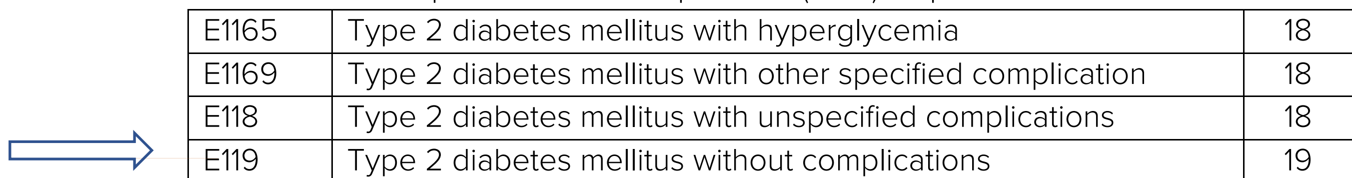
- **Use Additional Code/Code First** - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.
- **Not Otherwise Specified (NOS) Note** - This abbreviation is the equivalent of unspecified. Used when the documentation does not provide specific information to assign a more specific code.
- **Not Elsewhere Classifiable (NEC) Note** - This abbreviation in the Alphabetic Index represents “other specified.” When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

ICD-10 Coding Guidelines Sections I.B.1 and I.B.2

- First locate the term in the Alphabetic Index, and then verify the code in the Tabular List
- Search the sub-terms under each main term to be more specific.
- Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.
- It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List.
- Diagnosis codes are to be used and reported at their highest number of characters available.
- Code assignment must be to the highest specificity possible. Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.
- If the provider documents an ICD-10-CM code with a condition, **DO NOT ASSUME** the ICD-10 code is correct. CareOregon Risk Adjustment coders must verify the code based on the documentation provided by the provider.
- All completed code(s) **must be verified by CareOregon Risk Adjustment coders** with the appropriate CMS HCC MAPPING EXCEL FILE, to confirm which, if any, HCC category codes apply. Since HCC coding is retrospective, if using an encoder tool, it is still important to utilize

the CMS Crosswalk for the **correct year** being coded/audited.

Example: DMII w/o complication (E11.9) maps to HCC 19



E1165	Type 2 diabetes mellitus with hyperglycemia	18
E1169	Type 2 diabetes mellitus with other specified complication	18
E118	Type 2 diabetes mellitus with unspecified complications	18
E119	Type 2 diabetes mellitus without complications	19

Uncertain Diagnosis

Inpatient

When reviewing a medical chart, coding guidelines for coding of "uncertain" conditions when identified as a diagnosis at the time of discharge from an inpatient admission.

- If the diagnosis documented at the time of discharge is qualified as "probable", "suspected "likely," "questionable," "possible," or "still to be ruled out," or other similar terms indicating uncertainty, code the condition as if it existed or was established. [iii] Coders look at the discharge summary or the last progress note to determine if the uncertain diagnosis was ruled out during the admission or if it was still a possible diagnosis at the time of the discharge. A physician has 30 days to document the discharge summary, but most do not take the full 30 days.
  - Exception: Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza viruses (category J10). This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).
- In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed, and the diagnoses are sequenced according to the circumstances of the admission. [iv]

Outpatient

- Do not code diagnoses documented as "consistent with," "I believe," "compatible with," "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. (ICD-10 Coding Guidelines Section IV.H)
- **However**, when the provider documents "evidence of" a particular condition, it is not considered an uncertain diagnosis and should be appropriately coded and reported in the **outpatient** setting. [v]

Using Problem Lists (and Past Medical History)

CareOregon will accept coding from the Problem List only in these instances:

- Amputations
  - Although, if there is conflicting information within the encounter, review and if needed, send questions to Risk Adjustment Coding Analyst.
- Ostomies

    - Although, if there is conflicting information within the encounter, review and if needed, send questions to Risk Adjustment Coding Analyst.
    - The entire encounter needs to be reviewed for mention of reversal of the ostomy. If none found, then it can be coded. If there is documentation of a reversal, the ostomy is not to be coded.
        - *Example: On a past medical history, the note shows patient has a colostomy documented, with no evidence of a reversal anywhere in the note. The status code Z93.3 for the colostomy can be captured from the past medical history.*
- Transplants
    - Although, if there is conflicting information within the encounter, review and if needed, send questions to Risk Adjustment Coding Analyst.
        - *Example: On a past medical history, within the eligibility period, there is documentation of a liver transplant. The status code Z94.4 for the liver transplant status can be captured from the past medical history.*

When capturing status codes from a problem list or past medical history, review documentation for any contradictions.

Medication Lists

CareOregon feels due to potential issues with the Med list (copy/paste, pulled over from previous encounters, etc.), medications from the Med list should not be used as support.

- Use of the Med list should only be as an indicator of what you might be looking for within the encounter.
- Providers will occasionally note a diagnosis next to a medication in the Med list. Do not pull diagnoses from the Med list.

Acceptable Facility/Provider Types

Not all facility/provider types are accepted for Risk Adjustment. Reference table at end of document. [vii]

Table 7B – Types of acceptable physician signatures and credentials

TYPE	ACCEPTABLE
Hand-written signature or initials, including credentials	Mary C. Smith, MD or MCS, MD
Signature stamp, including credentials	Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	Requires authentication by the responsible provider (for example, but not limited to, “Approved by,” “Signed by” and “Electronically signed by”)
	Must be password protected and used exclusively by the individual physician

Acceptable Documentation Types

Not all types of documentation are accepted for Risk Adjustment.

Unacceptable Types of Medical Record Documentation

- Superbill
- Physician-signed attestation
- A list of patient conditions
- A diagnostic report that has not been interpreted

Acceptable Diagnosis Types

Not all diagnoses are accepted for Risk Adjustment

Unacceptable Types of Diagnoses (outpatient hospital and physician settings)

- Probable
- Suspected
- Questionable
- Rule out
- Working

Acceptable Facilities

According to CMS, diagnoses must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility. Please refer to the list at the end of the document. Error! Bookmark not defined.

- Hospital **inpatient** services include those for which the patient is admitted to the facility for at least one overnight stay.
- Hospital **outpatient** services are therapeutic and rehabilitative services provided for sick or injured persons who require inpatient hospitalization or institutionalization.

Hierarchical condition categories (HCCS)

Overview

The CMS-HCC Classification System, used for Medicare Advantage beneficiaries, begins with over 7770 ICD-10-CM codes that map to one or more of the 115 HCC codes included in the CMS-HCC Risk Adjustment Model (Version 28) and currently 9,979 ICD 10 codes that map to 86 HCC for Volume 24. A code can map to more than one HCC as ICD-10-CM contains combination codes.

Disease Hierarchy

The CMS-HCC Model incorporates disease hierarchies, in which payment will only be associated with the most severe manifestation of a disease. If another HCC in the hierarchy is reported in the same calendar year, then the lower severity HCC will be dropped. The HCC(s) that will be dropped are identified in the disease hierarchy column in the table.[vii]

- *For example: If HCC 37 (diabetes with chronic complication) is reported, then HCC 38 (diabetes without complication) will be dropped if both are reported in the same calendar year*

Factors that impact the coding of an HCC include:

- Identifying codes in an HCC Hierarchy Group and
- Identification of "known" HCCs (HCCs already reported for the year being reviewed).

Known HCCs

- Already reported
- Compare every possible HCC found in the chart to Known HCCs (already listed as reported)

Hierarchy Group HCCs

Hierarchy Groups – two or more HCCs that are part of a group of related HCCs that a condition may fall in.

- Each HCC in a hierarchy has its individual reimbursement rate assigned by CMS.

HCCs reflect hierarchies among related disease categories.

Example: The Known HCC (the HCC already reviewed for the year) is HCC 38. The coder finds documentation of a diagnosis that maps to HCC 37. The coder would be able to capture the diagnosis because HCC 37 is a higher level of severity in the Hierarchical Group than HCC 38.
Example: The Known HCC (HCC already reviewed) is HCC 277 Cystic Fibrosis. The coder finds documentation of a diagnosis that maps to HCC 279 Severe Persistent Asthma. The coder would NOT capture the diagnosis because HCC 279 is a lower level of severity in the Hierarchical Group than HCC 277.
If two or more ICD-10-CM conditions are mapped to the same HCC category, it will result in a payment for only one code, and that will be to the highest specificity code.

Specificity

Because ICD-10-CM codes are used in risk adjustment, the documentation of specificity can be significant. These are some examples of the increased specificity needs that are important to include in the documentation for risk adjustment:[viii]

- Obesity:
  - Obesity - no HCC
  - Morbid obesity - HCC 48
- CKD:
  - Unspecified, Stage 1, 2 - no HCC
  - Chronic Kidney Disease, Moderate (Stage 3B) – HCC 328
  - Chronic Kidney Disease, Moderate (Stage 3, Except 3B) – HCC 329
  - Chronic Kidney Disease, Severe (Stage 4) – HCC 327
  - Chronic Kidney Disease, Stage 5 – HCC 326

Commonly Missed Conditions:[viii]

Diabetes and manifestations
- Ex: Diabetes with Chronic Kidney Disease

Secondary cancers
- Ex: Metastatic Bone Cancer

Drug/alcohol dependence
- Ex: Alcohol Dependence, Uncomplicated

Hemiplegia/paresis
- Ex: Left Hemiplegia

Amputation status
- Ex: Right, BKA

Ostomy status
- Ex: Colonostomy

Asymptomatic HIV infection status
Renal dialysis status
Ventilator dependence

CMS HCC Key Points:[viii]

The CMS-HCC risk adjustment model is a prospective payment model: It is an actuarial model used to predict future costs of a beneficiary based on a specific set of conditions.
CMS-HCC follows a calendar year.
The slate is wiped clean every January 1st; therefore, all ongoing conditions must be addressed and documented again each calendar year.
The encounter must be face-to-face except for pathology report reading/interpretation.
The CMS-HCC risk adjustment model is based on ICD-10-CM codes only, not PCS, CPT or HCPCS codes.
Code assignment must be in accordance with the International Classification of Diseases (ICD), Clinical Modification Guidelines for Coding and Reporting.

Coding Issues and Tips

Neuropathy: Neuralgia is not the same as neuropathy!
- Note: Diabetes with neuralgia DOES code to E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy)

Use, Abuse and Dependence:[ix]
When the provider documentation refers to use, abuse and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

If both use and abuse are documented, assign only the code for abuse.
If both abuse and dependence are documented, assign only the code for dependence.
If use, abuse, and dependence are all documented, assign only the code for dependence. If both use and dependence are documented, assign only the code for dependence.

Alcoholism: Physician must state alcohol dependence or alcoholism to code F10.20. Alcohol Abuse is coded F10.10 and is not an HCC.

Depression: Physician must specify “recurrent or major” and episode and severity of depression to code. If this is a situational event or the physician has not specified - use the lower specificity codes.

Venous Stasis Ulcers: If a patient has chronic venous insufficiency (I87.2 - not an HCC) you can code the additional code for the ulceration if significant enough. (ie: L97.209 ulceration of calf) Documentation must be very clear that it is not a stasis ulcer.

Osteoporosis / Compression Fractures: If patient has a compression fracture of hip (M84.453A) or spine (M84.48XA) make sure to look for documentation in chart note.

- You may only code compression on the initial fracture –
  - Do not code history of pathological fracture to the active code.
- Compression Fractures can be traumatic or pathologic - it is hard to tell!
  - If non-traumatic then code as pathologic (per the code book index).
- Spontaneous = pathologic. Healing or healed fractures should be coded as hx of not current unless documented as "Chronic" see below.

Chronic Pathologic Fractures: If a patient is on meds ok to code M84.48XA but documentation must state "Chronic Pathological Fracture".

- Question: When a patient is in a skilled nursing facility (SNF) for multiple problems including a chronic vertebral pathological fracture with orders for pain medication, what is the appropriate code to assign to identify the chronic pathological vertebral fracture?
  - Assign code M84.48XA, Pathologic fracture of vertebrae, for a chronic vertebral fracture for which the patient is receiving medication.[x]

Dialysis Status: Codes Z99.2 for patients receiving dialysis treatment or Z91.15 for patients that are non-compliant with dialysis. These are frequently not coded. Also, codes Z49.01 – Z49.02 and Z49.31

- Z49.32 should be used for dialysis testing and catheter fitting and adjustment.

Pneumonia: For risk adjustment, it is important to determine the etiology of pneumonia.

- ICD-10 code "J18.9 Pneumonia, Organism Unspecified" does not map to an HCC.
- While specified bacterial pneumonia (Ex: J15.8) map to HCC 282.
  - Lower lobe pneumonia is not the same as Lobar Pneumonia. Coders can look at sputum culture (though you cannot code from the sputum) to verify if a bacteria type of pneumonia is present.
- Coding Clinic and Official Coding Guidelines state:[xi]
  - **September 23, 2018 And Before**: For discharges/dates of service and before – Coders could only code Lobar Pneumonia when specified by a provider
  - **September 24, 2018 Discharges – through Sept 30 2021**: Coders MAY code Lobar Pneumonia when RUL Pneumonia is noted, or if it is in multiple lobes.
  - **Effective October 1, 2021**: Coders may only code Lobar Pneumonia when it is specified by the provider.

"Metastatic": Caution in coding "metastatic" – this can mean either primary or secondary site.

- Coders need to investigate in the documentation as to whether it is
  - "Metastatic to the breast -C79.81" (HCC 10) or
  - "Metastatic from the breast" C50.919 (HCC 12).

- This is a particularly challenging area – and coders must use extreme caution – asking for clarification whenever possible.

Urinary Catheter: If the catheter is a suprapubic (inserted through the abdominal wall just above the pubic bone and into the bladder then code Z93.59.

- If having problems, then potentially code to complication code (if documented) T83.9XXA.
- An indwelling catheter is NOT a urethrostomy – this implies cutting which is not done in an indwelling.
- These codes are only used in subsequent visits – NOT on visits or hospitalization in which the catheter is placed.
    - The only instance we would capture an indwelling catheter is when there is an infection or reaction – T83.511A.

Atrial Fibrillation on a pacemaker:

- It is appropriate to code for A-fib when patient has a pacemaker (CCQ1Y2019P33)
- You can also code Afib if there is evidence of treatment with
    - an anticoagulant (e.g., warfarin or Coumadin) and
    - the treatment cannot be linked to another condition (e.g., Pulmonary Embolism (PE), Deep Vein Thrombosis (DVT) and
    - if the provider documentation clearly indicates that the condition is current/active.
    - If the provider documents “Atrial fibrillation s/p ablation” it may be coded if the patient is on an antiarrhythmic medication that indicate treatment

Ulcer of Breast: Ulcer of the breast codes to N61 (no HCC)

- NOT L98.499 (skin NEC)

Complication Coding: Be incredibly careful with this! Do not assume something is a complication.

Cauda Equina: Do not code G83.4 Cauda Equina Syndrome when only Cauda Equina is documented. The syndrome is very SEVERE.

PEG Tube: Cannot be coded on admission where the tube has been placed. This would be a procedure code. Needs to be found on subsequent documentation to code it.

- Z93.1 – Gastronomy status (HCC)

Collagenous Colitis: Code K52.831 (No HCC) IS NOT the same as M35.9 Collagen (vascular) disease NOS.

Myelodysplasia vs Myelodysplastic Syndrome: These conditions are different and carry different risks. Review the chart note carefully to make sure the documentation supports the code.

- D46.9 Myelodysplastic syndrome, unspecified (HCC 19)
- Q06.1 Myelodysplasia of spinal cord (no HCC)

Liver transplant – Coding transplant status cannot be done from the same encounter the

transplant occurred.

- In that case it would be the procedure code. For it to be the status code it would be in subsequent encounters.
- The same goes for any other such status codes (Amputations, other transplants, etc.)

Ostomies - Ostomy coding is dependent upon whether it is current or not.

- If the ostomy is located in the Past Medical History/Problem List, if there is documentation elsewhere within the chart note (i.e. Physical Exam, Surgical Hx, etc.) that shows it was reversed, it would not be reported.
- If there is no documentation showing the ostomy as reversed, it should be reported.

Congenital Conditions – Coding of congenital conditions can be a tricky thing.

- One thing to note if/when you see a congenital condition within a chart note; if the condition has been remedied with surgery and no longer requires care, it would be a history code.
- "If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly. Codes in subcategory Z87.7 are used for congenital malformations that may still be present but do not require additional care, as well as corrected anomalies that are no longer present." [xii]

Auto-transplant – Auto-transplant is when a patient's organ (kidney, liver, etc.) is moved to another part of the patient's body due to illness, injury, or pain. This is not considered a transplant so a transplant status code would not be reported.

Alzheimer's/Dementia –

Code first – Some of the Dementia codes have a "code first the underlying physiological condition" note. Alzheimer's is included in this note. If a patient has Alzheimer's documented in the same DOS as dementia, following the "code first" guideline, you would code the Alzheimer's first.

- Use additional code – The Alzheimer's codes have a "use additional code to identify" note. Dementia with/without behavioral disturbance are included in this note.
- Tip – Along with the "use additional code to identify" there is also a tip/note that states "A code from subcategory F02.8 should always be assigned with a code from this category, even in the absence of documented Dementia."
  - If the patient has Alzheimer's documented, you would also report either F02.80 (dementia w/o behavioral disturbance or F02.81 (dementia w behavioral disturbance).
  - Both Alzheimer's and Dementia without behavioral disturbance are HCC 52, and generally we would only report an HCC once. But since there are the "code first" and "use additional" guidelines, please note both codes when appropriate.
  - Dementia with behavioral disturbance is HCC 51. In the case Alzheimer's is coded as well, you would report both HCC 51 and HCC 52. There is no outranking on the Hierarchy List for these, so we would report both.

New/Old compression fractures – This is an area that is difficult to confirm. Review the entire note for mention of "Previous Imaging" results, mention of "old" regarding the fracture, or if there is a past date stated.

- If it is OLD, we cannot code it to a Compression Fracture and get an HCC.
- Collapsed vertebra, NEC, lumbar region - M48.56XA – HCC
- Collapsed vertebra, NEC, lumbar region - M48.56XD – Not an HCC

Osteonecrosis - When coding osteonecrosis, it is important to verify if the condition is current.

- Example – documentation states "she is status post multiple debridement's…received six-week course of iv penicillin and is now on oral amoxicillin."
- Although the documentation mentions the diagnosis, the rest of the documentation does not discuss the condition as a current condition.

7th character A "Initial Character"- The use of this 7th character is for active treatment only and is rarely used in the OP/Clinic setting. More often it will be coded in IP or ER settings.

- "7th character "A", initial encounter is used for each encounter where the patient is receiving active treatment for the condition."
- "While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time."[xiii]

Lymphoma – When coding lymphomas, unless the documentation states the condition is healed or includes wording indicating the condition is gone, it would be coded as an active condition.

- "Lymphoma patients who are in remission are still considered to have lymphoma and should be assigned the appropriate code from categories C83-C88 (200-202)".[xiv]
- If the disease is completely cured and documented as "history of," assign code Z85.72

Spinal Stenosis with cord compression –Not all spinal stenosis cases are so severe that they have cord compression. Also make sure that you are coding to the most specific diagnosis code.

- According to the below Coding Clinic the compression WOULD be coded -
  - But it would be G99.2 – Myelopathy in diseases classified elsewhere.
- Instead of G95.20 – Unspecified cord compression (HCC 72), which is frequently reported.

Cervical Spinal Stenosis with Spinal Cord and Nerve Root Compression[xv]

Question: The provider's documentation describes cervical stenosis with spinal cord and nerve root compression. What is the proper code assignment for cervical stenosis with C4-C7 spinal cord and nerve root compression?
Answer: In this case, the patient has cervical spinal stenosis (C4-C7) with both radiculopathy (nerve root compression) and myelopathy (spinal cord compression). Assign codes M48.02, Spinal stenosis, cervical region, M54.12, Radiculopathy, cervical region, and G99.2, Myelopathy in diseases classified elsewhere.

Immunodeficiency Status - Previously, if a person was noted as Immunocompromised and it was due to a transplant, RA meds, etc. it was not reported. This has changed.**Error! Bookmark not defined.**

- New codes were created to report specific causes for a patient's immunocompromised state. An immunocompromised state refers to the weakened condition of an individual's immune system that makes it less able to fight infections and other diseases. Treating a patient who is immunocompromised poses more risks and challenges; therefore, it is important to identify a patient with this status.
  - **Code D84.821, Immunodeficiency due to drugs**, was created for immunodeficiency due to medications that interfere with the immune system. These medications include but are not limited to immunosuppressants, corticosteroids and chemotherapy.
  - **Code D84.822, Immunodeficiency due to external causes**, was created for immunodeficiency caused by external factors such as exposure to radiation therapy or due to bone marrow transplant.
  - **Code D84.81, Immunodeficiency due to conditions classified elsewhere**, was created for an immunocompromised state due to a specific medical condition such as HIV, AIDS, certain cancers, and genetic disorders that are classified elsewhere in ICD-10-CM.
  - **Code D84.89, Other immunodeficiencies**, is for immunodeficiency due to other causes.

Multiple codes may be assigned to show immunodeficiency due to multiple causes (e.g., cancer and antineoplastic medication). In cases where the cause of the immunosuppression is not clearly documented, make a note.

Question: A patient was seen in the emergency department for cellulitis of two fingers on her right hand. She was admitted to start intravenous antibiotics due to having an immunocompromised state caused by immunosuppressant medication that she takes for systemic lupus erythematosus (SLE). What are the appropriate code assignments for the admission?

Answer: Assign code L03.011, Cellulitis of right finger, as the principal diagnosis. Assign codes M32.9, Systemic lupus erythematosus, unspecified, for SLE, D84.821, Immunodeficiency due to drugs, and Z79.899, Other long-term (current) drug therapy, for the patient's immunosuppressed state due to long-term use of immunosuppressants.

In this case, the immunosuppressant medication was prescribed by the provider to suppress the patient's immune system. An adverse effect code is not assigned when the medication has achieved its intended result in lowering the patient's immune response to systemic lupus erythematosus.

Question: A patient with multiple myeloma was seen for ear pain and cold symptoms due to acute otitis media of the left ear and acute viral bronchitis. The provider documented that the patient is immunosuppressed due to current long-term chemotherapy. What are the appropriate code assignments for this encounter?

Answer: Sequence either code J20.8, Acute bronchitis due to other specified organisms, or code H66.92, Otitis media, unspecified, left ear, as the first-listed diagnosis. Assign codes

D84.821, Immunodeficiency due to drugs, for the patient's immunosuppressed state as a result of chemotherapy, and T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter. In this case, the immune suppression is not part of the intended effect of the antineoplastic drugs and is coded as an adverse effect. Additionally, assign codes C90.00, Multiple myeloma not having achieved remission, for the multiple myeloma and Z79.899, Other long term (current) drug therapy, for the chemotherapy.

Facet Arthropathy/Facet joint arthropathy -This diagnosis equals osteoarthritis of facet joint and does not map to an HCC. See the paths/examples below.

- M46.XX codes, which do code to an HCC, are occasionally incorrectly reported.
  - The path taken is Arthropathy to Arthritis, spine to Spondylopathy, inflammatory.
- Since facet joint arthropathy equals osteoarthritis, this is the incorrect path.
  - M47.XX codes are the correct codes, which do not map to an HCC.
  - The path to take is Osteoarthritis, spine to Spondylosis, without myelopathy or radiculopathy.

Hypoparathyroidism/Secondary Hypoparathyroidism – When coding this diagnosis, coders need to make sure they are using the correct MEAT/support. At times, this diagnosis will be reported with Vitamin D as MEAT/support.

- Because Vitamin D is an OTC medication, to use it for this condition it needs to be specifically tied to it in the chart note.
- When looking for other MEAT/support for the diagnosis (labs, other documentation, etc.) we also need to determine if the condition is active.

Dependence on Ventilator – To be able to code this condition, the patient needs to come into the facility already on a vent.

- If a patient comes into a facility, and because of their condition, needs to be intubated/put on a vent, this cannot be coded for use as an HCC.
- We do not code status codes for temporary measures.
  - Ex: Patient comes into hospital after being intubated by EMS or patient is intubated while in the hospital (after a surgery, etc)
  - "Codes from category Z99-. Dependence on enabling machines and devices, not elsewhere classified, should only be reported when physician documentation supports dependence."[xvi]

Acute/chronic conditions - Some acute/chronic conditions can only be coded if the provider specifically notes "acute" or "chronic." Coders cannot make assumptions as to the severity.

Amputation status – This should not be captured during the initial surgical phase; it should be captured on subsequent encounters.

- We can only use the Pre and Post Op Diagnosis. The other documentation would be coded in PCS for the procedure.

Ostomy Status – As with Amputation status, this cannot be captured in the surgical phase.

Liver transplant – Coding transplant status cannot be done from the same encounter the transplant occurred. In that case it would be the procedure code. For it to be the status code it would be in subsequent encounters.

Osteonecrosis - When coding osteonecrosis, it is important to verify if the condition is current.

- *Example – documentation states "she is status post multiple debridement's…received six-week course of iv penicillin and is now on oral amoxicillin." Although the documentation mentions the diagnosis, the rest of the documentation does not discuss the condition as a current condition.*

Bacteremia – When coding this condition, make sure there is not another condition the patient already has that would be coded instead of.

- *Example – On DC summary, both Bacteremia and Sepsis are noted. Under Bacteremia in the Index it says, "with Sepsis – see Sepsis." So, you would go to, and code the Sepsis instead of the Bacteremia.*

Hemiplegia/Hemiparesis – If weakness is noted due to a stroke/cva/etc, it can be coded to hemiplegia/hemiparesis following a cerebral infarction.

- Residual Right-Sided Weakness Due to Previous Cerebral Infarction[xvii]

  Question: The patient is a 72-year-old male admitted to the hospital, because of gastrointestinal bleeding. The provider documented that the patient had a history of acute cerebral infarction with residual right-sided weakness (dominant side) and ordered an evaluation by physical and occupational therapy. What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA without mention of hemiplegia/hemiparesis?

  Answer: Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury.

Monoplegia – like above, if weakness of one limb is noted due to a cva/etc you can code it to monoplegia of following cerebral infarction.

- Upper or Lower Extremity Weakness Following Acute Cerebrovascular Accident[xviii]

  Question: A patient presented with weakness of the right arm due to an old cerebrovascular accident (CVA). The provider documented, "h/o CVA with mild residual right arm weakness." How would weakness of one extremity (upper or lower) be coded in a patient who is post CVA?

  Answer: Assign the appropriate code from subcategory I69.33-, Monoplegia of upper limb following cerebral infarction, or I69.34-, Monoplegia of lower limb following cerebral infarction,

for upper or lower limb weakness that is clearly associated with a CVA.
- Previous advice in Coding Clinic, First Quarter 2015, states that, "unilateral weakness that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis or hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury." This same logic would apply to upper or lower limb weakness that is clearly associated with a stroke.

Hemiplegia/hemiparesis/weakness due to an acute cva – If weakness/hemiplegia/hemiparesis is noted during a stay with an acute cva, category "g81.x" can be coded.
- Acute Cerebral Infarction with Left-Sided Weakness[xix]

  Question: An 88-year-old male patient is admitted secondary to a cerebral infarction. In the final diagnostic statement, the provider documented "acute cerebral infarction involving the right hemisphere with left-sided (nondominant) weakness." How should left-sided weakness due to an acute cerebral infarction be coded when there is no specific mention of hemiplegia/hemiparesis?

  Answer: Assign code I63.9, Cerebral infarction, unspecified, as the principal diagnosis. Assign code G81.94, hemiplegia, unspecified affecting left nondominant side, as an additional diagnosis. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury.

AAA: If/when an aneurysm is documented along with an endograft procedure, make sure the condition is still currently active. Due to the fact that the endograft procedure is to fix aneurysms.

Code specificity – Always make sure that you are reporting the most specific code. Even if the HCC stays the same, it is important to report the code with the most specificity.

- Ex: E11.40 - Type 2 diabetes mellitus with diabetic neuropathy, unspecified vs. E11.42 - Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- Both map to the same HCC, but the E11.42 is a more specified code.

Multiple codes, same HCC - When there are multiple codes found that map to the same HCC, report the one with the best documentation. Or, if both are documented equally, choose the most severe condition. Because an HCC is only reported once a year, we would only report a finding once.
- Example: BMI 40+ and Morbid obesity. Both map to HCC 22
- Example: DM with diabetic kidney disease and DM with cataract. Both map to HCC 18

Conditions noted as Resolved - For Inpatient facility coding, you can code a condition that occurs during the admit (or ER visit that patient was put into inpatient status from) that resolves prior to discharge.

Unstageable pressure ulcers - Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle

graft). This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement. (ICD-10-CM Official Guidelines Section C.12.2)

CareOregon Staff are asked to submit questionable items for further review/second opinion. Educational items are key to improving documentation.

HCC 1: HIV/AIDS

Not included in a Hierarchy Group

- Human immunodeficiency virus (HIV) disease, is captured for all types of HIV infections which are described by a variety of terms, such as the following:
    - AIDS
    - Acquired immune deficiency syndrome
    - Acquired immunodeficiency syndrome
    - AIDS-related complex (ARC)
    - HIV disease
- Exposure to AIDS or HIV is not captured under an HCC[xx]

- ICD-10 code B20 is not captured when the diagnostic statement at the time of discharge indicates that the infection is "suspected," "possible," "likely," or "?." Code only confirmed cases of HIV infection/illness
    - This is an exception to the "hospital inpatient guidelines" that directs the reviewer to assign a code for a diagnosis documented as "suspected" or "possible."
- ICD-10 code z21 is captured when a patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology
    - Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV related illnesses or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

HCC 2: Sepsis and SIRS

Not included in a Hierarchy Group

- Sepsis is a systemic inflammatory response due to an infection. Severe sepsis is sepsis with acute organ dysfunction or multi-organ dysfunction. The organ dysfunctions commonly associated with severe sepsis are listed under R65.2 (Symptoms and signs specifically associated with systemic inflammation and infection in ICD-10-CM). Septic shock generally refers to circulatory failure associated with severe sepsis, usually manifested by hypotension. Septic shock is a form of organ failure.[xxi]
- The coding of severe sepsis requires a minimum of 2 codes:
    - First a code for the underlying systemic infection, followed by a code from subcategory R65.2x, Severe sepsis. If the causal organism is not documented assign code A41.9, Sepsis unspecified organism, for the infection. Additional code(s) for the associated organ dysfunction are also required.

- Septic shock generally refers to circulatory failure associated with severe sepsis and, therefore, it represents a type of acute organ dysfunction.
  - For cases of septic shock, the code for the systemic infection should be sequenced first followed by code R65.21, Severe sepsis with septic shock or code T81.12, post-procedural septic shock.
  - Any additional codes for the other acute organ dysfunctions should also be assigned. The code for septic shock cannot be assigned as a principal or first listed diagnosis.
- If sepsis or severe sepsis is documented as associated with a non-infection condition, such as a burn or serious injury, the code for the non-infectious condition should be coded and a code for systemic infection (R65.1x).
  - Additional codes for any associated acute organ dysfunction should also be assigned for the cases of severe sepsis.

- For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection.
  - If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.
  - A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

HCC 6 Opportunistic Infections

Not included in a Hierarchy Group

- Opportunistic infections (OIs) are infections that occur more frequently and are more severe in individuals with weakened immune systems, including people with HIV.

HCC For Neoplasms (HCC 17 through HCC 23)

Hierarchy Group

- Cancer coding requires detailed specificity. Several different HCCs exist for cancer and assigning the appropriate HCC requires closely following the cancer coding guidelines. The HCC varies depending on whether the cancer is a primary site or a secondary site.

Coding Cancer

- Code only cancers that are current or still actively being treated or documented as refusal of treatment.
  - Chemo/Radiation
  - Surgery
  - Immunotherapy
  - Prophylactic therapy (Ex: Tamoxifen)
- Some benign tumors are also captured in this hierarchy (e.g., benign brain tumors)
- A malignant neoplasm of a transplanted organ should be coded as a transplant complication. [xxii]
- Assign first the appropriate code from category T86.-, Complications of transplanted

organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ.

o Use an additional code for the specific malignancy.

When a patient has had their cancer treated with surgery, even if the document states "NED, no evidence of disease, etc.", if the surgery occurred within a year of the encounter, the cancer should still be reported as active.

HCC 17 Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic

Included in a Hierarchy Group – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (17) takes precedence over the following HCCs:

- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
- 20 - Lung and Other Severe Cancers
- 21 - Lymphoma and Other Cancers
- 22 - Bladder, Colorectal, and Other Cancers
- 23 - Prostate, Breast, and Other Cancers and Tumors

- May also be documented as "mets," "secondary neoplasms," or "secondary malignancies."
- Leukemia in remission has its own 'remission' code, which maps to an HCC and can be captured
  if the documentation provides evidence of MEAT.[xxiii]

The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic, and related tissues.

HCC 18 Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid

Included in a Hierarchy Group – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (18):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic

Qualifying for this HCC (18) takes precedence over the following HCCs:

- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
- 20 - Lung and Other Severe Cancers
- 21 - Lymphoma and Other Cancers
- 22 - Bladder, Colorectal, and Other Cancers
- 23 - Prostate, Breast, and Other Cancers and Tumors

HCC 19 Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (19):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid

Qualifying for this HCC (19) takes precedence over the following HCCs:

- 20 - Lung and Other Severe Cancers
- 21 - Lymphoma and Other Cancers
- 22 - Bladder, Colorectal, and Other Cancers
- 23 - Prostate, Breast, and Other Cancers and Tumors

HCC 20 Lung and other Severe Cancers

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (20):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers

Qualifying for this HCC (20) takes precedence over the following HCCs:

- 21 - Lymphoma and Other Cancers
- 22 - Bladder, Colorectal, and Other Cancers
- 23 - Prostate, Breast, and Other Cancers and Tumor

- Upper digestive cancer maps to this HCC
- Additional HCCs may be found with upper digestive cancer (eg..feeding tube etc.)

HCC 21 Lymphoma and Other Cancers

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (21):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
- 20 – Lung and Other Severe Cancers

Qualifying for this HCC (21) takes precedence over the following HCCs:

- 22 - Bladder, Colorectal, and Other Cancers
- 23 - Prostate, Breast, and Other Cancers and Tumors

- o Primary malignancy brain tumors map to this HCC
- o Lymphomas are classified to ICD-10-CM categories C83-C88. The specific code assignment depends on the cell type as documented by the physician. A fifth-digit sub-classification is required to identify the site of the organ or lymph node involved.

HCC 22 Bladder, Colorectal and Other Cancers

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (22):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
- 20 – Lung and Other Severe Cancers
- 21 – Lymphoma and Other Cancers

Qualifying for this HCC (22) takes precedence over the following HCCs:

- 23 - Prostate, Breast, and Other Cancers and Tumors

HCC 23 Prostate, Breast, and Other Cancers and Tumors

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC.

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (23):

- 17 - Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic
- 18 - Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
- 19 - Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
- 20 – Lung and Other Severe Cancers
- 21 – Lymphoma and Other Cancers
- 22 – Bladder, Colorectal, and Other Cancers

- Only code cancers or tumors that are currently active or receiving treatment within the eligibility DOS of the review.
  - Tamoxifen and Arimidex may be considered "active" treatments for breast cancer.
  - Goserelin may be considered "active" treatment for prostate cancer.

Question: A patient had a malignant breast neoplasm excised three years ago and has completed radiation and chemotherapy. Currently there is no evidence of residual disease on exam, on radiographic images or histologically. However, the patient is receiving consolidative treatment for breast cancer with Herceptin indicated for five years. How is maintenance on Herceptin coded?

Answer: Assign code, C50.919 Malignant neoplasm of female breast, unspecified, as the first-listed diagnosis since Herceptin is considered cancer treatment. Assign code Z79.899 (does not map to an HCC), Long term (current) use of other medications, for the Herceptin maintenance. Herceptin therapy is not antineoplastic chemotherapy but is a biological adjuvant treatment for women with breast cancers that are HER2 positive (with cancer cells overexpressing Human Epidermal Growth Factor Receptor 2).[xxiv]

HCC35 Pancreas Transplant Status

Not included in a Hierarchy Group

HCC for Diabetes (HCC 36 thru HCC 38)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

- If "diabetes with a specified complication" and "diabetes without complications" are both documented within the same encounter note, code to the highest specified diabetes condition per hierarchy rules.

Diabetes "with"

- The sub term "with" in the Index should be interpreted as a link between diabetes and any of those conditions indented under the word "with." The physician documentation does not need to provide a link between the diagnoses of diabetes and chronic kidney disease to accurately assign code E11.22,
- Type 2 diabetes mellitus with diabetic chronic kidney disease. This link can be assumed since the chronic kidney disease is listed under the sub term "with."
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause besides diabetes. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.[xxv]

The following example from the Alphabetic Index for the main term "Diabetes" and the subterm "with" demonstrates this linkage:

Diabetes, diabetic (mellitus) (sugar) E11.9 with

amyotrophy E11.44
arthropathy NEC E11.618
autonomic (poly) neuropathy E11.43
cataract E11.36
Charcot's joints E11.610
chronic kidney disease E11.22

HCC36 Diabetes with Severe Acute Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (36) takes precedence over the following HCCs:

- 37 - Diabetes with Chronic Complications
- 38 - Diabetes without Complication

HCC37 Diabetes with Chronic Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (37):

- 36 - Diabetes with Acute Complications

Qualifying for this HCC (37) takes precedence over the following HCCs:

- 38 - Diabetes without Complication

HCC38 Diabetes with Glycemic, Unspecified, or No Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (38):

- 36 - Diabetes with Acute Complications
- 37 - Diabetes with Chronic Complications

HCC48 Morbid Obesity

When using ICD-10 codes to capture Body Mass Index (BMI) or morbid/severe obesity, follow this guidance:[xxvi]

- In order to code Body Mass Index (BMI) (Z68.X) from a medical record, the reviewer must see the documentation from an acceptable provider for conditions such as "obese," "obesity," "morbid obesity," "morbidly obese," ''severe obesity," or "severely obese."
- The BMI codes should only be reported as a secondary diagnosis.
- A BMI of 40 or greater is considered morbidly obese.
- There are 3 stages of Obesity. If Stage 3 obesity is documented, this codes to Morbid Obesity.
    - Class 1 (low-risk) obesity, if BMI is 30.0 to 34.9.
    - Class 2 (moderate-risk) obesity, if BMI is 35.0 to 39.9.
    - Class 3 (high-risk) obesity, if BMI is equal to orgreater than 40.0.
- BMI of 35-39.9 can be reported as long as there is support of one of the following chronic conditions.
    - COPD
    - GERD
    - Prediabetes
    - Hypertension
    - Sleep Apnea
    - Heart Failure
    - Arthritis (Osteo/Rheum/Psoriatic)
    - Hypothyroidism
    - Hyperlipidemia/Hypercholesterolemia
    - CKD
- If obese is noted only in the "Abdomen" section of Physical exam, it should not be used as support for BMI. An abdomen can be obese because of many disease processes. Review the remainder of the note for support.

- Official coding guidelines indicate that someone who cannot make a diagnosis (e.g., nurse, dietician) may document the BMI. However, the guidelines state that BMI should only be reported as a secondary diagnosis; therefore, to report BMI, a related primary diagnosis (such obesity) should be documented by the patient's provider.

Body Mass Index (BMI) code assignment may be based on documentation recorded by non-physician clinicians, but the codes for overweight and obesity should be based on the provider's documentation. The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet the criteria for a reportable secondary diagnosis, the BMI would need to have some bearing or relevance in turns of patient care. Once the provider has provided documentation of the clinical condition, such as obesity, the coder can assign the appropriate BMI codes from category Z68.X.[xxvii]

HCC49 Specified Lysosomal Storage Disorders

Not included in a Hierarchy Group

HCC50 Amyloidosis, Porphyria, and Other Specified Metabolic Disorders

Not included in a Hierarchy Group

- Diabetes Insipidus (DI) is not the same as Diabetes Mellitus (DM)

HCC51 Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders

Not included in a Hierarchy Group

HCC62 Liver Transplant Status/Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Qualifying for this HCC (62) takes precedence over the following HCCs:

- 63 - Chronic Liver Failure/End-Stage Liver Disorders
- 64 - Cirrhosis of Liver
- 65 - Chronic Hepatitis
- 68 - Cholangitis and Obstruction of Bile Duct Without Gallstones

HCC63 Chronic Liver Failure/End-Stage Liver Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (63):

- 62 – Liver Transplant Status/Complications

Qualifying for this HCC (63) takes precedence over the following HCCs:

- 64 - Cirrhosis of Liver
- 65 - Chronic Hepatitis
- 68 - Cholangitis and Obstruction of Bile Duct Without Gallstones

HCC64 Cirrhosis of Liver

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (64):

- 62 – Liver Transplant Status/Complications
- 63 - Chronic Liver Failure/End-Stage Liver Disorders

Qualifying for this HCC (64) takes precedence over the following HCCs:

- 65 - Chronic Hepatitis
- 68 - Cholangitis and Obstruction of Bile Duct Without Gallstones

HCC65 Chronic Hepatitis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (65):

- 62 – Liver Transplant Status/Complications
- 63 - Chronic Liver Failure/End-Stage Liver Disorders
- 64 - Cirrhosis of Liver

HCC68 Cholangitis and Obstruction of Bile Duct Without Gallstones

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (68):

- 62 – Liver Transplant Status/Complications
- 63 - Chronic Liver Failure/End-Stage Liver Disorders
- 64 - Cirrhosis of Liver
- 65 - Chronic Hepatitis

HCC77 Intestine Transplant Status/Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (77) takes precedence over the following HCCs:

- 78 - Intestinal Obstruction/Perforation
- 80 - Crohn's Disease (Regional Enteritis)
- 81 - Ulcerative Colitis

HCC78 Intestinal Obstruction/Perforation

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (78):

- 77 – Intestine Transplant Status/Complications

Peptic/gastric ulcers with perforation or hemorrhage map to this HCC
Fecal impaction map to this HCC
Paralytic ileus map to this HCC

HCC79 Chronic Pancreatitis

Not included in a Hierarchy Group

HCC80 Crohn's Disease (Regional Enteritis)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (80):

- 77 – Intestine Transplant Status/Complications

Hierarchy Precedence

Qualifying for this HCC (80) takes precedence over the following HCCs:

- 81 - Ulcerative Colitis

HCC81 Ulcerative Colitis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (81):

- 77 – Intestine Transplant Status/Complications
- 80 – Crohn's Disease (Regional Enteritis)

HCC92 Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis

Staphylococcal arthritis map to this HCC
Code the joint affected and type of arthritis
Osteomyelitis map to this HCC
Pyogenic arthritis, sometimes called septic arthritis map to this HCC

HCC93 Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (93) takes precedence over the following HCCs:

- 94 – Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders

Polymyalgia rheumatica maps to this HCC
Sicca Syndrome map to this HCC

HCC94 Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (94):

- 93 – Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders

HCC107 Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (107) takes precedence over the following HCCs:

- 108 - Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major

HCC108 Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (108):

- 107 – Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders

HCC109 Acquired Hemolytic, Aplastic, and Sideroblastic Anemias

Not included in a Hierarchy Group

HCC111 Hemophilia, Male

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (111) takes precedence over the following HCCs:

- 112 - Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions

HCC112 Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (112):

- 111 – Hemophilia, Male

- Thrombocytopenia map to this HCC
- Coagulation defects (also known as clotting disorder/bleeding disorder)
- Polycythemia Vera map to this HCC

HCC114 Common Variable and Combined Immunodeficiencies

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (114) takes precedence over the following HCCs:

- 115 - Specified Immunodeficiencies and White Blood Cell Disorders

HCC115 Specified Immunodeficiencies and White Blood Cell Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (115):

- 114 – Common Variable and Combined Immunodeficiencies

HCC125 Dementia, Severe

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (125) takes precedence over the following HCCs:

- 126 - Dementia, Moderate
- 127 - Dementia, Mild or Unspecified

HCC126 Dementia, Moderate

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (126):

- 125 - Dementia, Severe

Hierarchy Precedence

Qualifying for this HCC (126) takes precedence over the following HCCs:

- 127 - Dementia, Mild or Unspecified

HCC127 Dementia, Mild or Unspecified

Included in Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (127) takes precedence over the following HCCs:

- 125 - Dementia, Severe
- 126 - Dementia, Moderate

HCC135 Drug Use with Psychotic Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (135) takes precedence over the following HCCs:

- 136 - Alcohol Use with Psychotic Complications
- 137 - Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
- 138 – Drug Use Disorder, Mild, Uncomplicated, Except Cannabis
- 139 - Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications

The provider documentation must show linkage of drug use to condition.

o Do not assume drug use as the cause of the condition

HCC136 Alcohol Use with Psychotic Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (136):

- 135 - Drug Use with Psychotic Complications

Hierarchy Precedence

Qualifying for this HCC (136) takes precedence over the following HCCs:

- 137 - Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
- 138 – Drug Use Disorder, Mild, Uncomplicated, Except Cannabis
- 139 - Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications

The provider documentation must show linkage of alcohol use to condition

o Do not assume alcohol use as the cause of the condition

HCC137 Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (137):

- 135 - Drug Use with Psychotic Complications
- 136 - Alcohol Use with Psychotic Complications

Hierarchy Precedence

Qualifying for this HCC (137) takes precedence over the following HCCs:

- 138 – Drug Use Disorder, Mild, Uncomplicated, Except Cannabis
- 139 - Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications

HCC138 Drug Use Disorder, Mild, Uncomplicated, Except Cannabis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (138):

- 135 - Drug Use with Psychotic Complications
- 136 - Alcohol Use with Psychotic Complications
- 137 - Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
-

Hierarchy Precedence

Qualifying for this HCC (138) takes precedence over the following HCCs:

- 139 - Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications

HCC139 Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (139):

- 135 - Drug Use with Psychotic Complications
- 136 - Alcohol Use with Psychotic Complications
- 137 - Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
- 138 – Drug Use Disorder, Mild, Uncomplicated, Except Cannabis

HCC151 Schizophrenia

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (151) takes precedence over the following HCCs:

- 152 – Psychosis, Except Schizophrenia
- 153 – Personality Disorders; Anorexia/Bulimia Nervosa
- 154 – Bipolar Disorders without Psychosis
- 155 – Major Depression, Moderate or Severe, without Psychosis

HCC152 Psychosis, Except Schizophrenia

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (152):

- 151 – Schizophrenia
-

Hierarchy Precedence
Qualifying for this HCC (152) takes precedence over the following HCCs:

- 153 – Personality Disorders; Anorexia/Bulimia Nervosa
- 154 – Bipolar Disorders without Psychosis
- 155 – Major Depression, Moderate or Severe, without Psychosis

HCC153 Personality Disorders; Anorexia/Bulimia Nervosa

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (153):

- 151 – Schizophrenia
- 152 – Psychosis, Except Schizophrenia

Hierarchy Precedence
Qualifying for this HCC (153) takes precedence over the following HCCs:

- 154 – Bipolar Disorders without Psychosis
- 155 – Major Depression, Moderate or Severe, without Psychosis

HCC154 Bipolar Disorders without Psychosis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (154):

- 151 – Schizophrenia
- 152 – Psychosis, Except Schizophrenia
- 153 – Personality Disorders; Anorexia/Bulimia Nervosa

Hierarchy Precedence
Qualifying for this HCC (154) takes precedence over the following HCCs:

- 155 – Major Depression, Moderate or Severe, without Psychosis

HCC155 Major Depression, Moderate or Severe, without Psychosis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (155):

- 151 – Schizophrenia
- 152 – Psychosis, Except Schizophrenia
- 153 – Personality Disorders; Anorexia/Bulimia Nervosa
- 154 – Bipolar Disorders without Psychosis

- Major depression (MD), major depressive disorder (MDD), or severe depression
- Code to the highest degree of specificity (e.g., mild, moderate, severe)

HCC180 Quadriplegia

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (180) takes precedence over the following HCCs:

- 181 – Paraplegia
- 182 – Spinal Cord Disorders/Injuries
- 253 – Hemiplegia/Hemiparesis
- 254 – Monoplegia, Other Paralytic Syndromes

- Quadriplegia: Paralysis of all four limbs
- Functional quadriplegia map to this HCC
- Complete lesion of the cervical spinal cord map to this HCC

HCC181 Paraplegia

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (181):

- 180 – Quadriplegia
- 191 – Quadriplegic Cerebral Palsy
- 192 – Cerebral Palsy, Except Quadriplegic

Hierarchy Precedence

Qualifying for this HCC (181) takes precedence over the following HCCs:

- 182 – Spinal Cord Disorders/Injuries
- 254 – Monoplegia, Other Paralytic Syndromes

Paraplegia: Paralysis of both lower limbs
Complete lesion of the thoracic spinal cord map to this HCC

HCC182 Spinal Cord Disorders/Injuries

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (182):

- 180 – Quadriplegia
- 181 – Paraplegia
- 191 – Quadriplegic Cerebral Palsy
- 192 – Cerebral Palsy, Except Quadriplegic

- Unspecified spinal cord injury at any level map to this HCC
- Spina Bifida maps to this HCC

HCC190 Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy

Not included in a Hierarchy Group

HCC191 Quadriplegic Cerebral Palsy

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (191) takes precedence over the following HCCs:

- 180 – Quadriplegia
- 181 – Paraplegia
- 182 – Spinal Cord Disorders/Injuries
- 192 – Cerebral Palsy, Except Quadriplegic
- 253 – Hemiplegia/Hemiparesis
- 254 – Monoplegia, Other Paralytic Syndromes

Motor neuron disease (MND) is a group of related diseases that affect the motor neurons in the brain and spinal cord.
Amyotrophic lateral sclerosis (LAS) is also called motor neuron disease but is better known as Lou Gehrig's Disease

HCC192 Cerebral Palsy, Except Quadriplegic

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (192):

- 191 – Quadriplegic Cerebral Palsy

Hierarchy Precedence

Qualifying for this HCC (191) takes precedence over the following HCCs:

- 180 – Quadriplegia
- 181 – Paraplegia
- 182 – Spinal Cord Disorders/Injuries
- 253 – Hemiplegia/Hemiparesis
- 254 – Monoplegia, Other Paralytic Syndromes

Cerebral palsy is a condition in which the cerebrum becomes damaged in the womb, during delivery, or in the first few weeks of life due to lack of oxygen or a congenital malformation in the brain.
There is no cure for cerebral palsy.

HCC193 Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy

Not included in a Hierarchy Group

HCC195 Myasthenia Gravis with (Acute) Exacerbation

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (195) takes precedence over the following HCCs:

- 196 - Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders

HCC196 Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (196):

- 195 – Myasthenia Gravis with (Acute) Exacerbation

Guillain-Barre syndrome (G60.1) is a disorder in which the body's immune system attacks the nerves.

HCC197 Muscular Dystrophy

Not included in Hierarchy Group

Muscular dystrophy is a genetic myopathy which causes progressive weakness and wasting of the muscles.
There is no cure for muscular dystrophy, so treatment focuses on enhancing the patient's quality of life.

HCC198 Multiple Sclerosis

Not included in Hierarchy Group

Multiple sclerosis (MS) is an autoimmune disorder in which the body's immune system attacks its own nervous system.
There is no cure for MS, and treatment centers on managing symptoms and making the patient comfortable.

HCC199 Parkinson and Other Degenerative Disease of Basal Ganglia

Not included in Hierarchy Group

- Tremors (or Parkinson's-like tremors) are not the same as the condition noted as "Parkinsonism" and do not map to an HCC.

HCC200 Friedreich and Other Hereditary Ataxias; Huntington Disease

Not included in Hierarchy Group

HCC201 Seizure Disorders and Convulsions

Not included in Hierarchy Group

Code to the highest specificity type of seizure
Seizure disorder and recurrent seizures code to epilepsy
Seizure codes to unspecified convulsions (R56.9)

HCC202 Coma, Brain Compression/Anoxic Damage

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (202):

- 397 – Major Head Injury with Loss of Consciousness > 1 Hour
- 398 - Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified

Glasgow coma scale map to this HCC
Persistent vegetative state map to this HCC

HCC211 Respirator Dependence/Tracheostomy Status/Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (211) takes precedence over the following HCCs:

- 212 - Respiratory Arrest
- 213 - Cardio-Respiratory Failure and Shock

- ➢ Ventilator/respirator dependence or patients with a tracheostomy map to this HCC
- ➢ Tracheostomy should not be captured during the initial surgical encounter phase.
- ➢ Complications: tracheostomy or ventilator/respirator map to this HCC

HCC212 Respiratory Arrest

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (212):

- 211 – Myasthenia Gravis with (Acute) Exacerbation

Hierarchy Precedence
Qualifying for this HCC (212) takes precedence over the following HCCs:

- 213 - Cardio-Respiratory Failure and Shock

HCC213 Cardio-Respiratory Failure and Shock

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (213):

- 211 – Myasthenia Gravis with (Acute) Exacerbation
- 212 - Respiratory Arrest

HCC221 Heart Transplant Status/Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (221) takes precedence over the following HCCs:

- 222 – End-Stage Heart Failure
- 223 – Heart Failure with Heart Assist Device/Artificial Heart
- 224 – Acute on Chronic Heart Failure
- 225 – Acute Heart Failure (Excludes Acute on Chronic)
- 226 – Heart Failure, Except End-Stage and Acute
- 227 – Cardiomyopathy/Myocarditis

HCC222 End-Stage Heart Failure

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (222):

- 221 – Heart Transplant Status/Complications

Hierarchy Precedence
Qualifying for this HCC (222) takes precedence over the following HCCs:

- 223 – Heart Failure with Heart Assist Device/Artificial Heart
- 224 – Acute on Chronic Heart Failure
- 225 – Acute Heart Failure (Excludes Acute on Chronic)
- 226 – Heart Failure, Except End-Stage and Acute
- 227 – Cardiomyopathy/Myocarditis

HCC223 Heart Failure with Heart Assist Device/Artificial Heart

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (223):

- 221 – Heart Transplant Status/Complications
- 222 – End-Stage Heart Failure

HCC224 Acute on Chronic Heart Failure

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (224):

- 221 – Heart Transplant Status/Complications
- 222 – End-Stage Heart Failure

Hierarchy Precedence
Qualifying for this HCC (224) takes precedence over the following HCCs:

- 225 – Acute Heart Failure (Excludes Acute on Chronic)
- 226 – Heart Failure, Except End-Stage and Acute
- 227 – Cardiomyopathy/Myocarditis

HCC225 Acute Heart Failure (Excludes Acute on Chronic)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (225):

- 221 – Heart Transplant Status/Complications
- 222 – End-Stage Heart Failure
- 224 – Acute on Chronic Heart Failure

Hierarchy Precedence
Qualifying for this HCC (225) takes precedence over the following HCCs:

- 226 – Heart Failure, Except End-Stage and Acute
- 227 – Cardiomyopathy/Myocarditis

HCC226 Heart Failure, Except End-Stage and Acute

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (226):

- 221 – Heart Transplant Status/Complications
- 222 – End-Stage Heart Failure
- 224 – Acute on Chronic Heart Failure
- 225 – Acute Heart Failure (Excludes Acute on Chronic)

Hierarchy Precedence

Qualifying for this HCC (226) takes precedence over the following HCCs:

- 227 – Cardiomyopathy/Myocarditis

HCC227 Cardiomyopathy/Myocarditis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (227):

- 221 – Heart Transplant Status/Complications
- 222 – End-Stage Heart Failure
- 224 – Acute on Chronic Heart Failure
- 225 – Acute Heart Failure (Excludes Acute on Chronic)
- 226 – Heart Failure, Except End-Stage and Acute

HCC228 Acute Myocardial Infarction

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (228) takes precedence over the following HCCs:

- 229 – Unstable Angina and Other Acute Ischemic Heart Disease

MI time frame 4 weeks or less

Code categories for initial AMIs is I21 and subsequent AMIs is I22

- ➢ A code from category I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction is to be used when a patient who has suffered an AMI has a new AMI within the four-week time frame of the initial AMI. A code category of I22 must be used in conjunction with a code category of I21.

Acute myocardial infarction unspecified has a default code of I21.3

HCC229 Unstable Angina and Other Acute Ischemic Heart Disease

Included in a Hierarchy– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (229):

- 228 – Acute Myocardial Infarction

Chronic ischemic heart disease is a long-term or possibly permanent condition that occurs when the heart is deprived of oxygen, usually due to coronary disease which obstructs the flow of blood to the heart.
CAD with unstable angina map to this HCC

HCC238 Specified Heart Arrhythmias

Not included in a Hierarchy Group

- Cardiac rhythms addressed with chronic cardiac pacemakers are not to be coded if no attention or treatment is provided to the condition or the device. If Sick Sinus Syndrome is being assessed and evaluated (not just listed as a dx), okay to code even if patient has a pacemaker (Coding Clinic 1993, 5th Issue, Page: 12)
- Bradycardia unspecified does not map to an HCC.

HCC248 Intracranial Hemorrhage

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (248) takes precedence over the following HCCs:

- 249 – Ischemic or Unspecified Stroke

Nontraumatic Subarachnoid hemorrhage map to this HCC
Nontraumatic Intra-cerebral hemorrhage map to this HCC

HCC249 Ischemic or Unspecified Stroke

Included in a Hierarchy Group – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (249):

- 248 – Intracranial Hemorrhage

Stroke and CVA are often used interchangeably to refer to a cerebral infarction. Stroke can only be coded in the acute care phase during the initial event.

HCC253 Hemiplegia/Hemiparesis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (253) takes precedence over the following HCCs:

- 254 – Monoplegia, Other Paralytic Syndromes

Unilateral weakness that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis or hemiplegia.

HCC254 Monoplegia, Other Paralytic Syndromes

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (254):

- 253 – Hemiplegia/Hemiparesis

Monoplegia - paralysis restricted to one limb or region of the body.

HCC263 Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for this HCC (263) takes precedence over the following HCCs:

- 264 – Vascular Disease with Complications
- 383 – Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle
- 409 – Amputation Status, Lower Limb/Amputation Complications

HCC264 Vascular Disease with Complications

Included in a Hierarchy Group - – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (264):

- 263 – Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene

Leg ulcers with varicosities map to this HCC

Pulmonary embolism (PE) map to this HCC

HCC267 Deep Vein Thrombosis and Pulmonary Embolism

Not included in a Hierarchy Group

Leg ulcers with varicosities map to this HCC

Pulmonary embolism (PE) map to this HCC

Acute vs Chronic: Acute PE is a new embolism that requires the initiation of anticoagulant therapy. A chronic PE is an old or previously diagnosed embolism that requires continuation of anticoagulation therapy. Specific code assignment is based on physician documentation. The coder cannot assume whether the PE is acute or chronic unless the physician documents the acuity. There are no specific guidelines for when PE is considered chronic. PE NOS defaults to “acute” in ICD-10-CM.[xxviii]

HCC276 Lung Transplant Status/Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (276) takes precedence over the following HCCs:

- 277 – Cystic Fibrosis
- 278 – Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis
- 279 – Severe Persistent Asthma
- 280 – Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders

HCC277 Cystic Fibrosis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (277):

- 276 - Lung Transplant Status/Complications

Hierarchy Precedence
Qualifying for this HCC (277) takes precedence over the following HCCs:

- 278 – Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis
- 279 – Severe Persistent Asthma
- 280 – Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders

HCC278 Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (278):

- 276 - Lung Transplant Status/Complications
- 277 - Cystic Fibrosis

Hierarchy Precedence
Qualifying for this HCC (278) takes precedence over the following HCCs:

- 279 – Severe Persistent Asthma
- 280 – Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders

Sarcoidosis of lung map to this HCC

HCC279 Severe Persistent Asthma

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (279):

- 276 - Lung Transplant Status/Complications
- 277 - Cystic Fibrosis
- 278 - Severe Persistent Asthma

Hierarchy Precedence

Qualifying for this HCC (279) takes precedence over the following HCCs:

- 280 – Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders

HCC280 Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (280):

- 276 - Lung Transplant Status/Complications
- 277 - Cystic Fibrosis
- 278 - Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis
- 279 - Severe Persistent Asthma

HCC282 Aspiration and Specified Bacterial Pneumonias

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (282) takes precedence over the following HCCs:

- 283 – Empyema, Lung Abscess

Code J95.851, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP)
Walking, community-acquired, and viral pneumonias do NOT map to an HCC.

HCC283 Empyema, Lung Abscess

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (283):

- 282 - Aspiration and Specified Bacterial Pneumonias

Gangrene and necrosis of lung map to this HCC
Abscess of lung with pneumonia map to this HCC

HCC298 Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage

Not included in a Hierarchy Group

HCC300 Exudative Macular Degeneration

Not included in a Hierarchy Group

Exudative age-related macular degeneration, also known as wet macular degeneration.

HCC326 Chronic Kidney Disease, Stage 5

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (326):

- 327 – Chronic Kidney Disease, Severe (Stage 4)
- 328 – Chronic Kidney Disease, Moderate (Stage 3B)
- 329 – Chronic Kidney Disease, Moderate (Stage 3, Except 3B)

CKD stage V and End Stage Renal Disease (ESRD) map to this HCC
Code I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease does not map to an HCC.
If both a stage of CKD and ESRD are documented, assign code N18.6 (ESRD) only.
If both CKD 5 and dialysis are documented within the same note, N18.6 would be reported.
If two stages of CKD are documented, code the highest or most severe stage.

- Example: CKD stage 4-5, stage 5 would be coded

HCC327 Chronic Kidney Disease, Severe (Stage 4)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (327):

- 326 - Chronic Kidney Disease, Stage 5

Hierarchy Precedence

Qualifying for this HCC (327) takes precedence over the following HCCs:

- 328 – Chronic Kidney Disease, Moderate (Stage 3B)
- 329 – Chronic Kidney Disease, Moderate (Stage 3, Except 3B)

HCC328 Chronic Kidney Disease, Moderate (Stage 3B)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (328):

- 326 - Chronic Kidney Disease, Stage 5
- 327 - Chronic Kidney Disease, Moderate (Stage 3B)

Hierarchy Precedence

Qualifying for this HCC (328) takes precedence over the following HCCs:

- 329 – Chronic Kidney Disease, Moderate (Stage 3, Except 3B)

HCC329 Chronic Kidney Disease, Moderate (Stage 3, Except 3B)

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (329):

- 326 - Chronic Kidney Disease, Stage 5
- 327 - Chronic Kidney Disease, Moderate (Stage 3B)
- 328 - Chronic Kidney Disease, Moderate (Stage 3B)

HCC379 Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (379):

- 380 – Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle
- 381 – Pressure Ulcer of Skin with Full Thickness Skin Loss
- 382 – Pressure Ulcer of Skin with Partial Thickness Skin Loss
- 383 – Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle

Codes from category L89, Pressure ulcer, identify the site of the pressure ulcer as well as the stage of the ulcer.

No code is assigned if the documentation states that the pressure ulcer/ non-pressure ulcer is completely healed.

HCC380 Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (380):

- 379 - Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone

Hierarchy Precedence
Qualifying for this HCC (380) takes precedence over the following HCCs:

- 381 – Pressure Ulcer of Skin with Full Thickness Skin Loss
- 382 – Pressure Ulcer of Skin with Partial Thickness Skin Loss
- 383 – Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle

HCC381 Pressure Ulcer of Skin with Full Thickness Skin Loss

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence
Qualifying for one of these HCCs takes precedence over this HCC (381):

- 379 - Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
- 380 - Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle

Hierarchy Precedence
Qualifying for this HCC (381) takes precedence over the following HCCs:

- 382 – Pressure Ulcer of Skin with Partial Thickness Skin Loss
- 383 – Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle

Documented as pressure ulcer, bed sore, decubitus.

HCC382 Pressure Ulcer of Skin with Partial Thickness Skin Loss

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (382):

- 379 - Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
- 380 - Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle
- 381 - Pressure Ulcer of Skin with Full Thickness Skin Loss

Hierarchy Precedence

Qualifying for this HCC (382) takes precedence over the following HCCs:

- 383 – Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle

HCC383 Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle

Included in a Hierarchy Group – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (383) takes precedence over the following HCCs:

- 263 – Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene
- 382 - Pressure Ulcer of Skin with Partial Thickness Skin Loss

HCC385 Severe Skin Burn

Not included in a Hierarchy Group

Burns:

- ❖ Chemical burn
- ❖ Burn due to frostbite
- ❖ Thermal burn
- ❖ Gasoline burn
- ❖ Burn due to explosion

Sunburn does not map to an HCC

Burn requirements: 3rd degree burn and cover at least 10% of the body.

HCC387 Pemphigus, Pemphigoid, and Other Specified Autoimmune Skin Disorders

Not included in a Hierarchy Group

HCC397 Major Head Injury with Loss of Consciousness > 1 Hour

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (397) takes precedence over the following HCCs:

- 202 – Coma, Brain Compression/Anoxic Damage
- 398 – Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified
- 399 – Major Head Injury without Loss of Consciousness

HCC398 Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (398):

- 397 - Major Head Injury with Loss of Consciousness > 1 Hour

Hierarchy Precedence

Qualifying for this HCC (398) takes precedence over the following HCCs:

- 202 – Coma, Brain Compression/Anoxic Damage
- 399 – Major Head Injury without Loss of Consciousness

HCC399 Major Head Injury without Loss of Consciousness

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (39):

- 397 - Major Head Injury with Loss of Consciousness > 1 Hour
- 398 – Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified

HCC401 Vertebral Fractures without Spinal Cord Injury

Not included in a Hierarchy Group

Traumatic fracture is defined as: a fracture that has arisen as a result of injury. (S02-S92)

Collapsed vertebra fracture (M48.5XXX) codes to this HCC

Acute Traumatic Fractures vs. Aftercare of Traumatic Fractures

- Traumatic fractures are coded using the acute fractures code category (S02-S92) while the patient is receiving **active treatment** for the fracture.

HCC402 Hip Fracture/Dislocation

Not included in a Hierarchy Group

HCC405 Traumatic Amputations and Complications

Included in a Hierarchy Group– the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for this HCC (405) takes precedence over the following HCCs:

- 409 – Amputation Status, Lower Limb/Amputation Complications

Trauma-related amputations map to this HCC
Post-traumatic wound infections T79.8XXA map to this HCC
Complications of re-attached body parts map to this HCC

HCC409 Amputation Status, Lower Limb/Amputation Complications

Included in a Hierarchy Group – the hierarchy is only relevant in audit projects where a less severe HCC is identified but a more severe HCC has already been reported. In these cases, do not record the less severe HCC

Hierarchy Precedence

Qualifying for one of these HCCs takes precedence over this HCC (409):

- 263 – Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene
- 405 - Traumatic Amputations and Complications

Amputation status codes (Z codes) may be coded from a past medical history or problem list.

Amputations complication map to this HCC

- o BKA – Below the knee amputation
- o AKA – Above the knee amputation
- o TMA – Trans-metatarsal amputation

HCC454 Stem Cell, Including Bone Marrow, Transplant Status/Complications

Not included in a Hierarchy Group

HCC463 Artificial Openings for Feeding or Elimination

Not included in a Hierarchy Group

Artificial opening should not be coded during the initial surgical encounter phase.
History of an artificial opening can be coded as long as there is no evidence of closure.

Acceptable Physician Specialty Types for 2023 Payment Year (2022 Dates of Service) Risk Adjustment Data Submission Error! Bookmark not defined.

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	29	Pulmonary Disease	81	Critical Care (Intensivists)
2	General Surgery	33*	Thoracic Surgery	82	Hematology
3	Allergy/Immunology	34	Urology	83	Hematology/Oncology
4	Otolaryngology	35	Chiropractic	84	Preventive Medicine
5	Anesthesiology	36	Nuclear Medicine	85	Maxillofacial Surgery
6	Cardiology	37	Pediatric Medicine	86	Neuropsychiatry
7	Dermatology	38	Geriatric Medicine	89*	Certified Clinical Nurse Specialist
8	Family Practice	39	Nephrology	90	Medical Oncology
9	Interventional Pain Management	40	Hand Surgery	91	Surgical Oncology
10	Gastroenterology	41	Optometry	92	Radiation Oncology
11	Internal Medicine	42	Certified Nurse Midwife	93	Emergency Medicine
12	Osteopathic Manipulative Medicine	43	Certified Registered Nurse Anesthetist	94	Interventional Radiology
13	Neurology	44	Infectious Disease	97*	Physician Assistant
14	Neurosurgery	46*	Endocrinology	98	Gynecological/Oncology
15	Speech Language Pathologist	48*	Podiatry	99	Unknown Physician Specialty
16	Obstetrics/Gynecology	50*	Nurse Practitioner	C0*	Sleep Medicine
17	Hospice And Palliative Care	62*	Psychologist	C3*	Interventional Cardiology
18	Ophthalmology	64*	Audiologist	C5*	Dentist
19	Oral Surgery (Dentists only)	65	Physical Therapist	C6	Hospitalist
20	Orthopedic Surgery	66	Rheumatology	C7	Advanced Heart Failure and Transplant Cardiology
21	Cardiac Electrophysiology	67	Occupational Therapist	C8	Medical Toxicology
22	Pathology	68	Clinical Psychologist	C9	Hematopoietic Cell Transplantation and Cellular Therapy
23	Sports Medicine	72*	Pain Management	D3*	Medical Genetics and Genomics
24	Plastic And Reconstructive Surgery	76*	Peripheral Vascular Disease	D4	Undersea and Hyperbaric Medicine

25	Physical Medicine And Rehabilitation	77	Vascular Surgery	D5	Opioid Treatment Program
26	Psychiatry	78	Cardiac Surgery	D7*	Micrographic Dermatologic Surgery (MDS)
27	Geriatric Psychiatry	79	Addiction Medicine	D8	Adult Congenital Heart Disease (ACHD)
28	Colorectal Surgery (formerly Proctology)	80	Licensed Clinical Social Worker		

* Indicates that a number has been skipped.

Disease Hierarchies[xxix]

Model version	HCC	Description	HCCs to drop
2024	17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
2024	18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
2024	19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
2024	20	Lung and Other Severe Cancers	21, 22, 23
2024	21	Lymphoma and Other Cancers	22, 23
2024	22	Bladder, Colorectal, and Other Cancers	23
2024	35	Pancreas Transplant Status	36, 37, 38
2024	36	Diabetes with Severe Acute Complications	37, 38
2024	37	Diabetes with Chronic Complications	38
2024	62	Liver Transplant Status/Complications	63, 64, 65, 68
2024	63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
2024	64	Cirrhosis of Liver	65, 68
2024	77	Intestine Transplant Status/Complications	78, 80, 81
2024	80	Crohn's Disease (Regional Enteritis)	81
2024	93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	94
2024	107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	108
2024	111	Hemophilia, Male	112
2024	114	Common Variable and Combined Immunodeficiencies	115
2024	125	Dementia, Severe	126, 127
2024	126	Dementia, Moderate	127
2024	135	Drug Use with Psychotic Complications	136, 137, 138, 139
2024	136	Alcohol Use with Psychotic Complications	137, 138, 139
2024	137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	138, 139
2024	138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	139

2024	151	Schizophrenia	152, 153, 154, 155
2024	152	Psychosis, Except Schizophrenia	153, 154, 155
2024	153	Personality Disorders; Anorexia/Bulimia Nervosa	154, 155
2024	154	Bipolar Disorders without Psychosis	155
2024	180	Quadriplegia	181, 182, 253, 254
2024	181	Paraplegia	182, 254
2024	191	Quadriplegic Cerebral Palsy	180, 181, 182, 192, 253, 254
2024	192	Cerebral Palsy, Except Quadriplegic	180, 181, 182, 253, 254
2024	195	Myasthenia Gravis with (Acute) Exacerbation	196
2024	211	Respirator Dependence/Tracheostomy Status/Complications	212, 213
2024	212	Respiratory Arrest	213
2024	221	Heart Transplant Status/Complications	222, 223, 224, 225, 226, 227
2024	222	End-Stage Heart Failure	223, 224, 225, 226, 227
2024	224	Acute on Chronic Heart Failure	225, 226, 227
2024	225	Acute Heart Failure (Excludes Acute on Chronic)	226, 227
2024	226	Heart Failure, Except End-Stage and Acute	227
2024	228	Acute Myocardial Infarction	229
2024	248	Intracranial Hemorrhage	249
2024	253	Hemiplegia/Hemiparesis	254
2024	263	Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	264, 383, 409
2024	276	Lung Transplant Status/Complications	277, 278, 279, 280
2024	277	Cystic Fibrosis	278, 279, 280
2024	278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	279, 280
2024	279	Severe Persistent Asthma	280
2024	282	Aspiration and Specified Bacterial Pneumonias	283
2024	326	Chronic Kidney Disease, Stage 5	327, 328, 329
2024	327	Chronic Kidney Disease, Severe (Stage 4)	328, 329
2024	328	Chronic Kidney Disease, Moderate (Stage 3B)	329
2024	379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	380, 381, 382, 383
2024	380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle	381, 382, 383
2024	381	Pressure Ulcer of Skin with Full Thickness Skin Loss	382, 383
2024	382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	383
2024	397	Major Head Injury with Loss of Consciousness > 1 Hour	202, 398, 399
2024	398	Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified	202, 399
2024	405	Traumatic Amputations and Complications	409

CMS HCCs[xxx]

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[i] *"CMS" 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide*
[ii] *ICD-10 Coding Guidelines Section I.A1*
[iii] *ICD-10 Coding Guidelines Section II.H*
[iv] *ICD-10 Coding Guidelines Section II.D*
[v] *Coding Clinic Quarter 3, 2009*
vi
[vii] *Retrieved From "Empire BlueCross" CMS-HCC Risk Adjustment Model (V22)*
[viii] *www.medpartners.com/risk-adjustment-cms-hcc-101/*
[ix] *ICD-10-CM Coding Guidelines Section: 1.C.5.b*
[x] *Coding Clinic 3rd Quarter, 2008*
[xi] *Coding Clinic 3rd Quarter, 2019*
[xii] *ICD-10 Coding Guidelines Section I.C.17*
[xiii] *ICD-10 Coding Guidelines Section I.C.19.a*
[xiv] *Coding Clinic 2nd Quarter, 1992*
[xv] *Coding Clinic 3rd Quarter 2018*
[xvi] *Coding Clinic 1st Quarter, 2021*
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