This guide offers general tips on risk adjustment coding and documentation. It is for educational purposes only and is intended to be used as a reference to help capture common and often overlooked chronic conditions. Providers are responsible for accurately assessing and documenting patient diagnoses, including the clinical rationale to support ICD-10-CM code assignment in accordance with official guidelines.

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Risk Adjustment Coding & Documentation

Guidance for Healthcare Providers, Coders, and Administrative Support Staff

Preventive Visits

Utilize preventive visits to assess ongoing chronic condition diagnoses:

- Identify patients who need disease management or intervention
- Improve meaningful data exchanges between the health plan and providers
- Improve the quality of care provided and patient health outcomes

The medical record must support all diagnoses and all services billed on the claim.

- Address all conditions that require or affect patient care, treatment, or management
- Thoroughly document the specific diagnoses and care plan
- Code to the highest specificity using ICD-10 guidelines
- Include CPT© II codes as applicable to provide additional details
- Submit claim/encounter data for each service rendered
- Ensure claim/encounter data is accurate and submitted in a timely manner

Annual Wellness Visits		
"Welcome to Medicare" Initial Preventive Physical Exam (IPPE)	**G0402** (Once-in-a-lifetime benefit)	The Annual Wellness Visit (AWV) includes Personalized Prevention Plan Services (PPPS) that focus on disability and disease prevention. This service is covered once per calendar year. Refer to the Medicare Claims Processing Manual for other services covered at the time of an IPPE or AWV.
Initial Annual Wellness Visit	**G0438** (Once-in-a-lifetime benefit)	
Subsequent Annual Wellness Visit	**G0439** (All subsequent visits)	
FQHC visit that includes IPPE or AWV	**G0468** (initial or subsequent)	

Annual Physical Exams			
Exam Type	**Initial**	**Subsequent**	Annual Physical Exams include an appropriate history and exam with risk counseling and/or intervention. The extent and focus of the exam are dependent on the age and sex of the patient. This service is covered once per calendar year. Refer to the CPT© manual to view other services covered separately preventive medicine exam.
Ages 18–39	**99385**	99395	
Ages 40–64	**99386**	99396	
Ages 65+	**99387**	99397	

Exam Components:

Welcome to Medicare Exam

Review:

- Medical and social history
- Risk factors for depression and mood disorders
- Functional ability and level of safety

Examine:

- Height, weight, and BMI
- Blood pressure
- Visual acuity screen
- Any other factors based on patient's medical and social history

Include:

- End of life planning — patient may decline
- Education, counseling, and referral as appropriate
  - Based on review and exam assessment
  - To obtain screenings and other preventive services
- Brief written plan — provided to the patient

Annual Wellness Visit

Establish/Review or Update:

- Health Risk Assessment (HRA), if needed
- Medical, social, and family history
  List current providers
- Risk Factor Screenings
  - Depression and mood disorders
  - Functional ability
  - Level of safety
- Written preventive screening schedule
- Risk factors/conditions that need and/or receive intervention
- Treatment options with associated risks/benefits
- Personalized health advice/referrals provided to patient
- Health education/counseling/preventive services:
  - Weight loss
  - Physical activity
  - Nutrition
  - Smoking cessation
  - Fall prevention

Who Can Perform the AWV?

- Physician: Doctor of medicine or osteopathy
- Qualified non-physician: Physician assistant, nurse practitioner, or clinical nurse specialist
- Medical professional: Health educator, registered dietitian, nutrition professional, or other licensed practitioner. Clinical staff or a team of such medical professionals working under the direct supervision of a physician or qualified non-physician. Clinical staff includes registered nurses, licensed practical nurses, and medical assistants.

Non-authorized medical professionals and clinical staff are not permitted to perform any part of the AWV that requires the exercise of independent clinical judgment or the making of clinical assessments, evaluations, or interpretations.

Annual Physical Exam

- Exam focused on modifiable risk factors and disease prevention
  - No chief complaint
  - Not due to present illness
- Comprehensive history and physical exam findings
  - Complete systems review
  - Past medical, social, and family history
  - Pertinent risk factors
- Description and status of chronic conditions that are *not significant enough to require additional work-up*
- Risk factor and age-appropriate counseling, screening labs, tests, and vaccines including orders and/or referrals
  - Individual preventive medicine counseling, alcohol/substance abuse screening and intervention, and smoking/tobacco cessation are NOT separately reportable when performed at the time of an Annual Physical Exam.
- Description and care plan for minor problems that do not require additional work-up
  - Document and code any abnormalities found during the visit, regardless of whether the finding requires an additional work-up.

Additional Preventive Services:

Refer to the Medicare Claims Processing Manual for information about preventive services that are separately covered with an IPPE or AWV.

Preventive Services:

- Alcohol Use Counseling
- Bone Mass Measurement
- Counseling to Prevent Tobacco Use
- Diabetes Self-Management Training
- HIBC to Prevent STIs
- HIV PrEP
- IBT for Cardiovascular Disease
- IBT for Obesity
- Medical Nutritional Therapy
- Medicare Diabetes Prevention Program
- Prolonged Preventive Services

Screening Tests:

- Alcohol Misuse
- Cervical Cancer
- Colorectal Cancer
- Depression
- Glaucoma
- Hepatitis B
- Hepatitis C
- HIV
- Lung Cancer
- Mammography
- Prostate Cancer
- Pap Smear
- Pelvic Exam
- STI
- Ultrasound AAA
- Electrocardiogram

Vaccines and Administration:

- Flu
- Pneumonia
- Hepatitis B
- COVID-19

Separate Evaluation and Management (E/M)

Provider may perform separately identifiable services 99202– 99215, 99385–99387, 99395– 99397, G0402, G0438–G0439 on the same day.

- A separately identifiable E/M service may be reported if prompted by symptoms or chronic conditions assessed during the AWV/Physical. Select the appropriate level of E/M services based on the following:
  1. The level of the medical decision making as defined for each service; or
  2. The total time for E/M services performed on the date of the encounter.
- The components of both the AWV and the Physical Exam must be met and documented.
- Report E/M and routine Physical with modifier -25 when performed on the same date.
- If the provider's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use code 99211.

ICD-10: Encounter for General Adult Medical Exam

with normal findings, Z00.00

- Use when conditions are stable or improving.
- Report additional codes for chronic conditions.

with abnormal findings, Z00.01

- Use when any abnormality is found during the visit.
- Report additional codes for all existing conditions.

Report the documented reason for the encounter as the primary diagnosis code and assign additional diagnosis codes if applicable. Follow the current year's official ICD-10-CM guidelines for coding and reporting.

Tips for the Provider

Document each patient encounter as if it is the only encounter.

Codes should be assigned for every condition documented in the medical record that have evidence of M.E.A.T., not just the condition for which the patient presented.

When seeing a patient who comes less frequently, ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.

Avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, DM, or atrial fibrillation.

All chronic and complex conditions should be assessed and reported annually. Review, document, and report conditions managed by a specialist.

Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "history of."

Focus on Documentation

Each year, the diagnosis list is zeroed out by CMS. All patients are considered healthy until diagnoses are again reported, ensuring patients are being treated for the chronic conditions they have.

The two most important things for providers to know regarding HCC coding are:

See the patient at least once a year to determine health status.

- Evaluate and document ALL active conditions.
- Simply listing every diagnosis in the medical record is not acceptable and does not support reporting an HCC.

Be as specific as possible in the documentation.

- This will allow for the most accurate ICD-10 code to be reported.
- Documentation should include additional manifestations or complications related to a chronic disease.

HCC Code Capture

The challenge with HCCs is the end-to-end capture of clinical documentation and diagnosis data, with supporting clinical evidence and the specific requirements as defined by CMS and HHS.

- An encounter each calendar year and diagnosis by an acceptable provider type (PA, NP or physician)
  - Unacceptable provider types include diagnostic testing facilities, LPNs, LVNs, medical assistants, medical supply companies, ambulatory surgery centers, nursing assistants, ambulance service providers, and anesthesiology assistants.
- Documentation must be accurate and support the diagnosis.
  - Capture patient's complexity via ICD-10 code assignment.
  - Diagnoses submitted on claim must be supported in the medical record.

The medical record must support all diagnoses and all services billed on the claim.

M.E.A.T. Guidance

M — **Monitoring**

- How is the patient doing?
- Are there new signs or symptoms?
- Conceptually represents ongoing surveillance of the condition(s).

E — **Evaluation**

- What is the current state of the condition?
- What is the provider's judgment of the condition currently?
- This can be the review of results or treatment outcomes.

A — **Assessment**

- How will the condition(s) be evaluated or estimated?
- This can be documented with prior records review, counseling, or ordering further studies.

T — **Treatment**

- What care is being offered, or what is being done to help the patient with the condition(s)?
- This can be a medication, a diagnostic study, or a therapeutic service.

"History of" means *historical*

whenassigning the diagnosis code

- Do not code an active diagnosis for conditions for which treatment is complete and/or that have resolved and no longer exist.
- Do not code "history of" for active conditions.

	HPI	Correct Coding	
Example: 1	"Patient ***has*** Type 2 diabetes mellitus currently stable, controlled with metformin."	E11.9, Type 2 diabetes mellitus without complications Z79.84, long-term (current) use of oral hypoglycemic drugs	Use ***"has"*** when condition is present and being actively manged
Example:2	"Patient has a ***history of*** DVT, s/p thrombolysis, Currently taking warfarin as directed, no issue reported."	Z86.718, personal history of other venous thrombosis and embolism Z79.01, long-term (current) use of anticoagulants	Use ***"history of"*** when condition has resolved and treatment is no longer needed

Patient Reported Conditions need provider confirmation of diagnosis. This includes patient completed registration forms. Do not report a diagnosis if only the patient's declaration that the condition exists is documented by the provider.

Lifelong Chronic Conditions often require ongoing medical attention, and the associated diagnosis is typically unresolved once diagnosed. Assess and report these conditions, even when stable, at least once per year. Document the medical record as appropriate to support the presence and status of the condition at the time of the encounter.

Condition Status (Z Codes) indicate that a patient is either a carrier of a disease or has the sequela or residual of a past disease or condition. The status can affect the course of treatment and its outcome, but they are commonly overlooked (e.g., amputation, artificial opening, organ transplant, respirator dependence/supplemental oxygen, renal dialysis, etc.).

BMI ≥ 40 (Z68.41–Z68.45)	
▸ **Height and weight must be documented** ▸ **Document counseling (diet, exercise)** ▸ **Morbidly obese (E66.01)** ▸ **Obesity, class 3 (E66.813)**	• BMI may be recorded by other clinicians (dieticians, CMS, RN). • In order to assign a BMI code, the associated condition must be documented by the provider (obesity, morbid obesity, overweight).
Artificial Openings	
▸ **Document Presence (Z93.-)** ▸ **Document if attention was given (Z43.-)** ▸ **Document any complications (K94.-, J95.-)**	• Document whether a stoma is temporary or permanent. • If temporary, document when it was reversed in the surgical history portion of the note.
Organ Transplant (Z91.-)	
▸ **Heart, lung, liver, bone marrow, pancreas, intestine, kidney** ▸ **Document status and any post-transplant complications** ▸ **Document anti-rejection drug therapy**	• Report a status code when there are no complications. • A status code should not be reported along with a transplant complication code. Refer to the appropriate subcategory for complications of a transplant.

Conditions Managed by a Specialist

- Document and code all conditions as appropriate when addressed in an encounter even if it's currently managed by specialist.
- Incorporate specialist notes into the EMR and bring the patient's diagnoses from the Active Medical Problems List into the Assessment and Plan to drive documentation details.

Hypertension

The relationship between hypertension, heart disease, and chronic kidney disease is assumed when conditions are documented together unless noted otherwise. Use the appropriate combination codes when reporting these conditions.

Hypertensive Heart Disease: Category I11	
▶ Presumed relationship between HTN and Heart Disease • Code separately only if documentation states heart disease not due to HTN (Applies to any condition in I50.-, I51.4-I51.7, I51.89, I51.9)	▶ **Use additional code** from category I50, Heart failure (if applicable)

Hypertensive Chronic Kidney Disease: Category I12	
▶ Presumed relationship between HTN and CKD. • Code separately **only** if documentation specifies "unrelated" or cause other than HTN	▶ **Use additional code** to identify **the stage** of the chronic kidney disease • Use appropriate code from Category N18 ▶ **Also code** dialysis status with ESRD

Hypertensive Heart and Chronic Kidney Disease: Category I13	
▶ Hypertension with both Heart and Kidney involvement • **Do NOT** code separately for HTN, Heart disease, and CKD **or** assign codes from Category I11 or I12	▶ **Use additional code** from category I50, heart failure ▶ **Also code** the stage of CKD, and dialysis status, if applicable

Congestive Heart Failure

The type of congestive heart failure (diastolic, systolic, or combined) may be inferred when HFpEF, HFrEF, or other similar terms are documented by the provider.

Assign the ICD-10 code to the highest level of specificity supported by the medical record.

- ▶ Systolic dysfunction — reduced ejection fraction (HFrEF),
- ▶ Diastolic dysfunction — preserved ejection fraction (HFpEF)
- ▶ Right-sided heart failure — weakened right ventricle
- ▶ Left-sided heart failure — weakened left ventricle
- ▶ Congestive heart failure — congestion in body's tissue

Congestive Heart Failure: Category I50			
I50.1	Left ventricular failure, unspecified	**I50.4-**	Combined systolic (congestive) and diastolic (congestive) heart failure
I50.2-	Systolic (congestive) heart failure	**I50.8-**	Other heart failure
I50.3-	Diastolic (congestive) heart failure	**I50.9**	Heart failure, unspecified

Specified Heart Arrhythmias

Atrial Fibrillation				
Paroxysmal	**Persistent**		**Chronic**	
	Longstanding	**Other**	**Unspecified**	**Other**
I48.0 Rapid irregular heartbeat in the atrium	**I48.11** Continuous, lasting longer than one year	**I48.19** Persistent NOS, chronic persistent	**I48.20** Long history stated as chronic	**I48.21** Stated as chronic and permanent

Atrial Flutter		Unspecified (unsp.)	
Type 1 (Typical)	**Type 2 (Atypical)**	**Atrial Fibrillation, unsp.**	**Atrial Flutter, unsp.**
I48.3	**I48.4**	**I48.91**	**I48.92**

Tachycardia				
Paroxysmal				**Sinus**
Re-Entry	**Supraventricular**	**Ventricular**	**Unspecified**	**[sinusal]**
I47.0	**I47.10** Unspecified (sustained)	**I47.20** Unspecified (sustained)	**I47.9**	**R00.0** sinoauricular, NOS Unspecified (no HCC)
	I47.11 Inappropriate, so stated	**I47.21** Torsades de pointes		
	I47.19 other	**I47.29** other		

Documentation/Coding Tips:

Anticoagulant therapy

- The provider must document the relationship between anticoagulation therapy and cardiac arrhythmias. It cannot be assumed since anticoagulants are used to manage other conditions.
- Even when the conditions are linked, document the type, status, and severity of the arrhythmia. Anticoagulant therapy is also used to prevent blood clots in patients with a history of cardiac arrhythmia.

"History of"

- Document "history of" if the condition has resolved / been treated and no longer exists.
- There is not a specific code for personal history of cardiac arrhythmia. Use Z86.79, personal history of other diseases of the circulatory system.

Myocardial Infarction

Myocardial infarction Types:

- Acute myocardial infarction — AMI
- ST elevation myocardial infarction — STEMI
- Non-ST myocardial infarction — NSTEMI

Myocardial infarction is an acute event and typically reported by an acute care facility. If outside the acute event timeframe, use the most appropriate code supported in the medical record.

- **I25.2 —** Old myocardial infarction (past or healed) (diagnosed on ECG, but presenting no symptoms)
- **Z86.7 —** Personal history of diseases of the circulatory system

Type 1	Spontaneous
Type 2	Ischemic
Type 3	Unknown Type
Type 4a	Due to percutaneous procedure
Type 4b	Due to stent thrombosis
Type 4c	Due to restenosis
Type 5	Due to CABG

Review coding guidelines to determine correct code selection.

Myocardial Infarction (MI): Category I21

- Specified as acute, Type 1 or stated duration of less than 4 weeks (28 days)
- Unspecified AMI or unspecified type — I21.9
- AMI Types 3, 4a, 4b, 4c and 5 are assigned to code I21.A9

Subsequent MI: Category I22

- Use I22 only when subsequent MI occurs within 4 weeks of initial MI and both are Type 1 or unspecified
- Must be coded together with code from category I21

Current Complications following MI: Category I23

- Must code together with codes from categories I21 and I22
- May be outside 4 weeks of initial MI
- Post-infarction angina as complication must be stated to code I23.7

Cerebrovascular Accident (CVA)

Coding for CVA s/p Discharge

Inpatient Setting

→ **I63.xxx** — Cerebral infarction

Outpatient Setting

→ Residual Deficit(s)?

YES

I69.3xx — Sequelae of cerebral infarction

- Report sequelae for as long as they are present.
- Use as many codes from category I69.3 as needed to identify all late effects.
- Documentation should clearly tie deficit to CVA:
  - "due to CVA"
  - "late effect of CVA"

NO

Z86.73 — Personal history of TIA, and CVA without residual deficits

Chronic Kidney Disease

Staging Chronic Kidney Disease

Stage	Severity	GFR	ICD-10 Codes
Stage 1	Normal or High	≥90	N18.1
Stage 2	**Mild**	**60–89**	**N18.2**
Stage 3 unspecified	Moderate	30–59	N18.30
Stage 3a	Moderate	45–59	N18.31
Stage 3b	Moderate	30–44	N18.32
Stage 4	**Severe**	**15–29**	**N18.4**
Stage 5 **Stage 5, on dialysis** **ESRD**		<15	N18.5 · N18.6 + Z99.2 N18.6 + Z99.2 *Assign additional code for dialysis status*

Documentation/Coding Tips

- CKD s/p kidney transplant: Patients who have undergone a kidney transplant may still have some form of CKD, as the transplant may not fully restore kidney function.
- Coders may assign a code for kidney transplant status in addition to the appropriate CKD code, based on the patient's post-transplant stage.
- Diagnostic statement required: Coders cannot report CKD or assign a CKD stage based on GFR levels; the provider's documentation of the condition (with stage) is required.
- Acute renal failure: Report only if the patient is having an acute event during encounter; do not continue to report once the acute condition has resolved.
- CKD requiring dialysis: For patients undergoing dialysis, document dialysis status and any other pertinent information (dialysis schedule, presence of fistula, etc.).

Diabetes Mellitus

Documentation should specify the type of diabetes, the body system affected, and the complications affecting that body system. When coding diabetes mellitus, use as many codes within a particular category (E08–E13) as necessary to describe all complications and associated conditions of the disease.

Diabetes Category by Type	Description	Notes
E08	Diabetes mellitus due to underlying condition	Include the underlying condition diagnosis.
E09	Drug or chemical-induced diabetes mellitus	▶ Code first a diagnosis from (T36–T65). ▶ Use additional code(s) for adverse effect (T36–TSO).
E10	Type 1 diabetes mellitus	Type 1 diabetics develop the condition before reaching puberty, however, the age of a patient is not the sole determining factor.
E11	Type 2 diabetes mellitus	If the type of diabetes is not documented in the medical record the default is Ell.-, Type 2 diabetes mellitus.
E13	Other specified diabetes mellitus	Use this category when the diabetes is documented as diabetes type 1.5. Synonymous terms may include: combined DM type 1 and DM type 2, latent autoimmune diabetes of adults (LADA), slow progressing type 1 diabetes, or double diabetes.

Body System	Common Complications	Code Example	Code Description
Cardiovascular	CAD, PAD, PVD, CHV	Ell.51	Type 2 diabetes mellitus w/ diabetic peripheral angiopathy w/o gangrene
Neurological	Peripheral neuropathy	Ell.42	Type 2 diabetes mellitus w/ diabetic polyneuropathy
	Gastroparesis	Ell.43	Type 2 diabetes mellitus w/ autonomic neuropathy
Oral	Periodontal disease	Ell.630	Type 2 diabetes mellitus w/ periodontal disease
Eyes	Retinopathy	Ell.319	Type 2 diabetes mellitus w/ unspecified diabetic retinopathy w/o macular edema
	Cataract	Ell.36	Type 2 diabetes mellitus w/ diabetic cataract
Urinary	Nephropathy	Ell.21	Type 2 diabetes mellitus w/ diabetic nephropathy
	CKD + stage	Ell.21	Type 2 diabetes mellitus w/ diabetic CKD
Extremities	Foot Ulcer	Ell.621	Type 2 diabetes mellitus with foot ulcer

Major Depressive Disorder

Documentation Tips

- Document clinical indicators of MDD, including:
  - Symptomatic complaints
  - PHQ-9 results
  - Objective findings
- Document episode and severity.
- Document treatment plan; cite referrals and/or consultations requested, plus medications prescribed for the condition.
- Final diagnosis should be made with clinical interview and mental status examination (include assessment of patient's level of distress and functional impairment).

Coding Tips

- Coders cannot assign a diagnosis code for major depression based on PHQ-9 results. Coding is based solely on clinician's documentation. Document depression as specifically as possible to ensure accurate code assignment.

Episode

- **Single Episode**
- **Recurrent**

Single episode — Person has experienced only one episode of major depression.

Recurrent — When multiple major depressive episodes have occurred, and no manic or mixed episodes are observed.

Untreated — A major depressive episode may last, on average, about four months.

Severity

- **Single Episode**
- **Mild**
- **Moderate**
- **Severe Severe With Psychotic Features**

Mild — Few, if any, symptoms in excess of those required to make the diagnosis (about 5-6 symptoms); symptoms result in minor impairment in functioning.

Moderate — Symptoms or functional impairment between "mild" and "severe."

Severe — Most symptoms are present; marked interference with occupational functioning, usual social activities, and relationships with others (e.g., inability to work or care for children).

Severe with psychotic features — Presence of either hallucinations (typically auditory) or delusions; most commonly: content of delusions or hallucinations consistent with depressed mood, focusing on themes of guilt, personal inadequacy, or disease.

Remission

- **Partial Remission**
- **Full Remission**

Partial Remission — 1) Some symptoms of major depressive episode still present, but full criteria no longer met; or 2) No longer any significant symptoms of major depressive episode, but period of remission less than 2 months.

Full Remission — Without significant signs or symptoms for at least two months.

Identify remission type (partial or full) once criteria for MDD are no longer met.

Dementia

Severity of Dementia

The ICD-10-CM classifies dementia on the basis of the etiology and severity (unspecified, mild, moderate or severe). Selection of the appropriate severity level requires the provider's clinical judgment and codes should be assigned only on the basis of provider documentation, unless otherwise instructed by the classification.
If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity.

Behavioral Disturbances in Dementia

Psychotic disorders associated with dementia are identified in the code inclusion term as : hallucinations, paranoia, suspiciousness, and delusional state. Studies have shown a correlation between psychotic disorders acceleration of cognitive decline and increased mortality.

Mood disorders associated with dementia are identified in the code inclusion terms as: depression, apathy (lacking emotion), anhedonia (decreased ability to feel pleasure). Studies have shown a correlation between mood disorders and lower quality of life scores.

Anxiety is a common behavioral disturbance and is more common in vascular and frontotemporal dementia than Alzheimer's or Parkinson's. Anxiety tends to gradually decrease at the severe stages of dementia.

Types

Vascular Dementia (F01)

- Due to infarction of the brain due to vascular disease
- Due to hypertensive cerebrovascular disease

Dementia in Other Disease Classified Elsewhere (F02)

- Dementia w/Lewy Bodies
- Parkinson's/Parkinsonism
- Alzheimer's
- Early/Late Onset

Unspecified Dementia (F03)

- Presenile
- Senile
- Primary Degenerative dementia

Severity

Mild

Clearly evident functional impact on daily life, affecting mainly instrumental activities

Moderate

Extensive functional impact on daily life with impairment in basic activities

Severe

Complete dependency due to severe functional impact on daily life with impairment in basic activities, including basic self-care

Behavioral Disturbance

Without
Behavioral Disturbance

With
Behavioral Disturbance

(agitation, psychotic disturbance, mood disturbance, anxiety, or other behavioral disturbance)

Substance Use Disorders

DSM-5 Criteria

- ☐ Taking the substance in larger amounts or for longer than meant to
- ☐ Wanting to cut down or stop using the substance but not managing to
- ☐ Spending a lot of time getting, using, or recovering from use of the substance
- ☐ Cravings and urges to use the substance
- ☐ Not managing to do what should be done at work, home, or school because of substance use
- ☐ Continuing to use, even when it causes problems in relationships
- ☐ Giving up important social, occupational, or recreational activities because of substance use
- ☐ Using substances again and again, even when it puts person in danger
- ☐ Continuing to use, even when it is known to cause a physical or psychological problem that could have been caused or made worse by the substance
- ☐ Needing more of the substance to get the effect you wanted (tolerance)
- ☐ Development of withdrawal symptoms, which can be relieved by taking more of the substance

To determine severity, 11 criteria have been established that describe pathological patterns of behavior related to use of the substance.	Mild 2–3 criteria	Moderate 4–6 criteria	Severe 6+ criteria

- ▶ Early remission: None of the criteria for the substance use disorder have been met for at least three months but for less than 12 months.
- ▶ Sustained remission: None of the criteria for substance use disorder have been met at any time during a period of 12 months or longer.

Documentation and Coding Best Practices

- ▶ Clearly document the condition and level of use whenever possible.
- ▶ Include the name of the substance.
- ▶ Document each condition to the highest level of specificity, including:
  - Severity (Use/Abuse/Dependence)
  - Remission status when appropriate
  - Related symptoms such as intoxication, psychotic behavior, sleep disturbance, withdrawal, etc.
- ▶ Document treatment (medication, psychotherapy, or a combination of both) and current response to treatment.
- ▶ Document any treatment refusals, or non-compliance.

Rheumatoid Arthritis vs. Osteoarthritis

Rheumatoid Arthritis	Osteoarthritis	
Coding		
RA with rheumatoid factor without organ/systems involvement	Type	Primary, secondary, or post-traumatic
RA without rheumatoid factor		
Felty's Syndrome (RA with splenoadenomegaly and leukopenia)		
Juvenile RA		
Rheumatoid lung disease with RA	Location	Joint(s) involved
Rheumatoid vasculitis with RA		
Rheumatoid heart disease with RA		
Rheumatoid myopathy with RA	Laterality	Right, left, or unspecified
Rheumatoid polyneuropathy with RA		
RA with involvement of other organs/systems		
Documentation		
Document all affected joints	Document all affected joints	
Document laterality	Document laterality	
Presence or absence of rheumatoid factor	Type (primary, secondary, or post-traumatic)	
Organ or systems involvement	Treatment plan (Rx, physical therapy, lifestyle changes)	
Treatment plan (DMARDs, rheumatology follow-up)		

Combination codes for rheumatoid arthritis from Categories M05-M06, M08 specify:

- Presence of rheumatoid factor
- Organ or system affected
- Site and laterality

Manifestations and Complications

RA is commonly known as a joint disease, but it can also involve multiple organ systems.

Heart	Skin	Lungs	Eyes
Accelerated atherosclerosis	Rheumatoid nodules	Caplan syndrome	Episcleritis/scleritis
Pericarditis	Vasculitis	Interstitial lung disease	Keratoconjunctivitis sicca
Blood	**Nerves**	Pleural effusion	Peripheral ulcerative keratitis
Amyloidosis	Cervical myelopathy	Pulmonary nodules	
Felty's syndrome	Neuropathy		

COPD

Documentation should include:

- Positive findings from diagnostic studies
- Exposure to smoke, tobacco use, or history of
- Type of asthma, if applicable
- Plan of care/treatment

ICD-10-CM Guidance

To avoid coding mistakes, you must apply the notes that accompany the codes in the Tabular List. Please refer to the most current ICD-10-CM code book for all the additional subcategory code notes and Excludes 1/Excludes 2 notes.

Types of COPD

Chronic Bronchitis			
Simple — non-obstructive; smoker's cough	J41.0	Mixed — chronic simple and mucopurulent bronchitis	J41.8
Mucopurulent — production of sputum containing mucus and pus	J41.1	Chronic Bronchitis, NOS	J42
Emphysema			
Unilateral pulmonary emphysema — MacLeod's syndrome	J43.0	Centrilobular — affecting upper lobes	J43.2
Panlobular — affecting lower lobes	J43.1	Other & Unspecified	J43.8, J43.9
Chronic Obstructive Pulmonary Disease			
With (acute) lower respiratory infection	J44.0	Other specified	J44.8-
With (acute) exacerbation	J44.1	Unspecified	J44.9

Seizure Disorders and Convulsions

A single seizure does not automatically mean a diagnosis of epilepsy. Epilepsy is a condition characterized by recurrent, unprovoked seizures. Proper documentation will include specific details about the condition:

- Type of seizure (generalized idiopathic, localization-related, simple partial, complex partial)
- Epilepsy type (idiopathic, symptomatic, intractable, etc.)
- Complications (status epilepticus)
- Contributing factors (alcohol, drugs, or sleep deprivation)

ICD-10 code assignment:

- Use codes from Category G40 for epilepsy diagnoses.
- Use R56.9 for unspecified convulsions.
  - Don't use R56.9 for a documented seizure disorder or recurrent seizures.

Malnutrition

Mini Nutritional Assessment (MNA)

Nestle Self-MNA form identifies geriatric patients ages 65+ as:

- Normal nutritional status
- At risk of malnutrition
- Malnourished

ASPEN Criteria

Use ASPEN criteria to confirm diagnosis. Malnutrition should be diagnosed when at least two of following six criteria are present:

- ☐ Insufficient energy intake
- ☐ Weight loss
- ☐ Loss of muscle mass
- ☐ Loss of subcutaneous fat
- ☐ Localized or generalized fluid accumulation
- ☐ Diminished functional status as measured by handgrip strength

Determine Severity

The degree of malnutrition is determined by the presence of at least two indicators in a given category:

Criteria	Severe	Moderate	Mild
Albumin (g/dL)	<2.0	≤2.5	≤3.0
Prealbumin (mg/dL)	<5.0	<10.0	<15.0
Ideal body weight	<70%	<80%	<90%
Usual body weight	<75%	<85%	<95%
BMI (kg/m2)	<16	<17	<18.5

Note: Albumin and prealbumin should be considered one indicator, not two, and should be interpreted with caution.

You can visit mna-elderly.com to download the various MNA forms including the Self-MNA.

You can learn more on the ASPEN criteria by visiting nutritioncare.org.

Documentation Strategies

Do	▶ Refer to the ASPEN guidelines and verify that at least two of the six characteristics are present. ▶ Document clinical indicators of the condition. ▶ Document severity. ▶ Document context in which malnutrition occurs: • Acute injury/illness • Chronic illness • Social/environmental circumstances
Don't	▶ Use abnormal lab results as sole indicator of malnutrition. ▶ Diagnose malnutrition based on BMI alone.

Coding Malnutrition in ICD-10	
E40	Kwashiorkor
E41	Nutritional marasmus
E42	Marasmic kwashiorkor
E43	Unspecified severe protein-calorie malnutrition
E44.0	Moderate protein-calorie malnutrition
E44.1	Mild protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition

Anorexia Nervosa and Bulimia Nervosa

Anorexia Nervosa

Anorexia nervosa is defined as a psychological eating disorder characterized by an intense fear of gaining weight and an unrealistic perception of body image that perpetuates that feeling of being fat or having too much fat. Avoidance of food and restrictive or unhealthy eating are common.

Signs and symptoms of anorexia nervosa	
▶ Malnutrition	▶ Low blood pressure
▶ Obsessive behaviors	▶ Amenorrhea
▶ Abnormal blood counts	▶ Dry skin/brittle nails
▶ Irregular heartbeat	▶ Dehydration
▶ Fatigue, dizziness, or fainting	▶ Bone loss

Bulimia Nervosa

Bulimia nervosa is defined as an episodic pattern of overeating (binge eating) followed by purging or extreme exercise accompanied by an awareness of the abnormal eating pattern with a fear of not being able to stop eating.

Signs and symptoms of bulimia nervosa	
▶ Irregular heartbeat	▶ Sores, scars, or calluses on knuckles or hands (Russell's sign)
▶ Dehydration	▶ Severe dental erosion
▶ Fatigue	▶ Changes in color, shape, length, or teeth
▶ Bloating, abnormal bowel function	

Documentation Guidance

- ▶ Document all pertinent physical and behavioral observations.
- ▶ Document a treatment plan, including medication such as SSRIs, anti-psychotics, or anti-cholinergics.
- ▶ Document referrals to specialists, laboratory tests, and diagnostic studies, and incorporate abnormal findings into the progress notes.

Viral and Chronic Hepatitis

Acute viral hepatitis generally resolves within a few months from the date of onset. In other cases, the disease becomes a long-term or chronic illness.

Chronic hepatitis is classified as inflammation caused by viral hepatitis lasting longer than six months. If left untreated, chronic hepatitis can cause serious health problems, including liver damage, cirrhosis, liver cancer, and even death.

Coding & Documentation

Detailed documentation is necessary for proper code selection.

- Identify the type of hepatitis
- Indicate the acuity — chronic, acute, with/without hepatic coma, with/without delta agent
  - If viral hepatitis is not specified as acute or chronic, assign the appropriate code for unspecified viral hepatitis from Category B19
  - Viral hepatitis in remission, any type, code to hepatitis chronic, by type
  - For patients who have had a liver transplant, document and report the appropriate transplant status code and document any anti-rejection drugs if appropriate
- Specify the causal agent or behavior that led to the acquisition of hepatitis
- Refrain from using the term "history of" if a patient still has an active viral infection.
- Document treatment and follow up.

Chronic hepatitis NEC *see Category K73*
Persistent
Lobular
Active
Other

Hepatic Failure *see Category K70–K72, K76*
Acute, chronic, alcoholic, unspecified
Portal hypertension
Hepatorenal syndrome
Hepatopulmonary syndrome

Possible Related Conditions
Auto-immune hepatitis (K75.4)
Jaundice (R17)
Malignant neoplasm of liver (C22-)
Alcoholic liver disease (K70.9)
High risk sexual behavior (Z72-)

Cirrhosis *see Category K70, K74*
Primary/secondary biliary
Alcoholic, w/ or w/o ascites
unspecified

Cancer

Detection & Staging

Cancer staging is based on the extent of the tumor. Laboratory studies of blood, urine, and stool to detect abnormalities that may indicate cancer. Imaging tests such as X-rays, CT, MRI, ultrasound, and fiber-optic endoscopy help determine the suspected cancer's location and size. A biopsy can confirm the diagnosis of most cancers and other tests can provide specific information about the cancer.

The stage of cancer indicates information about the location, cell type, size, and grade, and if it has spread to a different part of the body. A cancer is always referred to by the stage it was given at diagnosis regardless of progression or regression.

Carcinoma in situ	Stage I, II, & III	Stage IV
Abnormal cells are present but confined to the point of origin without invasion of the surrounding normal tissue.	Cancer is present. The higher the number, the larger the cancer tumor and the more it has spread into nearby tissues.	Cancer has grown extensively and/or has spread to distant parts of the body.

Coding & Documentation

Clearly document all know details of the patient's condition. This should include:

- Behavior — malignant, benign
- Location — site-specific (cell type, anatomical location, laterality)
- Type — primary, secondary (include cancer stage)
- Status — active, in remission, "history of"
  - For active cancers, document the current treatment. If the patient has refused treatment or is under watchful waiting, document the reason and disease progress.
  - If the patient receives adjuvant therapy, indicate if it is for treatment or prophylactic purposes.

Active Cancer		In Remission
Malignancy Present	**Active Treatment**	
Cancer is reported as active whenever it's present in the body. ▶ Newly diagnosed ▶ Patient choice ▶ Watchful waiting ▶ Unresponsive to treatment	Neoplasm previously excised, patient still undergoing: ▶ Chemotherapy (Z51.11) ▶ Radiation therapy (Z51.0) ▶ Targeted therapy (Z51.12) ▶ Hormonal therapy (Z79.890) ▶ Additional surgery	Signs and symptoms of cancer are reduced, but the patient is considered to still have the disease. ICD-10-CM includes codes indicating remission status for: ▶ Leukemia ▶ Lymphoma ▶ Malignant plasma cell neoplasm ▶ Multiple myeloma

Personal History	
▶ Report a personal history of malignant neoplasm code when: ▶ Cancer has been previously excised or eradicated from its site, AND ▶ There is no further treatment (i.e., active treatment of the malignancy) directed at the site, AND ▶ There is no evidence of disease (NED) at the site.	ICD-10-CM provides separate codes for a personal history of these conditions: ▶ Personal history of leukemia Z85.6 ▶ Personal history of Hodgkin lymphoma Z85.71 ▶ Personal history of non-Hodgkin lymphoma Z85.72 ▶ Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues Z85.79

Pregnancy, Childbirth, and the Puerperium

ICD-10-CM codes from Chapter 15 have sequencing priority over codes from other chapters.

- Use additional codes from other chapters to further specify conditions when applicable.
- Use codes O00–O9A only on the maternal record, never on the record of the newborn.

Supervision of Normal Pregnancy

A code from Category Z34, encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis for routine outpatient prenatal visits when no complications are present.

- Report code Z33.1 Pregnant state, incidental when pregnancy is documented as incidental to the encounter instead of codes from Chapter 15.
- It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

Supervision of High-Risk Pregnancy

A code from Category O09, supervision of high-risk pregnancy, should be used as the first-listed diagnosis for routine prenatal outpatient visits for patients with high-risk pregnancies.

- Use only during the prenatal period.
- Use applicable Chapter 15 codes for complications during the labor or delivery episode as a result of a high-risk pregnancy.
- Other Chapter 15 codes may be used in conjunction with these codes if appropriate.
- Code the appropriate encounter for full-term uncomplicated delivery if there are no complications during the labor or delivery episode.

Documentation should include:

- Stage of pregnancy — Document gestation in weeks and days
  - 1st Trimester: <14 weeks
  - 2nd Trimester: 14 weeks–28 weeks
  - 3rd Trimester: 28 weeks–delivery
- Normal or high-risk pregnancy and reason for being high-risk, if applicable
- Underlying or pre-existing conditions
- Number of fetuses
  - Number or alpha assigned to each (e.g., 1–8, A–H), if multiple
- Complications with pregnancy, and/or during labor and delivery and fetal presentation

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