Risk Adjustment Coding Guide

Anorexia Nervosa & Bulimia Nervosa (Approx. RAF 0.396)

Anorexia Nervosa

DSM V criteria:

- Restriction of energy intake that leads to a low body weight, given the patient's age, sex, developmental trajectory, and physical health.
- Intense fear of gaining weight or becoming fat, or persistent behavior that prevents weight gain, despite being underweight.
- Distorted perception of body weight and shape, undue influence of weight and shape on self-worth, or denial of the medical seriousness of one's low body weight.

Specification	ICD-10 Code
Restricting Type	F50.01
Binge eating/Purging type	F50.02
Unspecified	F50.00

Key Point:

- Nervosa MUST be stated in order to capture the correct code. Anorexia alone will not be sufficient.
- Consider these other diagnoses instead of Anorexia Nervosa if weight loss is associated with a current medical condition (i.e., cancer, dementia, GI disorders, depression):
  — Anorexia/Loss of appetite (R63.0), Unintentional weight loss (R63.4), Cachexia (R64.0)

Bulimia Nervosa (F50.2)

DSM V criteria:

- Episodes of binge eating, which are defined as eating an unusually large amount of food in a discrete period of time (e.g., two hours). Patients feel that they cannot control their eating during the episode.
- Inappropriate compensatory behavior to prevent weight gain.
- Binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for three months.
- The patient's self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Screening Tools

Utilizing standardized tools can be effective in identifying patients who require further evaluation for eating disorders. Examples of assessment tools and questionnaires include:

- SCOFF Questionnaire
- ESP (Eating Disorder Screening for Primary Care)
- EDE (Eating Disorder Examination) & EDE-Q (Eating Disorder Questionnaire)

These codes are meant to help in general code selection and may not represent the patient's condition accurately. We encourage use of the ICD-10-CM code set to determine the most specific code that represents the actual condition.

Remission

- Anorexia nervosa and Bulimia nervosa should be documented as "in remission" instead of "history of."
- Remission can be reported regardless of patient being on a medication or treatment.

Complications/Co-morbidities

Acute	Chronic
Malnutrition (E46)	Major depressive disorder (F32 - F33)
GT/GJ Tubes/Buttons (Z93.x)	Cerebral atrophy (G31.9)

Accuracy by the Physician/APP is the goal of this education. No diagnosis should be reported if the diagnosis has not been confirmed. This education can be found by typing "RAF/" in your browser.

References

1. American Psychiatric Association. (2013). DSM-5 diagnostic criteria for eating disorders. Retrieved May 3, 2023, from **https://docslib.org/doc/776290/dsm-5-diagnostic-criteria-for-eating-disorders-anorexia-nervosa**

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Asthma

Document with severity annually as an active condition even when stable with or without medications.

Diagnostic Criteria (Ages 12–Adult)				
Mild intermittent J45.20	Mild persistent J45.30	Moderate persistent J45.40 ⟶ Severe persistent J45.50 (HCC)		
Symptoms <2 days/ wk and nighttime awakenings >=2 times/month	Symptoms > 2 days/week but not daily and nighttime awakenings 3-4x/ month	Symptoms daily and nighttime awakenings >1x/week	Symptoms daily and nighttime awakenings >1x/wk with lower lung function	Symptoms throughout the day and nightly

- Asthma (J45.909) should only be used when not able to accurately reflect disease severity.
- Acute exacerbation or status asthmaticus should only be reported during active episode.

Example: Patient was seen in clinic 2 months ago with symptoms throughout the day and night with Pulmicort use, prednisone and Fasenra added.

1. Severe Persistent Asthma (J45.50) - Patient with symptoms managed and tapering off prednisone. Continue Pulmicort and Fasenra.

Chronic Obstructive Asthma (J44.89)

- Used to show obstructive process for asthmatic patients.
- Consider if patient has an established diagnosis of an obstructive lung disease and at least one of the following:
  - Spirometry does not show complete reversal of obstruction post-bronchodilator – <0.70 FEV1/FVC
  - Persistent respiratory symptoms despite daily maintenance inhaler treatment
  - Long-term diagnosis/treatment of asthma

Other Chronic Pulmonary HCC Conditions	
COPD- (J44.9)	Chronic respiratory failure- (J96.10)
Chronic bronchitis- (J42)	Bronchiectasis- (J47.9)
Ventilator dependent- (Z99.11)	Tracheostomy status- (Z93.0)
Emphysema- (J43.9)	Pulmonary Hypertension- (I27.20)

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References

1. Intermountain Healthcare (2023). *Management of Asthma* [Care Process Model]. Retrieved from **https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=520257347**

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Cardiomyopathy (CM) – I42.9

RAF 0.189

When able, specify type:

Type	ICD
Dilated / congestive	I42.0
Obstructive hypertrophic	I42.1
Nonobstructive hypertrophic	I42.2
Restrictive / constrictive	I42.5
Alcoholic*	I42.6
Ischemic	I25.5 (non HCC)
Due to drug and external agent	I42.7

*Also consider alcohol use disorder (F10.-)

Heart Failure (HF) - I50.9

RAF 0.360

- When able, specify type and chronicity (acute, chronic, acute on chronic).
- Report both CM and HF when present.
- Stable with ongoing meds/treatment or medically controlled is still considered active disease.

Type	ICD
HFrEF (Systolic Congestive Heart Failure)	I50.20
HFpEF (Diastolic Congestive Heart Failure)	I50.30
Combined systolic and diastolic	I50.40

End-stage heart failure – I50.84

RAF 2.505

- Synonymous with Stage D Heart failure.
- Consider when:
  - Seeing transplant clinic provider pre-transplant or on transplant list
  - Progressing symptoms with potential for palliative care or hospice
  - NYHA class III-IV
  - Frequent heart failure exacerbations / hospitalizations

Select Health

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Heart assist device, artificial heart, heart transplant

Document when the following are present:

Type	ICD	
LVAD, BiVAD, RVAD	Z95.811	**RAF 2.505**
Artificial heart	Z95.812	**RAF 2.505**
Heart transplant status	Z94.1	**RAF 1.053**

*Does not include pacemaker, defibrillator, or artificial valve.

Related HCC Conditions

- **Secondary Hyperaldosteronism – E26.1**

  RAF 0.194

  Consider if your patient has heart failure with edema or on loop diuretics and/or aldosterone antagonists.

- **Chronic Respiratory Failure – J96.10**

  RAF 0.370

  Consider if patient is dependent on oxygen.

- **Pulmonary hypertension – I27.20**

  RAF 0.360

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Major Depression

Prevalence: Saratoga Springs 21.8%; Utah 15.7%; Nation 17.4% (2021)

Diagnostic Criteria

When documenting and coding major depressive disorder, documentation must state major AND severity or remission status.

Severity / Remission*	Continuing diagnosis PHQ 9	ICD	
Initial diagnosis of Major Depression: Severity Scale with 5 symptoms that persist most of the day, for at least 2 weeks in a row or any answer in question 9 (better off dead or self-harm). These 5 symptoms must include question 1 or 2.			
		Single	**Recurrent**
Full remission if greater than 2 months or Partial remission if less than 2 months	0-4	F32.5	F33.42
Partial remission (if greater than 2 months)	5-9	F32.4	F33.41
Mild	5-9	F32.0	F33.0
Moderate	10-14	F32.1	F33.1
Moderately Severe	15-19	F32.2	F33.2
Severe with psychotic features	20-27	F32.2	F33.2

**This is a guide and providers are ultimately responsible for interpreting and assigning a severity or remission.*

Remission

- Remission can be reported regardless of patient being on a medication or treatment.
- Major depression can be documented as "in remission" instead of "history of."

Reports Complexity	Does not report Complexity
Mild, Moderate, or Severe MDD (RAF 0.309)	History of MDD (RAF 0)
MDD In remission (RAF 0.309)	Major Depression, unspecified - F32.9 (RAF 0)
Recurrent MDD (RAF 0.309)	Depression, unspecified – F32.A (RAF 0)

Episode

- Single — Presence of a single major depressive episode
- Recurrent — Presence of two or more major depressive episodes separated by a period of remission

Other Points

- Major depression and bipolar disorder should not be reported together. Bipolar disorder includes depressive episodes.
- "Depression with anxiety" should only be diagnosed when the patient does not meet diagnostic criteria for major depression or generalized anxiety disorder.
- There is no code for "moderately severe" depression. Providers should document Moderate OR Severe depression in order to capture the correct code.

Select Health

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Documentation Example:

Patient with depression unspecified in problem list. Episodes of depression documented the last 5 years. PHQ 9 scoring of 0 on sertraline.

1. Major Depressive Disorder, recurrent, in full remission (F33.42)- continue sertraline

References

1. PHQ and GAD-7 Instructions. (n.d.). Retrieved September 19, 2022, from **https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf**

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Active vs. Historical

- In general, a diagnosis without active disease, current treatment, or surgically resolved should not be reported as active.
- "History of" means a past medical condition that has resolved and is no longer being treated.
- Consider using "Patient presents with" or "Patient receiving treatment for" instead of "history of" for a condition that is still active or managed with treatment.

Diagnosis	Only report	Do not report
Myocardial Infarction	Incident – 4 weeks (28 days)	After initial incident + 28 days
Cerebral Infarction/Stroke	Initial incident only	After initial incident
Cancer	Active disease/Active treatment	After treatment complete, monitoring for recurrence only, considered cured. **In remission:** leukemia, multiple myeloma, malignant plasma cell neoplasms, lymphoma
Deep Vein Thrombosis & Pulmonary Embolism	**Acute:** Clot is present **Chronic:** Clot present after initial treatment.	• When Anticoagulated for DVT or PE prophylaxis • No clot presumed to be present (No Symptoms or Negative Imaging)
Skin Ulcers	Active wound	When healed
Inflammatory polyps	Initial finding	When surgically removed Consider any **related diagnosis:** Ulcerative Colitis, Crohn's Disease
Senile Purpura	When present	When resolved
Osteomyelitis	Active disease/Active treatment	When treatment complete

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Status & Lifetime Codes

All conditions need to be documented annually.

Status Codes	
Transplant status • Heart • Liver • Bone marrow • Stem cell (not injections)	**Amputations** • Any extremity • Phantom limb pain • Stump complications
Artificial openings • Colostomy • Cystostomy (suprapubic catheter) • Nephrostomy • G-/J- tube	**Dialysis status*** – report in addition to ESRD • Peritoneal dialysis • Hemodialysis *This includes coding of a fistula, **do not code** AV fistula separately.

In general, conditions below are considered uncurable and should be reported yearly as active, symptoms managed, or in remission unless a transplant has occurred.

Conditions to consider as lifetime diagnosis:	
Diabetes, Type 1 & 2	COPD
Wet Macular Degeneration	Interstitial Lung Disease
Multiple Sclerosis	Cirrhosis
Atherosclerosis of Aorta	Substance Use Disorders *Please specify severity (mild/moderate/severe/in remission)

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References

1. U.S. Centers for Medicare & Medicaid Services. (2021, December). *ICD-10-CM Official Guidelines for Coding and Reporting.* **https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf**

Select Health

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This guide provides you with the most common chronic Risk Adjusted ICD-10 diagnosis codes for conditions frequently used in the ambulatory setting. The information presented herein is for informational purposes only. It is not intended nor is it to be used, to define a standard of care or otherwise substitute for informed medical evaluation, diagnosis and treatment which can be performed by a qualified medical professional.

Documentation Requirements & Support

M.E.A.T. Documentation: MUST support each diagnosis with MEAT.

- **M** — Monitoring (S — Subjective)
- **E** — Evaluation (O — Objective)
- **A** — Assessment (A — Assessment)
- **T** — Treatment (P — Plan)

ACTIVE VS. HISTORICAL

Diagnosis	Only Report	Do not report
AMI (Acute Myocardial Infarction)	Incident – post 4 weeks (28 days)	After initial incident +28 days
Cerebral Infarction/Stroke	Initial incident only	After initial incident
Cancer	Active disease / treatment	After treatment, only monitoring for reoccurrence is considered cured.*
**In remission: leukemia, multiple myeloma, malignant plasma cell neoplasms, lymphoma*		
Deep Vein Thrombosis & Pulmonary Embolism	Acute: Clot is present Chronic: Clot present after initial treatment.	When anticoagulated for DVT or PE prophylaxis or No apparent clot
Skin Ulcers	Active Wound	When healed
Osteomyelitis	Active disease / treatment	When treatment complete
Inflammatory polyps	Initial finding	When surgically removed
Senile Purpura	When present	When resolved

AMPUTATION STATUS (DOCUMENT ANNUALLY)

Absence of...		~RAF*
Z89.41_ (1/2)	Great toe, (R/L)	0.519
Z89.42_ (1/2)	Other toe(s), (R/L)	0.519
Z89.43_ (1/2)	Foot, (R/L)	0.519
Z89.44_ (1/2)	Ankle, (R/L)	0.519
Z89.51_ (1/2)	Below knee, (R/L)	0.519
Z89.61_ (1/2)	Above knee, (R/L)	0.519
Document complications/neuroma for all amputations.		

ARTIFICIAL OPENING STATUS (DOCUMENT ANNUALLY)

Document annually when opening is present		
Z93.0	Tracheostomy	0.534
Z93.1	Gastrostomy	0.534
Z93.2	Ileostomy	0.534
Z93.3	Colostomy	0.534
Z93.4	GI Tract (enterostomy)	0.534
Z93.50	Cystostomy, unspecified (suprapubic)	0.534
Z93.6	Urinary tract, other (nephrostomy, ureterostomy, urethrostomy)	0.534

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Select Health

TRANSPLANT STATUS (DOCUMENT ANNUALLY)

Z94.0	Kidney	0.00
Z94.1	Heart	0.832
Z94.2	Lung	0.832
Z94.3	Heart and lung	0.832
Z94.4	Liver	0.832
Z94.81	Bone marrow	0.832
Z94.82	Intestine	0.832
Z94.83	Pancreas	0.832
Z94.84	Stem cell	0.832

GASTROENTEROLOGY

K70.3_	Alcoholic cirrhosis of liver (w/ or w/o ascites)	0.363
K70.40	Alcoholic hepatic failure	0.363
K70.9	Alcoholic liver disease, unspecified	0.363
K72.10	Chronic hepatic failure, without coma	0.882
K74.3	Primary biliary cirrhosis	0.363
I85.10	Secondary esophageal varices, without bleeding	0.882
E26.1	Secondary hyperaldosteronism (common with liver failure)	0.194
D68.4	Acquired coagulation factor deficiency	0.192
K74.5	Biliary cirrhosis, unspecified	0.363
K74.60	Unspecified cirrhosis of liver	0.363
K75.4	Autoimmune hepatitis	0.147
K76.6	Portal hypertension	0.882
E83.110	Hereditary hemochromatosis	0.194
K50.9_	Crohn's disease	0.308
K51.9_	Ulcerative colitis	0.308
Documentation must state "chronic"		
K73.9	Chronic (active) hepatitis	0.147
B18.2	Chronic (active) viral hepatitis C	0.147
B18.9	Chronic (active) viral hepatitis	0.147
K86.0	Alcohol induced chronic pancreatitis	0.287
K86.1	Other chronic pancreatitis	0.287

ENDOCRINE

Diagnosis should always include type of diabetes (1, 2, other)		
E10.9	DM Type 1 w/o complications	0.105
E11.9	DM Type 2 w/o complications	0.105
Uncontrolled DM must be specified as hyper/ hypoglycemia		
E10.21	DM Type 1 w/ nephropathy	0.302
E10.649	DM Type 1 w/ hypoglycemia	0.302
E10.65	DM Type 1 w/ hyperglycemia	0.302
E11.21	DM Type 2 w/ nephropathy	0.302
E11.649	DM Type 2 w/ hypoglycemia	0.302
E11.65	DM Type 2 w/ hyperglycemia	0.302
Use additional CKD diagnosis to specify stage		
E10.22	DM Type 1 w/ CKD	0.302
E10.319	DM Type 1 w/ diabetic retinopathy w/o macular edema	0.302
E10.36	DM Type 1 w/ diabetic cataract	0.302
E10.40	DM Type 1 w/ neuropathy	0.302
E10.43	DM Type 1 w/ gastroparesis	0.302
E10.51	DM Type 1 w/ peripheral angiopathy w/o gangrene	0.302
E11.22	DM Type 2 w/ CKD	0.302
E11.319	DM Type 2 w/ diabetic retinopathy w/o macular edema	0.302
E11.36	DM Type 2 w/ diabetic cataract	0.302
E11.40	DM Type 2 w/ neuropathy	0.302
E11.43	DM Type 2 w/ gastroparesis	0.302
E11.51	DM Type 2 w/ peripheral angiopathy w/o gangrene	0.302
Use additional diagnosis to specify ulcer stage and location		
E10.622/621	DM Type 1 w/ skin/foot ulcer	0.302
E11.622/621	DM Type 2 w/ skin/foot ulcer	0.302
E10.69	DM Type 1 w/ other complications - specify (e.g. hyperlipidemia)	0.302
E11.69	DM Type 2 w/ other complications – specify (e.g. hyperlipidemia)	0.302

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HEMATOLOGY

D68.0	Von Willebrand disease	0.192
D68.1	Hereditary factor XI deficiency	0.192
D68.51	Activated Protein C resistance	0.192
D68.61	Antiphospholipid syndrome	0.192
D68.62	Lupus anticoagulant syndrome	0.192
D68.69	Secondary hypercoagulable state (common with atrial fibrillation)	0.192
D66	Hereditary factor VIII deficiency	1.372
D67	Hereditary factor IX deficiency	1.372
D61.9	Aplastic anemia, unspecified	1.372
D69.6	Thrombocytopenia, unspecified (Primary only)	0.192
D70.9	Neutropenia, unspecified	0.665
D61.818	Pancytopenia	0.665
D46.9	Myelodysplastic syndrome, unspecified	1.372
D56.1	Beta thalassemia	0.192
D75.81	Myelofibrosis	1.372
D45	Polycythemia vera (Primary only)	0.192
D57.1	Sickle-cell disease without crisis	1.372

NEPHROLOGY

CKD measured by eGFR x2 for > 3 months (outside of acute episodes)		
N18.30	CKD, stage 3 Unspecified (GFR 30-59)	0.069
N18.31	CKD, stage 3a (GFR 45-59)	0.069
N18.32	CKD, stage 3b (GFR 30-44)	0.069
N18.4	CKD, stage 4 (GFR 15-29)	0.289
N18.5	CKD, stage 5 (GFR <15)	0.289
N18.6	ESRD (Also document dialysis status)	0.289
Z99.2	Dependence on renal dialysis (includes fistula – do not code separately)	0.435
N25.81	Secondary hyperparathyroidism of renal origin	0.194

NEUROLOGY

F01.5_	Vascular dementia (w/ or w/o behavioral disturbance)	0.346
F03.9_	Unspecified dementia (w/ or w/o behavioral disturbance)	0.346
G30._	Alzheimer's disease (early/late onset/ unspecified)	0.346
G31.83	Dementia with Lewy bodies	0.346
G31.09	Frontotemporal Dementia	0.346
G31.9	Cerebral Atrophy (imaging + cognitive impairment)	0.346
G80.9	Cerebral palsy	0.339
R56.9	Unspecified convulsions	0.22
G40.909	Epilepsy, unspecified, intractable, without status epilepticus.	0.22
G12.21	Amyotrophic lateral sclerosis (ALS)	0.999
G35	Multiple Sclerosis	0.346
G71.0	Muscular dystrophy	0.346
G20	Parkinson's disease	0.606
G61.0	Guillain-Barre syndrome	
G82.50	Quadriplegia	1.242
G82.20	Paraplegia	1.068
G14	Post-polio syndrome	0.478
Late effects of Stroke (CVA) Dominant R/L (1/2) Non-dominant R/L (3/4)		
I69.35_	Hemiplegia/hemiparesis	0437
I69.33_	Monoplegia upper limb	0.331
I69.34_	Monoplegia lower limb	0.331

PULMONARY

J96.10	Chronic Respiratory Failure	0.282
J44.89	COPD / Chronic obstructive asthma (FEV1/FVC <0.7)	0.335
J43.9	Emphysema	0.335
J47.9	Bronchiectasis, uncomplicated or NOS	0.219

Continued on page 13...

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PULMONARY, CONTINUED

J41.0	Simple chronic bronchitis (Smoker's cough)	0.335
J41.1	Chronic mucopurulent bronchitis	0.335
J42	Unspecified chronic bronchitis	0.335
J84.9	Interstitial pulmonary disease, unspecified	0.219
J84.10	Pulmonary fibrosis, unspecified	0.219
J45.50	Severe persistent asthma	0.219
I27.20	Pulmonary Hypertension	0.331

RHEUMATOLOGY/IMMUNOLOGY

M35.3	Polymyalgia rheumatica (active)	0.421
M06.9	Rheumatoid arthritis, unspecified	0.421
M06.4	Inflammatory polyarthropathy	0.421
M32.9	Systemic Lupus erythematosus, unspecified	0.421
M34.9	Systemic sclerosis, unspecified	0.421
M35.00	Sjogren's syndrome, unspecified	0.421
B20	HIV	0.335
Z21	Asymptomatic HIV	0.335
D89.82	Autoimmune lymphoproliferative syndrome [ALPS]	0.665
D84.821	Immunodeficiency due to drugs	0.665
Sacroiliitis and other spinal arthritis' should be specified as degenerative unless inflammatory or autoimmune in nature		

SUBSTANCE USE DISORDERS

F10.20	Alcohol use disorder, moderate/severe	0.329
F10.21	** in remission	0.329
F11.20	Opioid use disorder, moderate/severe	0.329
F11.21	** in remission	0.329
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	0.329
F13.21	** in remission	0.329
F14.20	Cocaine use disorder, moderate/severe	0.329
F14.21	** in remission	0.329
F15.20	Other stimulant use disorder, moderate/severe	0.329
F15.21	** in remission	0.329
F19.20	Substance use disorder, moderate/severe	0.329
F19.21	** in remission	0.329

BEHAVIORAL HEALTH

Bipolar and Paranoia		
Bipolar and Major Depressive Disorder should not be reported together		
F31.9	Bipolar disorder, unspecified	0.309
F31.81	Bipolar II disorder	0.309
F22	Paranoia / Delusional disorders	0.309
F259	Schizoaffective disorder	0.524
F20.9	Schizophrenia	0.524
Major Depressive Disorder documentation should always state severity or remission status and any recurrence		
F32.0	Major Depressive Disorder single episode, mild	0.309
F32.1	Major Depressive Disorder single episode, moderate	0.309
F32.2/ F32.3	Major Depressive Disorder single episode, severe without/with psychotic features	0.309
F32.4/ F32.5	Major Depressive Disorder single episode, in partial / full remission	0.309
F33.0	Major Depressive Disorder recurrent, mild	0.309
F33.1	Major Depressive Disorder recurrent, moderate	0.309
F33.2/ F33.3	Major Depressive Disorder recurrent, severe without / with psychotic features	0.309
F33.41/ F33.42	Major Depressive Disorder recurrent, in partial / full remission	0.309

Continued on page 14...

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Bipolar and Paranoia		
F33.9	Major Depressive Disorder recurrent, unspecified	0.309

CARDIOLOGY

Arrhythmias		
I44.2	Atrioventricular block, complete (code w/ pacemaker)	0.268
I47.1	Supraventricular tachycardia	0.268
I47.2_	Ventricular tachycardia	0.268
I47.9	Paroxysmal tachycardia, unspecified	0.268
I48.0	Paroxysmal atrial fibrillation	0.268
I48.91	Unspecified atrial fibrillation	0.268
I48.92	Unspecified atrial flutter	0.268
I49.5	Sick sinus syndrome (code w/ pacemaker)	0.268
D68.69	Secondary hypercoagulable state (common with a. fib)	0.192
Angina Pectoris		
I20.0	Unstable angina	0.240
I20.8	Stable angina (consider w/ nitrate/ nitro)	0.195
I20.9	Other forms of angina pectoris	0.135
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina	0.240
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	0.135
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	0.135
Cardiomyopathy		
I42.0	Dilated Cardiomyopathy	0.331
I42.1	Obstructive hypertrophic cardiomyopathy	0.331
I42.6	Alcoholic cardiomyopathy (consider alcohol use disorder)	0.331
I42.7	Cardiomyopathy due to drug and external agent	0.331
I42.9	Cardiomyopathy, unspecified	0.331
I25.5	Ischemic cardiomyopathy	0.00
Heart Failure		
Document as active with symptoms managed with treatment or lifestyle changes		
I50.1	Left Ventricular failure, unspecified	0.331
I50.22	Chronic systolic (congestive) heart failure	0.331
I50.32	Chronic diastolic (congestive) heart failure	0.331
I50.42	Chronic combined systolic and diastolic heart failure	0.331
I50.812	Chronic right heart failure	0.331
I50.813	Acute on chronic right heart failure	0.331
I50.814	Right heart failure due to left heart failure	0.331
I50.82	Biventricular heart failure	0.331
I50.83	High output heart failure	0.331
I50.84	End stage heart failure (Class D)	0.331
I50.9	Unspecified Heart Failure	0.331
E26.1	Secondary Hyperaldosteronism (common with heart failure & edema)	0.194
Pulmonary Hypertension / Heart Disease		
I27.20	Pulmonary hypertension, unspecified	0.331
I27.21	Secondary pulmonary arterial hypertension	0.331
I27.22	Pulmonary hypertension due to left heart disease	0.331
I27.23	Pulmonary hypertension due to lung diseases and hypoxia	0.331
I27.24	Chronic thromboembolic pulmonary hypertension	0.331
I27.81	Cor pulmonale (chronic)	0.331
I27.82	Chronic pulmonary embolism	0.383
I27.83	Eisenmenger's syndrome	0.331
I27.89	Other specified pulmonary heart diseases	0.331
I27.9	Pulmonary heart disease, unspecified	0.331

Continued on page 15...

These codes are meant to help in general code selection and may not represent the patient's condition accurately. We encourage use of the ICD-10-CM code set to determine the most specific code that represents the actual condition.

CARDIOLOGY, CONTINUED

Circulatory		
I71.2	Thoracic aortic aneurysm, without rupture	0.288
I71.4	Abdominal aortic aneurysm, without rupture	0.288
I71.6	Thoracoabdominal aortic aneurysm, without rupture	0.288
I71.9	Aortic aneurysm of unspecified site, without rupture	0.288
I70.0	Atherosclerosis of aorta	0.288
I70.1	Atherosclerosis/stenosis of renal artery	0.288
I70.20_	Atherosclerosis of native arteries of extremities, leg(s) (R/L/B)	0.288
I70.21_	Atherosclerosis of native arteries of extremities with intermittent claudication, leg(s) (R/L/B)	0.288
I70.22_	Atherosclerosis of native arteries of extremities with rest pain, leg(s) (R/L/B)	0.288
I70.92	Chronic total occlusion of artery of the extremities	0.288
I72. _	Aneurysm of (multiple sites)	0.288
I77.81_	Aortic ectasia (thoracic/abdominal/ unspecified)	0.288
I82.5 _*	Chronic embolism and thrombosis of (multiple sites)	0.288
***Documentation must state "chronic"**		

NUTRITION

BMI <18.9 may indicate malnutrition. BMI >40 indicates morbid obesity. BMI 35–40 with comorbidities may indicate morbid obesity.		
E43	Unspecified severe protein-calorie malnutrition	0.455
E44.0	Moderate protein-calorie malnutrition	0.455
E44.1	Mild protein-calorie malnutrition	0.455
E46	Unspecified protein-calorie malnutrition	0.455
E66.01	Morbid (severe) obesity	0.25
F50.0_	Anorexia Nervosa	0.396
F50.2	Bulimia Nervosa	0.396
R64	Cachexia	0.455

ONCOLOGY

Most cancers should be reported as historical when treatment is complete and monitoring for recurrence only		
C43.9	Malignant melanoma of skin, unspecified	0.15
C50.919	Malignant neoplasm of unspecified site of unspecified female breast	0.15
C61	Malignant neoplasm of prostate	0.15
C81.90	Hodgkin lymphoma, unspecified, unspecified site	0.675
Chronic leukemia of unspecified cell type		
C95.10	NOT having achieved remission	0.675
C95.11	In remission	0.675
C95.12	In relapse	0.675
Leukemia Myeloid, unspecified...		
C92.90	NOT having achieved remission	1.024
C92.91	In remission	1.024
C92.92	In relapse	1.024
Multiple Myeloma...		
C90.00	NOT having achieved remission	1.024
C90.01	In remission	1.024
C90.02	In relapse	1.024
Metastatic cancers should be reported as secondary neoplasms		
C79. _	Secondary malignant neoplasm of other and unspecified sites	2.659

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