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CRC®

Certified Risk Adjustment Coder

STUDY GUIDE

2026

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Chapter 1

The Business of Medicine

Coding as a Profession

Each time an individual receives healthcare, a record is maintained of the resulting observations, medical or surgical interventions, diagnostic tests and studies, and treatment outcomes. Coding is the process of translating this written or dictated medical record into numeric and alphanumeric codes. There are separate code sets to describe diagnoses, medical and surgical services/procedures, and supplies. These code sets serve as a common language to ease data collection (for example, to track disease), to evaluate the quality of care, and to determine costs and reimbursements.

Proper code assignment is determined both by the content (documentation) in the medical record and by the unique rules that govern each code set in that particular instance. Coding rules also vary depending on who pays for the patient care (for example, self-pay versus health insurance).

Coding typically is performed by either the physician or a coder. When the physician performs the coding, the coder may act as an auditor to verify that the documentation supports the codes the physician selected. In some practices, the coder will receive the documentation and code the services based on what is documented in the medical record.

If the medical record is inaccurate or incomplete, it will not translate properly to the language of codes. The coder must evaluate the medical record for completeness and accuracy and communicate regularly with physicians and other healthcare professionals to clarify diagnoses or to obtain additional patient information.

Outpatient coding focuses on physician professional services and outpatient facility coding. Outpatient coders will focus on CPT®, HCPCS Level II, and ICD-10-CM codes. They will work in physician offices, outpatient clinics, and facility outpatient departments. Outpatient facility coders will also work with Ambulatory Payment Classifications (APCs).

Hospital inpatient coding focuses on a different subset of skills, where coders will work with ICD-10-CM and ICD-10-PCS. These coders also will assign medical severity diagnosis related groups (MS-DRGs).

Risk adjustment coding focuses on diagnosis coding using the ICD-10-CM code set. Risk adjustment diagnoses are reported from claims data and medical record documentation in all settings. Risk adjustment coders may work for health plans, providers, or other healthcare entities.

Regardless of the setting, code updates and insurance payment policies may change as often as quarterly. Coders require continuing education to stay abreast of these changes.

The Role of a Risk Adjustment Coder

Risk adjustment coders work in various roles. The main role for a risk adjustment coder is in a health plan or for a vendor who is working with a health plan. Risk adjustment coders also work in provider offices when the providers have risk-based contracts.

Risk adjustment coders need to know the complexity of diseases associated with chronic conditions or comorbidities to ensure the documentation supports an accurate health status of the patient. Payment to the Medicare Advantage Organization (MAO) depends on the diagnoses reported by a provider; therefore, proper documentation and coding is pertinent to proper reimbursement.

Some risk adjustment coders will be tasked with educating providers on proper documentation and coding. As such, a risk adjustment coder should have a well-rounded, firm knowledge of medications, treatments, and diagnostic tests to identify areas for improvement. For example, an educational opportunity exists if a patient is taking insulin, but the provider has not documented diabetes.

The goal is to represent an accurate clinical picture and risk adjustment coders are often required to code for other purposes, in which you must be able to know and apply the ICD-10-CM guidelines. Throughout this curriculum, we will first teach the application of the ICD-10-CM guidelines, then will apply risk adjustment guidelines. Unless otherwise noted, all documented diagnoses are to be coded, regardless of whether it is a risk-adjusted code.

Payer Perspective

Impact of risk adjustment

The Patient Protection and Affordable Care Act (ACA or "Obamacare") introduced risk adjustment to the mainstream. Although risk adjustment programs are subject to change every year, two factors remain the same:

1. These programs protect health plans from the risk of attracting a disproportionate number of unhealthy enrollees, while discouraging health plans from marketing to only healthier, less costly potential members.

Infrastructure

Most providers' electronic medical records (EMRs), systems, and workflows were created and maintained to be used in a fee-for-service environment. Many providers employed by larger organizations are paid based on fee-for-service methodologies. In a fee-for-service payment model, the focus is placed on CPT® codes; ICD-10-CM codes are viewed solely as a way to support medical necessity for the services being provided. This creates conflict with current quality initiatives.

Although electronic medical records ensure legibility and that documentation requirements are met efficiently, they introduce challenges, as well. All codes submitted must be supported in the documentation for that encounter. It is a good practice to ensure all necessary information is present on the records that will be produced for audit requests. It is crucial for providers to check with EMR, clearinghouses, and other vendors to ensure that a practice can submit up to 12 diagnosis codes, per claim. Systems commonly truncate the number of diagnoses submitted without the provider's knowledge. This does not illustrate the work and effort a provider has done, but instead creates an incomplete clinical picture for the patient.

Role of the professional coder

A professional coder in the outpatient provider setting plays a valuable role. Most providers in the outpatient setting choose their own codes at the point of care. The provider uses the lists available in their EMR. Either through lack of knowledge or convenience, sometimes these lists are not conducive to proving the amount of work or medical decision making that went into an encounter. The trend toward value-based reimbursement means that providers are often inundated with representatives from their various payers requesting information on the care they are providing. With the increased focus on risk adjustment coding and the number of dollars at stake, CMS has increased its audit scrutiny. CMS has made it clear that it is the responsibility of the health plan to gather diagnosis codes that support specific HCCs, look for over coded conditions and drive correct payment. Payers will often provide education sessions on accurately capturing the full specificity of diagnosis codes and submitting the correct quality reporting codes. A coder can ensure the claims submitted match the documentation in the medical record. They can help in applying the various coding guidelines laid out by ICD-10-CM and CPT® to the medical records they review. They may be able to offer assistance to ensure the doctor is updating the various lists in the EMR.

The professional coder in the outpatient setting is equipped with the skills needed to assist with the high volume of medical records requests that a provider receives. Having an in depth understanding of the types of records needed for a specific request (for example, risk adjustment vs. HEDIS) can save time and resources for the provider's office.

The professional coder can also serve as the first line of defense and provide an internal audit to ensure that all diagnosis codes are assigned appropriately. They can provide valuable feedback where discrepancies are noted. Using the results of these audits, they can work with the providers and administrators of the office to devise policies and procedures that support more accurate diagnosis coding.

Certified coders can work with the reports that are supplied by insurance companies, usually on a monthly or quarterly basis, to identify patients who appear to have a gap in care based on previously set policies within the practice. One effective way a coder can assist a provider is by providing a note or task on the provider's screen so that the provider is aware of the information needed. This allows the clinician to focus attention on patient care with minimal distraction. A certified coder may be a valuable part of the pre-visit planning process and play a key role in prepayment review. Per the ICD-10-CM guidelines, providers are instructed to code all documented conditions that coexist at the time of the encounter or visit, and that require or affect patient care treatment or management.

ICD-10-CM GUIDELINE

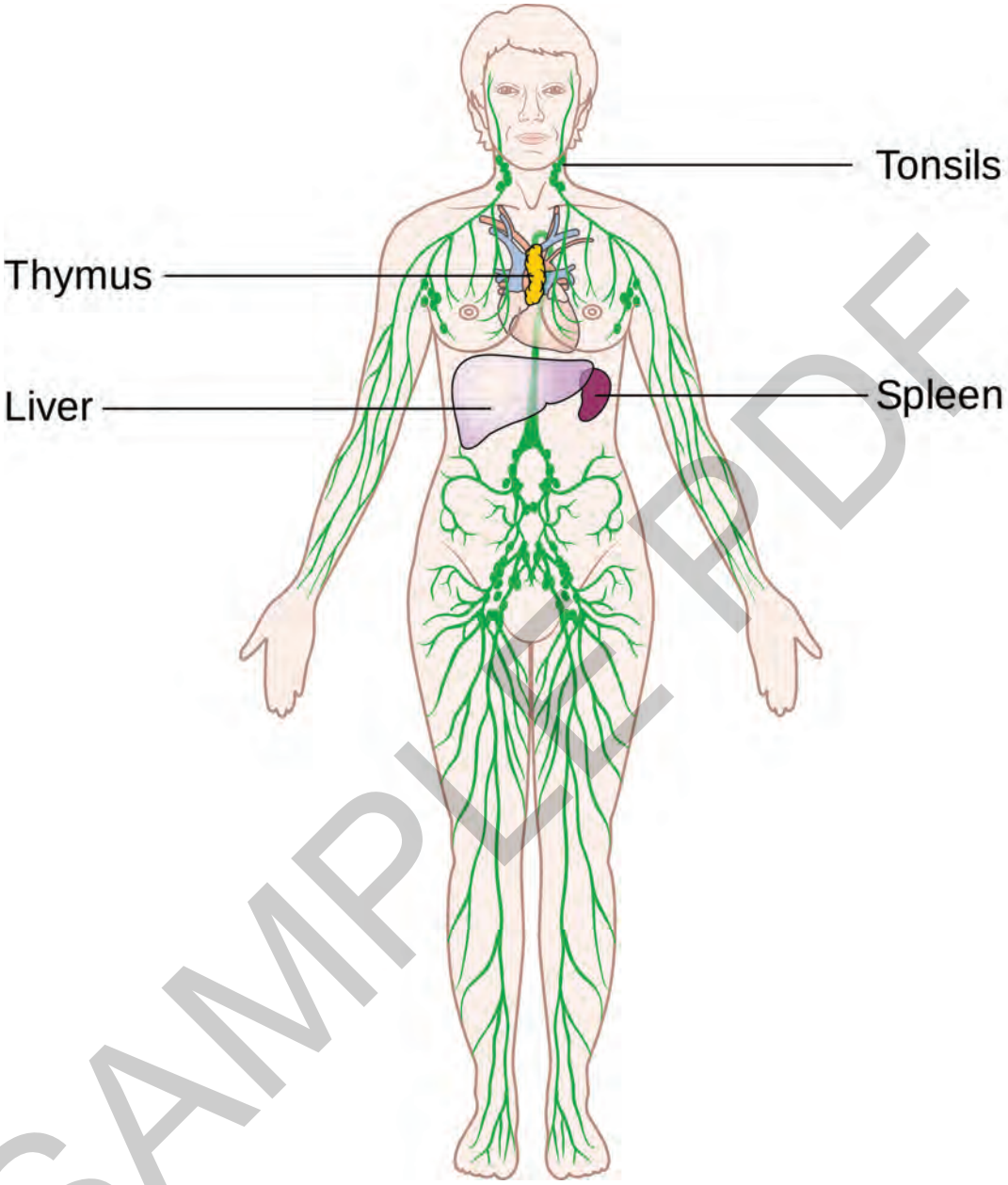
Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. History codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Appropriately querying a provider on potential omissions can save the practice from potential rework and financial loss. Providers often use default codes because they are unaware of the levels of specificity provided in ICD-10-CM regarding laterality, location, and underlying causes or manifestations, as well as cause-and-effect. A certified risk adjustment coder is familiar with the presumptive cause-and-affect nature of some conditions that ICD-10-CM allows, such as hypertensive conditions and diabetes mellitus with certain manifestations. The guidelines clearly state that conditions linked by the word "with" can be presumed to be related.

Lymphatic System



Source: By Cancer Research UK (Original email from CRUK) [CC BY-SA 4.0 (http://creativecommons.org/licenses/by-sa/4.0)], via Wikimedia Commons Peyer's Patches & Appendix

Peyer's Patches & Appendix

Peyer's patches are found in the lining of the intestine and contain high levels of white blood cells, which help to fight infection and disease. The appendix is a mass of lymphoid tissue attached to the first part of the large intestine. Both protect against invading microorganisms.

EXAMPLE

Look in the Alphabetic Index for Pain(s) (*see also* Painful) R52

abdominal R10.9

colic R10.83

generalized R10.84

with acute abdomen R10.0

lower R10.30

In this example, the subterms further define the location of pain and type of pain.

Tabular List

The Tabular List is a numerical listing of disease and injury. There are 22 chapters for the classification of diseases and injury, grouped by etiology (cause) or anatomical (body) site. The Tabular List is organized in three-character category codes and their titles. Some three-character codes are very specific and are not subdivided. These three-character codes can stand alone to describe the condition being coded. Most three-character categories (rubrics) have been subdivided with the addition of a decimal point, followed by up to four additional characters.

Each character for all categories, subcategories, and codes may be either a letter or a number. Codes can be three to seven characters in length. The 1st character of a category is a letter, followed by 2 additional characters that may be either numbers or alpha characters. Subcategories have an additional four to seven alpha numeric characters. The 7th character is called an extension (discussed later in this chapter). The 4th character in an ICD-10-CM code further defines the site, etiology, and manifestation or state of the disease or condition. To help describe the disease to the highest level of specificity, the subcategory includes the three-character category plus a decimal with an additional character. The 5th or 6th character subclassifications further represent the most accurate level of specificity regarding the patient's condition or diagnosis.

Certain ICD-10-CM categories require seven characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. If a code is three, four, or five characters, but requires a 7th character extension, a placeholder X must be used to fill the empty spaces in the code. There are symbols throughout the Tabular List to identify when a code requires an additional character.

EXAMPLES

- 4th F01 Vascular Dementia
- 5th H21.4 Pupillary membranes
- 6th I87.00 Postthrombotic syndrome without complications
- 7th O32.0 Maternal care for unstable lie

Conventions

To apply the diagnosis coding system correctly, coders need to understand the various conventions and terms. Section I of the official guidelines includes conventions, general coding guidelines, and chapter specific guidelines.

NEC Not elsewhere classifiable

This abbreviation is used when the ICD-10-CM system does not provide a code specific for the patient's condition. Selecting a code with the NEC classification means the provider documented more specific information regarding the patient's condition, but there is not a code in ICD-10-CM that reports the condition accurately.

NOS Not otherwise specified

This abbreviation is the equivalent of "unspecified" and is used only when the coder lacks the information necessary to report to a more specific code.

[ ] Brackets

Brackets are used in the Tabular List to enclose synonyms, alternate wording, or explanatory phrases.

EXAMPLE

- 5th B96.2 Escherichia coli [E. coli] as the cause of diseases classified elsewhere

[ ] Brackets

Brackets are used in the Alphabetic Index to indicate multiple codes are required.

EXAMPLE

Hepatitis

syphilitic (late) A52.74

congenital (early) A50.08 *[K77]*

late A50.59 *[K77]*

Chapter 4

Risk Adjustment Models

Risk adjustment is a modern methodology that accounts for known and discovered health data elements. All risk adjustment models use diagnosis codes to determine potential patient-level risks; the models compare levels of wellness among patients. Additional elements taken into consideration include a patient's:

- Age
- Gender
- Socioeconomic status
- Disability status
- Insurance status (Medicare, Medicaid, dual-eligible, etc.)
- Claims data elements such as procedure codes, place of service codes, etc.
- Special patient-specific conditions (for example, enrollment in hospice or being an end-stage renal disease [ESRD] patient)

Risk adjustment models are used to evaluate all patients on an equal scale; costs can vary greatly from one patient to another. Risk adjustment models level the playing field when evaluating all patients being treated within a plan or group. Documented variables can aid in identifying those patients who may have a higher medical need than others. These variables help to explain current trends in healthcare spending, assist in the forecasting of future needs of those patients, and identify where resources will be necessary to deliver care efficiently. Some of these variables can affect payment, and all influence quality of care endeavors as patient care needs are identified. From a payment perspective, risk adjustment models adjust health plan revenue to better reflect the projected costs of the patient population and to compensate plans that enroll high-cost patients.

Health plans and risk-bearing provider groups establish internal risk adjustment programs to help monitor the patient population, improve quality of care, to increase provider engagement, to improve accuracy and completeness of data submissions, and to achieve more accurate risk adjustment factor (RAF) scores.

Risk adjustment programs include review of the patient population's health status, and these generally fall into three main types of review: retrospective, concurrent, and prospective. These review types are based on the current date of service (DOS) compared to the treatment DOS being reviewed. Retrospective reviews are performed after the information has been reported; in risk adjustment these are typically the prior year's DOS. Concurrent reviews are performed ongoing, as patients are seen, and may occur after or prior to reporting; in risk adjustment, these are typically the current year, combined with the prior year's DOS. Prospective reviews are similar to concurrent reviews but are called prospective because when considering the current year's encounters, these will affect the next year and not the current year, where payment is concerned. In risk adjustment, risk assessments to include home assessments are often called "prospective."

The various medical documentation reviews are used to forecast future healthcare needs, while explaining current needs and expenses. The importance of risk adjustment has led to an increase in the utilization of medical record review and audit. Some of these reviews and audits are performed within health plans and other organizations, while some work is accomplished using trusted vendors to achieve medical record review. Coders who are well versed on proper diagnosis coding, International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding guidelines, as well as directives from The Coding Clinic®, are imperative for correct diagnosis code selection and a successful risk adjustment program. Although there are variations in the risk adjustment models, all risk adjustment programs collect diagnosis codes according to proper coding guidelines.

Types of Risk Adjustment Models

There are many risk adjustment models. Some add in patient functional abilities such as Activities of Daily Living (ADLs).

Diagnosis-based program risk adjustment examples:

- Health and Human Services Hierarchical Condition Category (HHS HCC)—Commercial, Individual, and Small Group
- Medicaid Chronic Illness and Disability Payment Systems (CDPS)
- Medicare Hierarchical Condition Category, Part C (Medicare HCC-C)
- Diagnosis Related Groups (DRG)—Inpatient
- Adjusted Clinical Groups (ACG)—Outpatient

Prescription-based program risk adjustment examples:

- MedicaidRx (UCSD)
- RxGroups (DxCG)
- Medicare Hierarchical Condition Category, Part D (RxHCC)
- Health and Human Services Hierarchical Condition Category (HHS HCC)

This is the v28 hierarchy list.

CMS HCC Hierarchy List

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC listed in this column
--	CMS-HCC Hierarchical Condition Category Label	--
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
20	Lung and Other Severe Cancers	21, 22, 23
21	Lymphoma and Other Cancers	22, 23
22	Bladder, Colorectal, and Other Cancers	23
35	Pancreas Transplant Status	36, 37, 38
36	Diabetes with Severe Acute Complications	37, 38
37	Diabetes with Chronic Complications	38
62	Liver Transplant Status/Complications	63, 64, 65, 68
63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
64	Cirrhosis of Liver	65, 68
77	Intestine Transplant Status/Complications	78, 80, 81
80	Crohn's Disease (Regional Enteritis)	81
93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	94
107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	108
111	Hemophilia, Male	112
114	Common Variable and Combined Immunodeficiencies	115
125	Dementia, Severe	126, 127
126	Dementia, Moderate	127
135	Drug Use with Psychotic Complications	136, 137, 138, 139
136	Alcohol Use with Psychotic Complications	137, 138, 139
137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	138, 139
138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	139
151	Schizophrenia	152, 153, 154, 155
152	Psychosis, Except Schizophrenia	153, 154, 155
153	Personality Disorders; Anorexia/Bulimia Nervosa	154, 155
154	Bipolar Disorders without Psychosis	155
180	Quadriplegia	181, 182, 253, 254
181	Paraplegia	182, 254

Acceptable Physician Specialty Types for Medicare HCC

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 (IPM)	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 Therapy	43	Certified Registered Nurse Anesthetist	94	Interventional Radiology
13	Neurology	44	Infectious Disease	97	Physician Assistant
14	Neurosurgery	46	Endocrinology	98	Gynecologist/Oncologist
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 & Reconstructive Surgery	76	Peripheral Vascular Disease	D4	Undersea and Hyperbaric Medicine
25	Physical Medicine & 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		

The Acceptable Physician Specialty Types can be found on the CSSC Operations website: Acceptable Physician Specialty Types for 2023 Payment Year (2022 Dates of Service) Risk Adjustment Data Submission (csscoperations.com)

diagnoses, be sure that the medication is current, prescribed for the diagnosis, and is linked by the provider. Some organizations may have policies whereby medications that are used to treat a specific diagnosis, only, are used to establish a diagnosis as current or valid to submit. Each organization will have a policy on which medications can be reported for a single diagnosis, and the policies may vary. Querying of the treating provider is the best method to validate the codes.

Special caution is advised for those records where diagnoses appear to be continually repeated or "cut and pasted" into each subsequent DOS. These may be accurate diagnoses, but they should be evaluated carefully to ensure that they are ongoing chronic conditions, and not historical in nature. Include only those diagnoses documented as currently active.

The following diagnoses often are coded improperly as current.

- Fractures—Fractures are not coded after they are repaired; however, compression fractures of the vertebrae are often not treated in the elderly. If a vertebral fracture appears to be a current diagnosis, it may be coded.
- Cancers—There are 'history of' diagnosis codes to express this, and these may not risk adjust (they do for some plans, but do not for CMS HCC purposes).
- CVA—Coding guidelines state a CVA may not be coded after a patient is discharged for this problem; instead, use a sequela or history of code.
- Myocardial Infarction—There is a specific code for old MI (I25.2) that does risk adjust, in most models.

When PMH is listed as a separately identifiable list of true historical conditions, coders are required to find evidence within that same date of service (DOS) to substantiate that particular PMH diagnosis as current.

PRACTICAL CODING NOTE

Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider who assesses and documents that condition.

Organizations may develop a list of conditions they consider life-long conditions. These policies will vary based on the organization. When coders are presented with documentation where PMH listings are separated from another listing noted as active, current, ongoing, etc., providers should be reminded of the importance of list headers and to categorize diagnoses appropriately. If a diagnosis seems miscategorized in such a list, the coder should use their judgment based on the clinical documentation.

Coding from Lists

Although it is appropriate to code for all known current diagnoses, exercise caution to avoid improperly coding any diagnosis in a list that could not be current, is not believed to be current, or appears to be mistakenly brought forward from a past visit documentation. Some of these lists have columns designating diagnoses as current or resolved; but, even with this level of detail, use caution to avoid coding any old diagnoses no longer present, or those which the coder knows could not be true.

EXAMPLE: CHRONIC PROBLEMS

- *A-Fib (on Coumadin)*
- *Acute Pancreatitis (admitted 2002)*
- *Old MI*
- *CVA (2000)*
- *CKD (Followed by Dr. Jones, nephrology)*
- *Prostate CA*

RATIONALE: The above list may be titled as "chronic problems," but not all of the conditions listed are current. This is a common problem for coders. The A-fib is clearly current as there is medical treatment. The acute pancreatitis appears to be historical only. The old MI may be coded as factual, and the CVA is not only historical (one could code a history of code or any related residual conditions, if noted), but an active CVA code cannot be coded after a patient has been discharged for the CVA. CKD is still under treatment, but prostate CA lacks any current ongoing treatment that would be necessary to code a cancer as current.

Coding Diagnoses from Review of Systems (ROS)

This portion of the medical record documentation is intended to document the provider's questioning of the patient for feedback regarding how they are doing, by systems. Many providers will document accurate diagnoses in this section of the record. The main warning in this area is to avoid coding for any patient-stated conditions. Conditions or diagnoses that are reported by the patient only as recounting to the current provider are not acceptable without provider validation. Based on the E/M documentation guidelines, the ROS can be recorded by anyone (even the patient), as long as the provider reviews it and documents pertinent positives and negatives.

In the two examples below, those diagnoses highlighted in green are appropriate to code, and those in yellow are PMH or questionable.

ICD-10-CM GUIDELINE

ICD-10-CM:
Section I. Conventions, general coding guidelines and chapter specific guidelines

B. General Coding Guidelines

14. Documentation by Clinicians Other than the Patient's Provider

Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions when code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). In this context, "clinicians" other than the patient's provider refers to healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record.

These exceptions include codes for:

- Body mass index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stage
- Coma scale
- NIH stroke scale (NIHSS)
- Social determinants of health (SDOH)
- Laterality
- Blood alcohol level
- Underimmunization status

This information is typically, or may be, documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, or a condition classifiable to category F10, Alcohol related disorders) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI, coma scale, NIHSS, blood alcohol level, code for social determinants of health, and underimmunization status should only be reported as secondary diagnoses.

See Section I.C.21.c.17 for additional information regarding coding social determinants of health.

Section I. Conventions, general coding guidelines and chapter specific guidelines

C. Chapter Specific Guidelines

21. Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

c. Categories of Z Codes

3) Status

Z68 Body mass index (BMI)

BMI codes should only be assigned when there is an associated reportable diagnosis (such as obesity).
Do not assign BMI codes during pregnancy.
See Section I.B.14 for BMI documentation by clinicians other than the patient's provider.

BMI Code Table: [Note that in ICD-10-CM, BMI adult codes are used for persons 20 years of age or older and pediatric codes are defined as persons 2-19 years of age. BMI measures in pediatrics are not based on a height/weight ratio, but instead based on a percentile based on the growth charts published by the Centers for Disease Control and Prevention (CDC)]. See "Status" guideline I.C.21.c.3.

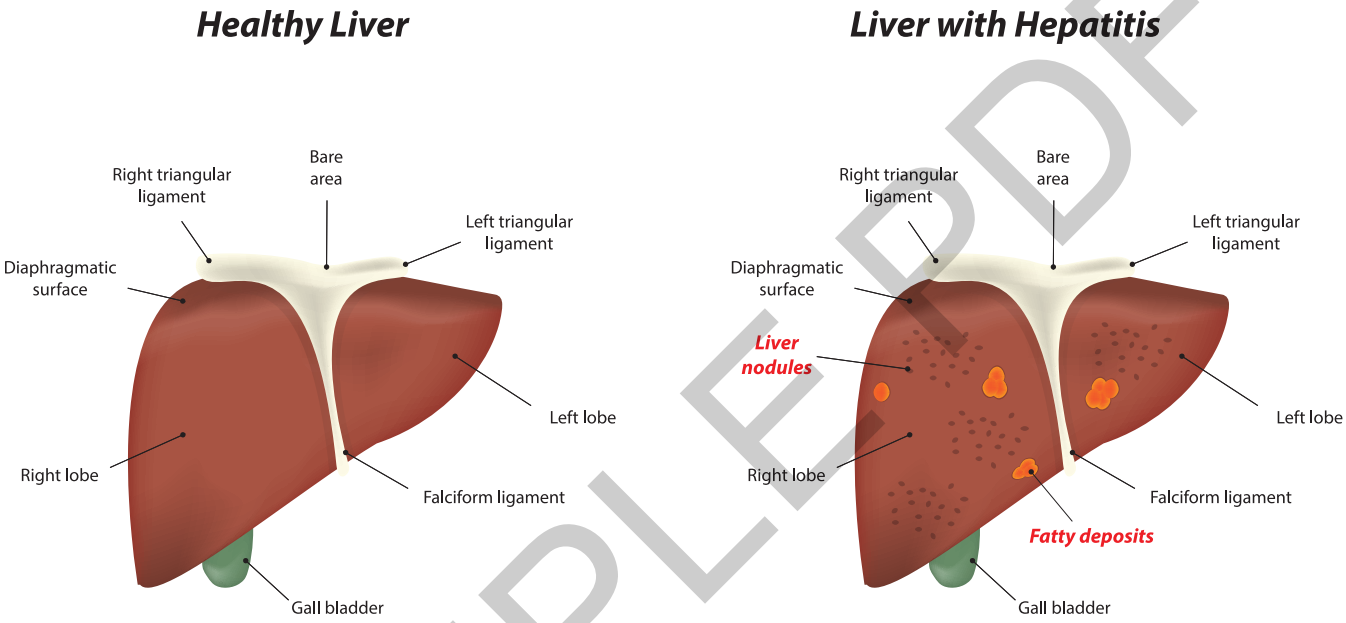
BMI Code Examples in ICD-10-CM

BMI in ICD-10-CM	ICD-10-CM
BMI 19.9 or less, adult	Z68.1
BMI 20.0 – 20.9, adult	Z68.20
BMI 21.0 – 21.9, adult	Z68.21
BMI 22.0 – 22.9, adult	Z68.22
BMI 23.0 – 23.9, adult	Z68.23
BMI 24.0 - 24.9, adult	Z68.24
BMI 25.0 – 25.9, adult	Z68.25
BMI 26.0 – 26.9, adult	Z68.26
BMI 27.0 – 27.9, adult	Z68.27
BMI 28.0 – 28.9, adult	Z68.28
BMI 29.0 – 29.9, adult	Z68.29
BMI 30.0 - 30.9, adult	Z68.30
BMI 31.0 – 31.9, adult	Z68.31
BMI 32.0 - 32.9, adult	Z68.32
BMI 33.0 – 33.9, adult	Z68.33
BMI 34.0 – 34.9, adult	Z68.34
BMI 35.0 - 35.9, adult	Z68.35
BMI 36.0 – 36.9, adult	Z68.36
BMI 37.0 – 37.9, adult	Z68.37
BMI 38.0 – 38.9, adult	Z68.38
BMI 39.0 – 39.9, adult	Z68.39

Hepatitis

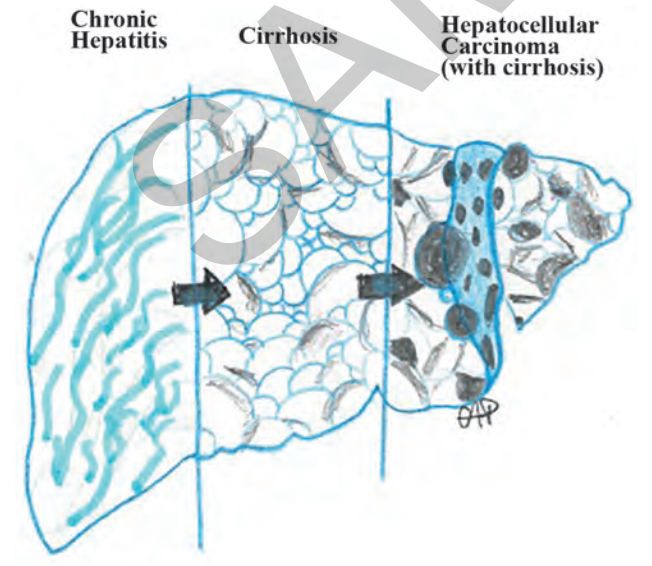
Hepatitis is an inflammation of the liver. It is acute when it lasts less than six months, and chronic when it persists longer. Chronic hepatitis, NOS (K73.9) excludes viral hepatitis (B15–B19). Hepatitis is a serious virus because it can live for 30 days or more outside of the human body (by comparison, HIV can survive only nine to 11 seconds outside of the human body). Those infected with hepatitis may have no signs or symptoms.

Hepatitis



Source: stock.adobe.com

The Liver



Source: ionHealthcare®, LLC

Coders should understand the types of hepatitis and how they are spread, in case a query to the treating provider is necessary.

- Hepatitis A (infectious hepatitis) is caused by eating food or drinking water infected with a virus called HAV. It can also be caused by anal-oral contact during sex. Although it can cause swelling and inflammation in the liver, it doesn't lead to chronic or lifelong disease. Almost every patient who contracts Hepatitis A has a full recovery.
- Hepatitis B (HBV) is spread through contact with an infected person's blood, semen, or other body fluid. It is classified as an STD. Unprotected sex, sharing used drug needles, getting a tattoo with a used needle, sharing a toothbrush, sharing a razor, or a bite from an infected person can cause hepatitis B. An infected woman can pass the virus on to her baby at birth, or through breast milk. Although there are vaccines for Hepatitis B, it is a chronic, life-long disease and may cause liver cancer and death.
- Hepatitis C (HCV) is spread the same way as hepatitis B, through contact with an infected person's blood, semen or body fluid (see above). Like hepatitis B, hepatitis C

38.

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the Disease Group(s) listed in this column
Hierarchical Condition Category (HCC) LABEL		
277	Cystic Fibrosis	278, 279, 280
278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	279, 280

Cystic fibrosis with pulmonary manifestations	277
Meconium ileus in cystic fibrosis	277
Cystic fibrosis with other intestinal manifestations	277
Cystic fibrosis with other manifestations	277
Cystic fibrosis, unspecified	277

Unspecified chronic bronchitis	280
Emphysema, unspecified	280
Chronic obstructive pulmonary disease with acute lower respiratory infection	280
Chronic obstructive pulmonary disease with (acute) exacerbation	280
Chronic obstructive pulmonary disease, unspecified	280

Allergic bronchopulmonary aspergillosis	280
Sarcoidosis of lung	
Sarcoidosis of lung with sarcoidosis of lymph nodes	
Bronchiectasis with acute lower respiratory infection	280
Bronchiectasis with (acute) exacerbation	280
Bronchiectasis, uncomplicated	280

Using the information provided above, which statement is TRUE?

a. Sarcoidosis of the lung trumps cystic fibrosis.
b. Cystic fibrosis trumps COPD.
c. Bronchiectasis trumps cystic fibrosis.
d. Emphysema trumps Bronchiectasis.

Quality Care

39. Which one of the following general statements is FALSE regarding Risk Adjustment practices and Quality?

a. Healthcare Plans with Four Star Quality Ratings can still improve their score because the highest rating is a Five (5).
b. From a data discovery perspective, HEDIS and Star Ratings are essentially inseparable.
c. Data Collection for HEDIS and Star Ratings Programs can be achieved during their prospective member evaluations.
d. Quality Measures like Star Ratings and HEDIS have no correlation with the medical record information that is collected in support of risk adjustment.

40. Which statement is TRUE regarding Stars Ratings?

a. Stars ratings help identify top performing health plans.
b. Stars ratings help identify the top performing providers.
c. Stars ratings identify Part C health plans by the amount of money paid to providers.
d. Stars ratings are only available to providers.

Risk Adjustment Models

41. Commercial plans through healthcare exchanges use which risk adjustment model?

    a. CDPS
    b. HHS-HCC
    c. CMS-HCC
    d. RxHCC

42. Of the following, which is a FALSE statement about Risk Adjustment Models?

    a. Coders are accustomed to submitting diagnosis codes on claims for the purposes of reimbursement validation for services rendered.
    b. Codes are submitted to accurately calculate each patient's risk score, which affects the financial reserves that will go toward future treatments related to these existing diagnoses.
    c. These diagnoses are collected not for submitting a claim but rather to include them in a supplemental file that will chronicle the patient's condition throughout the year.
    d. Diagnosis codes are converted to an HCC or Chronic Illness Disability Payment System value (risk adjustment factor or RAF), resulting in an adjusted risk score (RAS) composed of diagnosis values that are used to budget for annual patient care.

43. Which statement is coded as a history of condition?

    a. History of heart transplant.
    b. History of Alzheimer's dementia.
    c. History of prostate cancer, seed implant next week for radiation.
    d. History of breast CA, no further treatment necessary.

44. What is the rule regarding uncertain diagnosis for outpatient records?

    a. Conditions stated as likely or possible are reported as definitive diagnoses.
    b. Conditions stated as probable, suspected, likely, questionable, possible, or still to be ruled out are not reported.
    c. Conditions stated as consistent with are not reported.
    d. Conditions stated as still to be ruled out are reported.

45. Which of the following providers is an acceptable provider type for RADV audits?

    a. Nutritionist
    b. Pharmacist
    c. DME provider
    d. Audiologist

46. Which statement is TRUE regarding manifestations?

    a. To code a condition as a manifestation, the cause-and-effect relationship must be documented, unless the condition falls under the "with" guideline in ICD-10-CM.
    b. When two conditions are documented in the chief complaint and in the plan, they can always be reported as a manifestation without a documented linkage.
    c. All manifestation codes must have a documented linkage in the medical record to be reported as a manifestation.
    d. When a condition is documented in the past medical history, and a manifestation is documented in the plan, a documented link is not required.

Compliance

1. **Answer:** d. A record from a dietician that did not see the patient.

   Rationale: Review the CMS RADV checklist. The record should be legible with a signature or attestations from a valid provider type. A record may have multiple diagnoses in addition to the diagnosis targeted by the RADV audit. The record must be from a face-to-face visit.

2. **Answer:** a. I and II

   Rationale: Risk adjustment has created the need to ensure providers document care of chronic conditions at least once per year. As a result, it is important for a documentation specialist to be able to identify chronic conditions and determine when a provider has documented treatment of any existing chronic conditions. To qualify for risk adjustment, chronic conditions must be documented in a way that is reasonable to determine that a physician is managing the patient and treating the chronic condition within the year.

   CMS considers the following conditions as chronic conditions:

Alcohol Abuse	Drug Abuse/Substance Abuse
Alzheimer's Disease and Related Dementia	Heart Failure
Arthritis (Osteoarthritis and Rheumatoid)	Hepatitis (Chronic Viral B & C)
Asthma	HIV/AIDS
Atrial Fibrillation	Hyperlipidemia (High cholesterol)
Autism Spectrum Disorders	Hypertension (High blood pressure)
Cancer (Breast, Colorectal, Lung, and Prostate)	Ischemic Heart Disease
Chronic Kidney Disease	Osteoporosis
Chronic Obstructive Pulmonary Disease	Schizophrenia and Other Psychotic Disorders
Depression	Stroke
Diabetes	

3. **Answer:** b. A CMS audit of Part C HCCs to verify the diagnoses in the risk scores are supported by the documentation.

   Rationale: In a CMS Risk Adjustment Data Validation (RADV), CMS identifies a random stratified sample of patients to audit. The sample is ⅓ of patients with a high-risk factor, ⅓ of patients with a medium risk factor, and ⅓ of patients with a low risk factor. Only Part C HCCs are audited in a RADV. The health plans must submit up to five best records from an acceptable treating provider, demonstrating those diagnoses as current in the year being audited that support the HCC values that were paid. Supplemental diagnoses (those that were not originally submitted via claims) may be approved if they are documented as current diagnoses in the record. The submission of all diagnoses (with HCCs) are cumulative; therefore, there may be a negative or positive financial outcome in such an audit. The purpose of the audit is to evaluate the appropriateness of risk scores of patients.

4. **Answer:** c. Initial Validation Auditor

   Rationale: In an HRADV, there is an Initial Validation Auditor (IVA) that reviews the sample to identify DOS that support HCCs (through diagnosis codes) for the chosen patients in the sample.

Pathophysiology, Medical Terminology, Anatomy

32. **Answer:** b. A respiratory disorder

    Rationale: PND stands for paroxysmal nocturnal dyspnea. This is a condition of sudden shortness of breath during sleep.

33. **Answer:** c. HIV/AIDS is most commonly transmitted by coughing.

    Rationale: HIV/AIDs is not transmitted by casual contact, including through saliva, or tears.

Purpose and Use of Risk Adjustment Models

34. **Answer:** a. HCC 135

    Rationale: When HCC 135 is reported, HCC 136, HCC 137, HCC 138, and HCC 139 are dropped. Only HCC 135 is used by CMS.

35. **Answer:** d. I, II, and III

    Rationale: Known health information from claims data, disease management, durable medical equipment (DME) requests, prescription drug events (PDE), and similar elements are used in predictive modeling efforts. Some of the formulas may be quite simple, while others can be very complex.

36. **Answer:** b. Predictive modeling

    Rationale: Predictive modeling is an analytical review of known data elements to establish a hypothesis—or educated guess—related to the future health of patients. Health plans and other health specialists often use predictive modeling to anticipate potential future diagnoses for an individual patient (or groups of individuals). Those working in risk adjustment use this information to prepare for future needs, and to uncover potential current diagnoses that should be counted for risk adjustment purposes.

37. **Answer:** c. II, III, and IV

    Rationale: Predictive modeling is an analytical review of known data elements to establish a hypothesis—or educated guess—related to the future health of patients. Health plans and other health specialists often use predictive modeling to anticipate potential future diagnoses for an individual patient (or groups of individuals). Those working in risk adjustment use this information to prepare for future needs, and to uncover potential current diagnoses that should be counted for risk adjustment purposes. Predictive modeling is also used for provider education.

38. **Answer:** b. Cystic fibrosis trumps COPD.

    Rationale: In looking at the HCC Hierarchy Table, when HCC 277 is reported, HCC 278, HCC 279, and HCC 280 are dropped. Sarcoidosis does not map to an HCC in V28. Cystic fibrosis, unspecified maps to HCC 277 and COPD maps to HCC 280. Bronchiectasis maps to HCC 280. Emphysema maps to HCC 280.

Quality Care

39. **Answer:** b. From a data discovery perspective, HEDIS and Star Ratings are essentially inseparable.

    Rationale: Medicare recently began a Stars Ratings program, which will monitor quality of care endeavors by carriers. While plans not obtaining four stars or better may be penalized, plans that achieve higher quality ratings can achieve higher payments in the five-star rating program. CMS is also highlighting plans that have achieved an overall quality rating of five star with a High Performer or gold star icon so that patients with Medicare can easily find high quality plans. Data collected for the Stars Quality Rating program comes from patient surveys and performance of measures documented in the medical record while risk adjustment only obtains diagnosis data from the medical record.

40. **Answer:** a. Stars ratings help identify top performing health plans.

    Rationale: To make quality of care a priority, the Affordable Care Act set a requirement that CMS make quality bonus payments (QBPs) to Medicare Advantage health plans based on the plan's quality rating. CMS created the Part C & Part D Star Ratings to publicly provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services. The Stars Ratings help identify the top performing health plans. Medicare Advantage plans that earn four or more stars in a five-star quality rating system would receive a bonus payment. Those earning fewer than four stars would receive no bonus.

Alphabetic Index, look for Long-term (current) (prophylactic) drug therapy (use of)/hormone replacement which directs you to Z79.890. Verify code selection in the Tabular List.

Case 3

50. **CHIEF COMPLAINT:** Nausea and vomiting.

HISTORY OF PRESENT ILLNESS: This is a 29-year-old male with history of insulin-dependent diabetes mellitus and multiple hospital admissions over the past year for severe nausea and vomiting, thought to be secondary to gastroparesis. [1] He was last admitted to the hospital in early January for nausea and vomiting. He comes to clinic today for evaluation for GJ tube placement. He complains of significant nausea and vomiting currently to the point where he is not able to take any PO intake.

PAST MEDICAL HISTORY:

1. Insulin-dependent diabetes mellitus.
2. Gastroparesis.
3. Hyperlipidemia.
4. Depression.

PREVIOUS OPERATIONS: None.

MEDICATION ALLERGIES: Thorazine.

CURRENT MEDICATIONS:

1. Celexa.
2. Lantus.
3. NovoLog.
4. Phenergan.

FAMILY HISTORY: Patient notes a history of high blood pressure, diabetes, thyroid disease, and cancer in his family.

SOCIAL HISTORY: Patient lives with his mother. He is divorced with one son.

REVIEW OF SYSTEMS: As above in HPI. In addition, the patient notes recent weight loss, fatigue, and malaise. Patient also notes recent cold symptoms, including cough. Patient notes fainting, depression, low blood sugar, and high blood pressure.

PHYSICAL EXAMINATION:

Vital Signs: Temperature 36.0, pulse 132, blood pressure 152/82, respiratory rate 15.

General: Patient is in moderate distress secondary to continued nausea and vomiting.

Respiratory: Nonlabored breathing.

Chest: Tachycardic.

Abdomen: Soft, mild left upper quadrant tenderness. No guarding.

Psychiatric: A&OX3. Normal affect. [2]

ASSESSMENT/PLAN: This is a 29-year-old male with insulin-dependent diabetes mellitus and gastroparesis [3] related to his diabetes. He presents to the clinic today with recent history of multiple hospital admissions for severe nausea and vomiting and complaints of severe nausea and vomiting at time of presentation. He will undergo a laparoscopic versus open GJ tube placement tomorrow. He was consented in clinic today after discussion of risks, benefits, and alternative interventions.

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