BCA's Diagnosis Coding Booklet

Table of Contents

BCA Disclaimer ... 2

Diabetes Type 2 (T2DM) ... 3

Diabetes Type 1 (T1DM) ... 4

Hypertension, Heart Disease, and Renal Disease ... 5

Cardiovascular Conditions ... 6

Prevention ... 7

Weight Management ... 8

Pregnancy ... 9

Family Planning and STIs ... 10

Pediatric Conditions ... 12

Respiratory Conditions ... 14

Covid 19 ... 15

Chronic Pain and Substance Use Disorders ... 16

Psychiatric and Related Conditions ... 20

Injuries (Fractures, Burns, Lacerations) ... 23

Social Determinants of Health (SDoH) ... 25

Appendix E: (CMS-HCC) ... 26

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***BCA's Diagnosis Coding Booklets* are intended to be used as tools for diagnosis code selection in conjunction with the HIPAA mandated current, published coding guidelines for appropriate application and reporting.**

From the American Medical Association ICD-10-CM 2025 The Complete Official Codebook:

"These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits."

"These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular and Alphabetic Index of ICD-10-CM, but provide additional instruction. **Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).**"

Note from BCA: We have done our best to indicate in this guide if a code risk adjusts, by indicating yes in the Risk? column, if there's an asterisk (*) in this column, it's an indicator that this is a new code and we don't yet have risk adjustment information. This is based on our experience and research of HCC and CDPS value-based care models we have worked with and should not be construed as the authority on if a code risk adjusts; it's simply there as an indication that you may want to check this code carefully for risk adjustment. Please refer to your payer policy for their guidance on risk adjustment coding.

For additional BCA resources, including BCA's most current guidance on COVID-19 coding, visit www.bcarev.com/revu.

DIABETES TYPE 2 (T2DM)

T2DM without complications	RISK?	Code
Controlled and without complications	YES	E11.9
Uncontrolled w/ hyperglycemia	YES	E11.65
Uncontrolled w/ hypoglycemia, w/o coma	YES	E11.649
Hypoglycemia Level 1	*	+E16.A1
Hypoglycemia Level 2	*	+E16.A2
Hypoglycemia Level 3	*	+E16.A3
Always code when patient on insulin	YES	+Z79.4
Long-term use oral hypoglycemic med	N/A	+Z79.84
LT use of injectable non-insulin antidiabetic drugs	N/A	+Z79.85
T2DM w/ complication of CKD	YES	E11.22
T2DM w/ diabetic nephropathy	YES	E11.21
CKD stage 1 GFR >90 (Glomerular Filtration Rate)	N/A	+N18.1
CKD stage 2 GFR 60-89 (Mild)	N/A	+N18.2
CKD stage 3 unpsecified (Moderate)	YES	+N18.30
CKD stage 3a GFR 45-59 (Moderate)	YES	+N18.31
CKD stage 3b GFR 30-44 (Moderate)	YES	+N18.32
CKD stage 4 GFR 15-29 (Severe)	YES	+N18.4
CKD stage 5 GFR <15	YES	+N18.5
End Stage Renal Disease (ESRD)	YES	+N18.6
Code if T2DM is not in control	N/A	+E11.65
T2DM w/ proteinuria	YES	E11.29
T2DM w/ microalbuminuria	N/A	R80.9
T2DM w/ neurological complication, specifically;		
polyneuropathy	YES	E11.42
mononeuropathy	YES	E11.41
gastroparesis (autonomic polyneuropathy)	YES	E11.43
T2DM w/ unspecified neuropathy ***(AVOID USING)***	YES	E11.40
T2DM w/ neuropathic arthropathy	YES	E11.610
Code if T2DM is not in control	YES	+E11.65
T2DM - varied complications		
T2DM w/ arthropathy	YES	E11.618
dermatitis	YES	E11.620
foot ulcer *(Code also site L97.4-, L97.5-)*	YES	E11.621
skin ulcer *(Code also site L97.1-L98.49)*	YES	E11.622
other skin complication	YES	E11.628
Code if T2DM is not in control	YES	+E11.65
Diabetes in pregnancy - see ICD10 Category O24		

ALSO Assign Overweight/Obesity & BMI (adult) as indicated			RISK?	Code
Obesity, Class 1			*	**E66.811**
Overweight Code			YES	**E66.3**
BMI 25.0-25.9	+Z68.25	BMI 28.0-28.9		+Z68.28
BMI 26.0-26.9	+Z68.26	BMI 29.0-29.9		+Z68.29
BMI 27.0-27.9	+Z68.27	(See Peds Sheet for Ped BMI)		
Obesity, Class 2			*	**E66.812**
Obesity due to excess calories			YES	**E66.09**
BMI 30.0-30.9	+Z68.30	BMI 35.0-35.9		+Z68.35
BMI 31.0-31.9	+Z68.31	BMI 36.0-36.9		+Z68.36
BMI 32.0-32.9	+Z68.32	BMI 37.0-37.9		+Z68.37
BMI 33.0-33.9	+Z68.33	BMI 38.0-38.9		+Z68.38
BMI 34.0-34.9	+Z68.34	BMI 39.0-39.9		+Z68.39
Obesity, Class 3			*	**E66.813**
Morbid Obesity d/t excess calories			YES	**E66.01**
BMI 40.0 - 44.9			YES	+Z68.41
BMI 45.0 - 49.9			YES	+Z68.42
BMI 50.0 - 59.9			YES	+Z68.43
BMI 60.0 - 69.9			YES	+Z68.44
BMI 70 or greater			YES	+Z68.45
Genetic susceptibility to obesity			*	Z15.2
Status and History Codes				
Amputation, Below Knee, Left			YES	Z89.512
Amputation, Below Knee, Right			YES	Z89.511
Family history of diabetes			N/A	Z83.3
Family history of familial hypercholesterolemia			N/A	Z83.42
History of tobacco dependence			N/A	Z87.891
Underdosing of insulin and/or oral antidiabetic medications:				
Active Treatment Phase			N/A	T38.3X6A
Healing Phase			N/A	T38.3X6D
Sequela Event			N/A	T38.3X6S
ALSO code reason for Underdosing:				
Intentional d/t financial hardship				Z91.120
Intentional for other reasons				Z91.128
Unintentional d/t age-related disability				Z91.130
Unintentional d/t other reason				Z91.138

Additional Notes for Coding T2DM (Always refer to ICD-10-CM for Official Guidelines)

Coding for Diabetes can be complex, use as many codes from E08-E13 as needed to fully describe all complications related to diabetes, sequencing them according to the reason for the encounter. The hypoglycemia codes (E16.A1-E16.A3) may be used in conjunction with any form of diabetes with hypoglycemia (E08.64-, E09.64-, E10.64-, E11.64-, and/or E13.64-) to further specify the patient's condition.

Diagnosis codes are assigned base on the clinician's documentation that a condition exists. Code assignment does not require adherence to clinical criteria, only documentation in the encounter. In cases of conflicting documentation, query the clinician for clarification.

When a patient is treated with both oral hypoglycemics and insulin, assign **Z79.4 *and* Z79.84**

For patients treated with both insulin and injectable non-insulin drugs, assign **Z79.4 *and* Z79.85**

Tabular List. Per ICD guidelines, code these conditions as related even in the absence of clinician documentation that explicitly links them, *unless* documentation clearly states that the conditions are unrelated or when another guideline exists that specified a documented linkage between two conditions.

https://www.cdc.gov/nchs/icd/icd-10-cm/files.html?CDC_AAref_Val=https://www.cdc.gov/nchs/icd/Comprehensive-Listing-of-ICD-10-CM-Files.htm

DIABETES TYPE 1 (T1DM)

Diabetes without complications	Risk?	Type 1
DM controlled and without complications	*Yes*	E10.9
DM uncontrolled with hyperglycemia	*Yes*	E10.65
Hypoglycemia Level 1	·	✚E16.A1
Hypoglycemia Level 2	·	✚E16.A2
Hypoglycemia Level 3	·	✚E16.A3
Presymptomatic T1DM		**Type 1**
T1DM, Presymptomatic, unspecified	·	E10.A0
T1DM, Presymptomatic, stage 1	·	E10.A1
T1DM, Presymptomatic, stage 2	·	E10.A2
Diabetes with complications		**Type 1**
DM with complication of neurological system, specifically;		
polyneuropathy	*Yes*	E10.42
mononeuropathy	*Yes*	E10.41
gastroparesis (autonomic polyneuropathy)	*Yes*	E10.43
DM with neuropathic arthropathy	*Yes*	E10.610
DM with diabetic neuropathy, unspecified *(avoid)*	*Yes*	E10.40
If the DM is not in control assign *also*	*Yes*	**✚E10.65**
Diabetes with complication of circulatory system, specifically;		
DM with peripheral angiopathy, without gangrene	*Yes*	E10.51
DM with peripheral angiopathy, with gangrene	*Yes*	E10.52
DM with other circulatory complication	*Yes*	E10.59
If the DM is not in control assign *also*	*Yes*	**✚E10.65**
DM with diabetic nephropathy	*Yes*	E10.21
DM with diabetic CKD *code also CKD stage*	*Yes*	E10.22
CKD stage 1 GFR >90 (Glomerular Filtration Rate)		✚N18.1
CKD stage 2 GFR 60-89 (Mild)		✚N18.2
CKD stage 3 unspecified (Moderate)		✚N18.30
CKD stage 3a GFR 45-59 (Moderate)		✚N18.31
CKD stage 3b GFR 30-44 (Moderate)		✚N18.32
CKD stage 4 GFR 15-29 (Severe)	*Yes*	✚N18.4
CKD stage 5 GFR <15	*Yes*	✚N18.5
End Stage Renal Disease (ESRD)	*Yes*	✚N18.6
DM with complication of eyes, specifically;		**Type 1**
DM w/nonproliferative retinopathy w/o mac. edema	*Yes*	E10.329
with macular edema	*Yes*	E10.321
DM w/proliferative retinopathy *see choices* *(must have 6th & 7th characters to identify laterality)*	*Yes*	E11.351X- E11.359X
DM with diabetic cataract	*Yes*	E10.36
DM with other ophthalmic comp +add'l code for manifest	*Yes*	E10.39
If the DM is not in control assign *also*	*Yes*	**✚E10.65**

Miscellaneous Diagnoses	Risk?	Type 1
Prediabetes		R73.03
Lab Dx: Impaired fasting glucose		R73.01
Other abnormal glucose, not currently diabetic		R73.09
Hyperglycemia, unspecified		R73.9
Screening for diabetes mellitus		Z13.1
Lipoid Disorders: Pure hypercholesterolemia		E78.00
Familial hypercholesterolemia		E78.01
Hyperglyceridemia (very low density lipoid type)		E78.1
Mixed hyperlipidemia (combo of E78.0 & E78.1)		E78.2
Hyperlipidemia, unspecified *(avoid)*		E78.5
Noncompliance w/renal dialysis d/t financial hardship		Z91.151
Noncompliance w/renal dialysis for other reason		Z91.158
Caregiver's noncompliance w/dialysis d/t financial hardship		Z91.A51
Caregiver's noncompliance w/dialysis for other reason		Z91.A58
Signs/Symptom Codes		
Other visiual disturbances e.g. blurry vision		H53.8
Polydipsia Excessive thirst		R63.1
Polyphasia Excessive eating/appetite		R63.2
Polyuria Frequent urination Code 1st causal condition		R35.0
Anesthisa of skin Numbness in hands/feet		R20.0
Other Polyuria		R35.8
Paresthesia of skin Tingling in hands/feet		R20.2
Abnormal Weight loss		R63.4
Other complications		**Type 1**
DM with other arthropathy	*Yes*	E10.618
dermatitis	*Yes*	E10.620
foot ulcer *(Code also site L97.4-, L97.5-)*	*Yes*	E10.621
skin ulcer *(Code also site L97.1-L98.49)*	*Yes*	E10.622
other skin complication	*Yes*	E10.628
DM with hypoglycemia, without coma	*Yes*	E10.649
hypoglycemia, with coma	*Yes*	E10.641
DM with ketoacidosis, without coma	*Yes*	E10.10
ketoacidosis, with coma	*Yes*	E10.11
If DM is not in control assign *also*	*Yes*	**✚E10.65**

See Diabetes in pregnancy ICD10 Category O24 on pg. 9

Underdosing of insulin and/or oral antidiabetic medications: T38.3X6- 7th character considerations: Replace "-" with: A = Active treatment phase, D = Healing phase, S = Sequela

Also code reason for Underdosing: Intentional d/t financial hardship Z91.120; Intentional for other reason Z91.128, Unintentional d/t age-related disability Z91.130; Unintentional d/t other reason Z91.138

ICD10 Guidelines instruct to report all conditions that require or impact care today. See pg 25 for **SDOH** impacting care: ie, homelessness

HYPERTENSION, HEART DISEASE, AND RENAL DISEASE

I10 Hypertension without HD or CKD	Risk?	Code	Elevated blood pressure *(not hypertension)*	Risk?	Code
I10 Hypertension (HTN), essential hypertension		I10	Elevated blood pressure		R03.0

I11 Hypertensive Heart Disease (HHD)

When HTN & HD exist together, use HHD codes below & I50 code if heart failure exists

Hypertensive Heart Disease incudes: Heart Failure (I50.-), Myocarditis (I51.4), Myocardial degeneration (I51.5), Cardiomegaly (I51.7), Other ill-defined heart disease, e.g. Carditis, Pancarditis (I51.89),Takotsubo syndrome (I51.81) or Unspecified heart disease (I51.9).

Description	Risk?	Code	Description	Risk?	Code
HHD **with** heart failure (HF) *Code also HF fror*	*Yes*	I11.0	HHD **without** heart failure (HF)		I11.9
Heart Failure (I50) Specificity Options					
Left heart failure, CHF and Other heart failure			***Right heart failure***		
Left heart failure	*Yes*	I50.1	Right heart failure, unspecified	*Yes*	I50.810
End stage heart failure *(Code also heart failure, I50.2-*		I50.84	Acute right heart failure	*Yes*	I50.811
Other heart failure	*Yes*	I50.89	Chronic right heart failure	*Yes*	I50.812
Biventricular heart failure	*Yes*	I50.82	Acute on chronic right heart failure	*Yes*	I50.813
High output heart failure	*Yes*	I50.83	Right heart failure due to left heart failure	*Yes*	I50.814
Congestive heart failure *(CHF, unspecified*	*Yes*	I50.9			
Diastolic heart failure			***Systolic heart failure***		
Chronic diastolic heart failure	*Yes*	I50.32	Chronic systolic heart failure	*Yes*	I50.22
Acute diastolic heart failure	*Yes*	I50.31	Acute systolic heart failure	*Yes*	I50.21
Acute on chronic diastolic heart failure	*Yes*	I50.33	Acute on chronic systolic heart failure	*Yes*	I50.23
Combined systolic and diastolic					
Chronic systolic and diastolic heart failure	*Yes*	I50.42	Acute systolic and diastolic heart failure	*Yes*	I50.41
Acute on chronic systolic & diastolic heart	*Yes*	I50.43			

I12 Hypertensive Chronic Kidney Disease (HCKD)

When HTN & CKD exist together, use HCKD codes below & N18 code

Description	Risk?	Code	Description	Risk?	Code
HCKD w/stage 1-4 CKD or stage unspecified		I12.9	HCKD with stage 5 CKD or end stage (ESRD)	*Yes*	I12.0
N18 Chronic Kidney Disease-*Report stage w/HCKD above. Note: GFRs per National Kidney Foundation, 2017.*					
CKD stage 1 *GFR 90 or higher (Glomerular Filt*		N18.1	CKD stage 4 *GFR 15-29*	*Yes*	N18.4
CKD stage 2 *GFR 60-89*		N18.2	CKD stage 5 *GFR <15*	*Yes*	N18.5
CKD stage 3 unspecified		N18.30	End stage renal disease (ESRD)	*Yes*	N18.6
CKD stage 3a GFR 45-59		N18.31	CKD w/o stage documented in medical record *(avoid)*		N18.9
CKD stage 3b GFR 30-44		N18.32	Dependence on renal dialysis	*Yes*	Z99.2

I13 Hypertensive Heart Disease (HHD) and Chronic Kidney Disease (HCKD)

(1) When HTN, HD & CKD exist together, use appropriate code I13 below (2) Report also the stage of CKD from above.
(3) If heart failure exists, report the type of failure from I50 above.

HHD w/CKD, stage 1-4 or undoc., code I13, If HF add I50 code.	Risk?	Code	***HHD with CKD, stage 5 or ESRD, code I13, if HF add I50 code.***	Risk?	Code
with heart failure *(code also the failure fr*	*Yes*	I13.0	w/heart failure *(code also the failure from I50)*		I13.2
without heart failure		I13.10	without heart failure	*Yes*	I13.11

Additional Hypertension Specifiers

These codes are intended to be reported in addition to the code for the type of existing hypertension in order to provide greater detail.

Description	Code	Description	Code
Resistant hypertension*	**I1A.0**	***New code effective 10/01/23**	
Hypertensive urgency	I16.0	Hypertensive emergency	I16.1

Underdosing of Antihypertensive Drugs

(common drugs listed below, check a current code book for other choices)

In ICD10CM, Underdosing refers to taking less of a medication than is prescribed by a provider or manufacturer's instruction. Discontinuing the use of a RX on the patient's own initiative...is also classified as underdosing.

Description	Code	Description	Code
ACE Inhibitors (e.g. Lisinopril, Lotensin, Zester	T46.4x6-	Beta Blockers (e.g. Lopressor, Atenolol, Meto	T44.7x6-
Diuretics/thiazides (e.g. HCTZ)	T50.2x6-	Calcium Channel Blocker (e.g. Cardizem, Proc	T46.1x6-

th character code, replace "-" with A, D or S: A = initial (active treatment phase) or D = Subsequent (healing phase) or S = Seque

Also code reason for underdosing:

Description	Code	Description	Code
Intentional underdosing due to financial hardship	Z91.120	Intentional underdosing for other reason	Z91.128
Unintentional underdosing due to age-related debilit	Z91.130	Unintentional underdosing for other reason	Z91.138

Report Nicotine influence with hypertension: ie, Current cigarette smoker F17.210. See page 18 for other nicotine coding options.

Cardiovascular Conditions

Abnormal Findings	Risk?	Code
Nonspecific low blood pressure (if hypotension dx - see I95.X		R03.1
Elevated BP reading, w/o diagnosis of HTN		R03.0
Abnormal cardiovascular function study		R94.39
Other nonspecific, abnormal finding lung field		R91.8
Abnormal chest sounds (friction, rales)		R09.89
Abnormal echocardiogram		R93.1
Abnormal EKG *(if long QT syndrome, I45.81)*		R94.31
Abnormal serum enzymes (acid/alk phos, amylase, lipa		R74.8
Abnormal coagulation profile (PT/PTT, bleeding)		R79.1
Abnormal blood gas		R79.81
Angina		
Unspecified angina or ischemic chest pain	*Yes*	I20.9
Prinzmetal, angiospastic angina (w/documented sp	*Yes*	I20.1
Stable angina		I20.89
Unstable angina/Intermediate coronary sync	*Yes*	I20.0
Coronary Atherosclerosis (CAD)		
of native coronary artery, without angina pector		I25.10
with unstable angina pectoris	*Yes*	I25.110
with other forms of angina pectoris	*Yes*	I25.118
with unspecified angina pectoris	*Yes*	I25.119
of coronary artery bypass graft (NOS) w/o angin		I25.810
autologous artery coronary artery bypass graft(s		
with unstable angina pectoris	*Yes*	I25.720
with other forms of angina pectoris	*Yes*	I25.728
Chronic total occlusion of coronary artery *(Code first I25.1-, I25.7-, I25.81-)*		I25.82
Lipoid Disorders		
Dyslipidemia / Hyperlipidemia unspecified		E78.5
Pure Hypercholesterolemia		E78.00
Familial hypercholesterolemia		E78.01
Pure hyperglyceridemia		E78.1
Mixed hyperlipidemia		E78.2
Myocardial Infarction - *Basic codes, more choices…*		
MI, acute, STEMI unspec *(acute ≤ 28 days from epi*	*Yes*	I21.3
MI, acute, NSTEMI	*Yes*	I21.4
MI, acute, STEMI unsp *(subsequent ≤ 28 days fr*	*Yes*	I22.9
MI old, by EKG/Hx, no problem now		I25.2
Screening for		
Lipids		Z13.220
Anemia		Z13.0
Cardiovascular disorder		Z13.6
Hypertension		Z13.6
Ischemic heart condition		Z13.6
Anticoagulation Medication Management		
Therapeutic drug monitoring (#1 for PT/INRs)		Z51.81
Long term (current) use of anticoagulants		Z79.01
Family History of		
Family history of ischemic heart disease		Z82.49
Family history of sudden cardiac death		Z82.41
Family history of other cardiovascular condition:		Z82.49

ICD10 Guidelines instruct to report all conditions that require or impact care today. See pg 25 for SDOH impacting care: ie, homelessness

Conduction/Rhythm Disorders	Risk?	Code
Atrial fibrillation, longstanding persistent	*Yes*	I48.11
Atrial fibrillation, other persistent	*Yes*	I48.19
Atrial fibrillation, chronic, unspecified	*Yes*	I48.20
Atrial fibrillation, permanent	*Yes*	I48.21
Atrial fibrillation, paroxysmal	*Yes*	I48.0
Atrial flutter, typical (Type 1)	*Yes*	I48.3
Atrial flutter, atypical (Type II)	*Yes*	I48.4
Atrial flutter, unspecified	*Yes*	I48.92
Cardiac/Circulatory Signs and Symptoms		
Bradycardia (add code if Adverse Effect due to drug)		R00.1
Chest discomfort/chest pain		R07.89
Intercostal pain		R07.82
painful respiration		R07.1
Cough, chronic *(Smoker's cough J41.0, Hemoptysis R04*		R05.3
Debility, age related physical debility		R54
Dizziness, light-headedness		R42
Dyspnea, unspecified *(SOB R06.02)*		R06.00
Mouth breathing		R06.5
Wheezing		R06.2
Stridor		R06.1
Edema, unspecified		R60.9
Generalized edema		R60.1
Localized edema		R60.0
Falls, repeated, Tendency to fall		R29.6
Fluid overload, unspecified *(Fluid retention, R60.9)*		E87.70
Heart murmur, unspecified		R01.1
Benign, functional, innocent cardiac murmurs		R01.0
Weakness		R53.1
Other fatigue *(Chronic fatigue R53.82)*		R53.83
Other malaise (includes chronic debility)		R53.81
Nausea		R11.0
Nausea w/vomiting		R11.2
Vomiting w/o nausea		R11.11
Palpitations		R00.2
Shortness of breath		R06.02
Sleep apnea, unspecified		G47.30
Syncope		R55
Tachycardia		R00.0
Personal History of		
Cardiac pacemaker in situ		Z95.0
CABG		Z95.1
Heart valve replacement (mechanical)		Z95.2
Heart valve replacement (tissue)		Z95.3
PCI (angioplasty w/ implant/graft)		Z95.5
Cardiac defibrillator in situ		Z95.810
Coronary angioplasty status		Z98.61
CVA/TIA		Z86.73
DVT		Z86.718
Corrected congenital malformation heart/circ system		Z87.74
Pulmonary embolism		Z86.711
Sudden cardiac arrest		Z86.74
Surgery to heart and great vessels		Z98.890

Report **Nicotine influence** w/ CV conditions: ie, Current cigarette smoker F17.210. See page 18 for other nicotine options.

PREVENTIVE SERVICES

Typical Preventive Exams	Code
General adult med exam *(Annual Exam)*	Z00.00
without abnormal findings	
with abnormal findings	Z00.01
code also the abnormal finding	*code also*
Completed Pap with above, code also	Z12.4
Routine "GYN only" exam *(with/wo Pap)*	Z01.419
without abnormal findings	
with abnormal findings	Z01.411
code also the abnormal finding	*code also*
WCC *without* abnormal findings	Z00.129
WCC *with* abnormal findings	Z00.121
code also the abnormal finding	*code also*
Newborn Ck, 1-7 days old *(e.g., wt/color)*	Z00.110
if abnormalities, assign additional code(s)	*code also*
Newborn Ck, 8-28 days old *(e.g., wt/color)*	Z00.111
if abnormalities, assign additional code(s)	*code also*
Special Reasons Dx Codes	
Sports	Z02.5
Immigration, naturalization	Z02.89
School admission	Z02.0
Pre-employment	Z02.1
Recruitment to armed forces	Z02.3
Issue of other med certificate	Z02.79
Paternity	Z02.81
Adoption	Z02.82
Blood-alcohol & blood-drug	Z02.83
Child welfare exam	Z02.84
Medicare Preventive Visit and Service Diagnoses	
Welcome to MCare Visit	Z00.00
Medicare Annual Wellness Visit	
Obesity counseling *(Code also obesity & BMI)*	Z71.3
Screening; mammogram for breast CA	Z12.31
cardiovascular disorder	Z13.6
diabetes	Z13.1
eye and/or ear disorder	Z13.5
HIV	Z11.4
HPV	Z11.51
sexually transmitted infection	Z11.3
prostate malignancy (could be exam or PSA)	Z12.5
Special Exams: Eyes/Vision and Ears/Hearing	
Eyes/vision, w/o abnormal findings	Z01.00
with abnormal findings (code findings)	Z01.01
follow failed screen w/o abnormal findings	Z01.020
follow failed screen w/abnormal findings (code findings)	Z01.021
Screening for glaucoma	Z13.5
Ears/hearing, without abnormal findings	Z01.10
with other abnormal finding (code findings)	Z01.118
following failed hearing screen	Z01.110
Immunization Dxs	
One Dx code for any number of Immunizations.	Z23
Underimmunized *(as a diagnosis)*	Z28.3

Screening for Developmental Disorders in Childhood	
autism	Z13.41
for global developmental delays (milestones)	Z13.42
for other developmental delays	Z13.49
Screening for Mental Health and Behavioral Disorders	
depression	Z13.31
maternal depression	Z13.32
other mental health and behavioral disorders	Z13.39
Other Screening Studies	
Pregnancy test today - negative	Z32.02
Positive results today	Z32.01
Results cannot be confirmed today	Z32.00
Anemia (iron deficient)	Z13.0
Cardiovascular disorders	Z13.6
Developmental disorders in childhood, unspec.	Z13.40
Diabetes	Z13.1
Poisoning (chemical / heavy metal-lead)	Z13.88
HIV	Z11.4
Lipoid disorders	Z13.220
Osteoporosis	Z13.820
Routine cervical Pap smear	Z12.4
Respiratory TB	Z11.1
Latent TB	Z11.7
Sexually Transmitted Infection	Z11.3
Thyroid disorders	Z13.29
Prophylaxis	
Encounter for HIV pre-exposure prophylaxis	Z29.81
other specified pre-exposure prophylaxi	Z29.89
Personal History of Cancer	
Breast	Z85.3
Cervix uteri	Z85.41
Other parts of uterus	Z85.42
Colon	Z85.038
Prostate	Z85.46
Bladder	Z85.51
Family History of	
Breast cancer	Z80.3
Colon cancer	Z80.0
Colonic polyps, hyperplastic	Z83.711
Diabetes	Z83.3
Cardiovascular disease	Z82.49
Screening Dx's: Paps	
Routine cervical pap smear	Z12.4
Mcare screening pap; cervical; low risk, q2 yrs	
high risk, q1yr *(code also - spec risk factors Z91.89)*	
vaginal *(if applicable code also - absence of uterus)*	Z12.72
Pap to confirm normal after abnormal	Z01.42
Female Screening - Miscellaneous	
Breast - ordering mammogram today	Z12.31
Chlamydial infection screening	Z11.8
HPV Human papilloma virus	Z11.51
High risk sexual behavior (heterosexual)	Z72.51

PREVENTIVE SERVICES

Counseling For *(as a diagnosis)*	
Diet (Add code: BMI, underlying condition)	Z71.3
Exercise	Z71.82
Injury prevention	Z71.89
Drug abuse counseling (Type: F11-F16, F18-F19)	Z71.51
Alcohol abuse counseling	Z71.41
Health related to travel	Z71.84
See FP pg10 for contraception management codes	
Report all conditions that require or impact care today. See pg 25 for SDOH impacting care: ie, homelessness	

Vaccine not given today because:	
Acute illness	Z28.01
Chronic illness/condition	Z28.02
Immune compromised state	Z28.03
Allergy to vaccine or component	Z28.04
Other contraindication	Z28.09
Patient's belief or group pressure	Z28.1
Patient's refusal	Z28.21
Caregiver refusal	Z28.82
Patient had the disease	Z28.81

WEIGHT MANAGEMENT

Weight Dx (Adult/Child) *Code also, Adult or Peds BMI*				**Code**
Abnormal weight gain				R63.5
Obesity complicating pregnancy				O99.21-
Drug-induced obesity				E66.1
Obesity, Class 1			*	**E66.811**
Overweight Code			YES	**E66.3**
Code also ADULT BMI from below or PED BMI from right				
BMI 25.0-25.9	+Z68.25	BMI 28.0-28.9		+Z68.28
BMI 26.0-26.9	+Z68.26	BMI 29.0-29.9		+Z68.29
BMI 27.0-27.9	+Z68.27	(See Peds Sheet for Ped BMI)		
Obesity, Class 2			*	**E66.812**
Obesity due to excess calories			YES	**E66.09**
Other Obesity				E66.8
Code also ADULT BMI from below or PED BMI from right				
BMI 30.0-30.9	+Z68.30	BMI 35.0-35.9		+Z68.35
BMI 31.0-31.9	+Z68.31	BMI 36.0-36.9		+Z68.36
BMI 32.0-32.9	+Z68.32	BMI 37.0-37.9		+Z68.37
BMI 33.0-33.9	+Z68.33	BMI 38.0-38.9		+Z68.38
BMI 34.0-34.9	+Z68.34	BMI 39.0-39.9		+Z68.39
Obesity, Class 3			*	**E66.813**
Morbid Obesity d/t excess calories			YES	**E66.01**
Code also ADULT morbid obesity BMI from below				
BMI 40.0 - 44.9			YES	+Z68.41
BMI 45.0 - 49.9			YES	+Z68.42
BMI 50.0 - 59.9			YES	+Z68.43
BMI 60.0 - 69.9			YES	+Z68.44
BMI 70 or greater			YES	+Z68.45
Genetic susceptibility to obesity			*	Z15.2
Underweight				**R63.6**
BMI of 19.9 or less, adult				Z68.1
Malnutrition				**E40-E46**
Unspecified protein-calorie malnutrition				E46
Malnutrition; Protein-calorie, mild				E44.1
Malnutrition; Protein-calorie, moderate				E44.0
Malnutrition; Protein-calorie, severe				E43
Nutritional marasmus *(severe)*				E41
Kwashiorkor *(rare in US)*				E40

Pediatric BMI *Code type from the left & BMI from the right.*			**Code**
Overweight	E66.3	85th to < 95th % for age	Z68.53
Obese	E66.9	= / > 95th % for age	Z68.54
Underweight	R63.6	< 5th % for age	Z68.51

Underweight Conditions (code also BMI)	
Abnormal weight loss	R63.4
Failure to thrive, child	R62.51
Failure to thrive, adult	R62.7
Physical growth retardation	R62.52
due to malnutrition	E45
Anorexia (*appetite loss, excludes anorexia nervosa F50.*	R63.0
Other Miscellaneous Dx	
Inappropriate diet/eating habits	Z72.4
Inadequate diet *causing nutritional deficiency*	E63.9
Polyphagia (excessive eating)	R63.2
Here to discuss test findings	Z71.2
Dietary counseling and surveillance Use additional code for associated condition	Z71.3
Lack of physical exercise	Z72.3
Worried well *(concerns, but no problem)*	Z71.1
Deficiencies, Vitamins	
Vitamin A	E50.-
Thiamine	E51.-
Niacin	E52
Folate (folic acid) or Vitamin B12	E53.8
Vitamin C	E54
Vitamin D	E55.9
Vitamin E	E56.0
Vitamin K	E56.1
Deficiencies, Elements	
Calcium	E58
Zinc	E60
Other	E61.-
Starvation	
Initial visit	T73.0xxA
FU visit	T73.0xxD
Visit for sequela *(code also the condition)*	T73.0xxS

PREGNANCY

Supervision Normal Pregnancy

Assign ***Supervision Normal Pregnancy*** if no complications or risk factors exist. Z34 codes **may not** be reported with other pregnancy codes.

	Root Code	*		
First normal pregnancy	Z34.0*	1	2	3
Subsequent normal pregnancy	Z34.8*	1	2	3
Routine postpartum follow-up visit	Z39.2			
Pregnancy state, incidental	Z33.1			

Assign gestational weeks for all visits

Weeks	Code	Weeks	Code
<8 weeks	Z3A.01	26 weeks	Z3A.26
8 weeks	Z3A.08	27 weeks	Z3A.27
9 weeks	Z3A.09	28 weeks	Z3A.28
10 weeks	Z3A.10	29 weeks	Z3A.29
11 weeks	Z3A.11	30 weeks	Z3A.30
12 weeks	Z3A.12	31 weeks	Z3A.31
13 weeks	Z3A.13	32 weeks	Z3A.32
14 weeks	Z3A.14	33 weeks	Z3A.33
15 weeks	Z3A.15	34 weeks	Z3A.34
16 weeks	Z3A.16	35 weeks	Z3A.35
17 weeks	Z3A.17	36 weeks	Z3A.36
18 weeks	Z3A.18	37 weeks	Z3A.37
19 weeks	Z3A.19	38 weeks	Z3A.38
20 weeks	Z3A.20	39 weeks	Z3A.39
21 weeks	Z3A.21	40 weeks	Z3A.40
22 weeks	Z3A.22	41 weeks	Z3A.41
23 weeks	Z3A.23	42 weeks	Z3A.42
24 weeks	Z3A.24	> 42 weeks	Z3A.49
25 weeks	Z3A.25	Unspecified	Z3A.00

Supervision of High Risk Pregnancy

Assign High Risk Pregnancy codes when:

(1) Patient had a problem in previous pregnancy or,
(2) has had a condition that may complicate this pregnancy or,
(3) has other factors that increase risk in current pregnancy.
* May code high risk w/O00-O08, but not for same condition.
* Do not code high risk O09.xx codes with Z34.xx codes.

➡ ***Replace the * with trimester 1, 2 or 3***	Root Code	*		
High risk due to; insufficient antenatal care	O09.3*	1	2	3
history of pre-term labor	O09.21*	1	2	3
history of infertility	O09.0*	1	2	3
history of ectopic pregnancy	O09.1*	1	2	3
history of molar pregnancy	O09.A*	1	2	3
current social problems;	O09.7*	1	2	3
elderly primigravida age =/> 35@ delivery	O09.51*	1	2	3
elderly multigravada age =/> 35 @ delivery	O09.52*	1	2	3
young primigravida age< 16 @ delivery	O09.61*	1	2	3
young multigravada age< 16 @ delivery	O09.62*	1	2	3
poor OB Hx, or poor reproductive Hx	O09.29*	1	2	3
other documented reason for high risk	O09.89*	1	2	3

Complications of Pregnancy

	Root Code			
Anemia *Assign also code for type of anemia*	O99.01*	1	2	3
UTI in pregnancy	O23.4*	1	2	3
Bladder infection during pregnancy	O23.1*	1	2	3
Kidney infection during pregnancy	O23.0*	1	2	3
Vomiting, mild, before end of 20 weeks	O21.0			
Vomiting after 20 weeks *(excessive vomiting)*	O21.2			

Obesity, Weight & Malnutrition

	Root Code			
Obesity *Also report specific type of obesity E66.-*	O99.21*	1	2	3
Weight gain, excessive	O26.0*	1	2	3
Weight gain, low/inadequate	O26.1*	1	2	3
Malnutrition in pregnancy	O25.1*	1	2	3

More Complications of Pregnancy

Bleeding, TA, Preterm & Post Dates	Root Code	*		
Spotting, *Not hemorrhage*	O26.85*	1	2	3
Hemorrhage (other) in early pregnancy	O20.8			
Threatened abortion	O20.0			
Preterm labor without delivery	O60.0*		2	3
False labor before 37 weeks	O47.0*		2	3
Post term pregnancy >40 wks to 42 wks	O48.0			
beyond 42 weeks	O48.1			
Other Complications				
Miscarriage/SAB w/o comp; Incomplete	O03.4			
Miscarriage/SAB w/o comp; Complete	O03.9			
Missed abortion	O02.1			
Placenta previa w/o hemorrhage	O44.0*	1	2	3
Placenta previa with hemorrhage	O44.1*	1	2	3
HTN, pre-existing	O10.01*	1	2	3
HTN, gestational w/o significant proteinuria	O13.*	1	2	3
Pre-eclampsia, mild to moderate	O14.0*		2	3
Pre-eclampsia, severe	O14.1*		2	3
HELLP syndrome	O14.2*		2	3
Eclampsia	O15.0*		2	3
Edema, Gestational	O12.0*	1	2	3
Proteinuria, Gestational	O12.1*	1	2	3
Edema & proteinuria, Gestational	O12.2*	1	2	3
Abnormal glucose or GTT in pregnancy	O99.810			
GBS carrier in pregnancy	O99.820			
Uterine size date discrepancy	O26.84*	1	2	3
Pre-existing Diabetes				
DM2, pre-existing	O24.11*	1	2	3
DM2, pre-existing, postpartum/puerperium	O24.13			
Add code for all DM2's on insulin *HCC*	Z79.4			
DM1, pre-existing	O24.01*	1	2	3
DM1, pre-existing, postpartum/puerperium	O24.03			
Gestational Diabetes				
diet controlled, antepartum	O24.410			
insulin controlled, antepartum	O24.414			
oral hypoglycemic controlled, antepartum	O24.415			
diet controlled, puerperium	O24.430			
insulin controlled, puerperium	O24.434			
oral hypoglycemic controlled, puerperium	O24.435			
History of Gestational Diabetes	**Z86.32**			
Smoking *Assign also F17.- code below to identify type of nicotine*				
Smoking tobacco, antepartum	O99.33*	1	2	3
Smoking tobacco, puerperium	O99.335			
Alcohol & Drug Use *Assign also codes re: abuse/dependence*				
Alcohol use in pregnancy *Assign also F10 -*	O99.31*	1	2	3
Drug use in pregnancy *Assign F11-F19 code*	O99.32*	1	2	3
Mental Disorders				
Assign this code plus a code for the specific condition. See F20-F99.	O99.34*	1	2	3
Anxiety, generalized	F41.1			
Bipolar, unspec (more options avail.) *HCC*	F31.9			

Report **Nicotine influence** with pregnancy: ie, Current cigarette smoker F17.210. See section I.C.15.l.2 of ICD-10-CM Guidelines for further notes.

Report all conditions that require or impact care today. See pg 25 for SDOH impacting care: ie, homelessness

FAMILY PLANNING AND STIs

Family Planning/Contraception	Code
INITIAL CONTRACEPTION - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.011
Injectable contraceptive	Z30.013
IUD prescribed but no insertion today	Z30.014
IUD insertion today	Z30.430
Vaginal ring hormone	Z30.015
Transdermal patch hormone	Z30.016
Implantable subdermal	Z30.017
Other method (other than above; e.g. Condoms)	Z30.018
EC Emergency contraception	Z30.012
Follow-Up Contraception - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.41
Injectable contraceptive	Z30.42
IUD: insertion today	Z30.430
Interim **Follow-up**/Routine checking	Z30.431
Removal of IUD only today	Z30.432
Removal and reinsertion of IUD	Z30.433
Vaginal ring hormone	Z30.44
Transdermal patch hormone	Z30.45
Implantable subdermal	Z30.46
Other method (other than above; e.g. Condoms)	Z30.49
EC Emergency contraception	Z30.012
Preventive Examinations	
ANNUAL, COMPLETE: *no abnormal findings*	Z00.00
with abnormal findings today, *(code also)*	Z00.01
If cervical pap today, code also	Z12.4
GYN EX ONLY: *no abnormal findings*	Z01.419
with abnormal findings today, *(code also)*	Z01.411
Screening (Patient w/o signs/symptoms)	
Pregnancy test today - negative	Z32.02
Positive results today	Z32.01
Results cannot be confirmed today	Z32.00
Anemia, iron deficiency	Z13.0
Breast cancer screening exam only today	Z12.39
Breast - ordering mammogram today	Z12.31
Chlamydial infection screening	Z11.8
HIV (screening for)	Z11.4
HPV (screening for)	Z11.51
Screening Other STD/STI	Z11.3
Urinary Concerns	
Cystitis, acute w/o hematuria	N30.00
with hematuria	N30.01
Dysuria	R30.0
Hematuria, gross	R31.0
Hematuria, microscopic - benign	R31.1
Asymptomatic microscopic hematuria	R31.21
Other microscopic hematuria	R31.29
Stress incontinence, female	N39.3
Urethritis, unspecified	N34.1
Urinary frequency	R35.0
Urinary hesitancy	R39.11
Urinary straining	R39.16
Urinary urgency	R39.15
UTI (urinary tract infection) *(ID organism)*	N39.0

Female GYN Signs/Symptoms	Code
Amenorrhea, unspecified	N91.2
Cervicitis, unspecified organism	N72
DUB, unspecified	N93.8
Dysmenorrhea *cramps/pain*	N94.6
Dyspareunia, superficial *painful intercourse*	N94.11
Dyspareunia, deep	N94.12
Dypareunia, other specified	N94.19
Irregular menstrual cycle	N92.6
Leukorrhea *DC not confirmed infection*	N89.8
Menorrhagia	N92.0
Metrorrhagia / *break through bleed*	N92.1
Oligomenorrhea *infrequent/light*	N91.5
Pain, abdominal generalized	R10.84
Pain, pelvic	R10.2
Premenstrual tension syndrome	N94.3
Vaginal discharge	N89.8
Vaginitis, bacterial *Organism known? See ICD10*	N76.0
Vaginitis, yeast, acute *Candidiasis*	B37.31
Vaginitis, acute *Organism known? see ICD10*	N76.0
Lesions	
Herpetic ulceration vulva	A60.04
Warts, anogenital (veneral) *C. acuminatum*	A63.0
Conditions Reserved for Males	
Painful coitus or ejaculation, male	N53.12
Benign cyst of testis	N44.2
Erectile dysfunction, organic	N52.9
Hematospermia	R36.1
Herpesviral infection: penis	A60.01
Balanitis (*Add Code - infectious agent: B95-B97)*	N48.1
Orchitis	N45.2
Epididymitis	N45.1
Epididymo-orchitis	N45.3
Penile discharge	R36.9
Prostatitis, acute	N41.0
Stress incontinence, male	N39.3
Varicocele of scrotum	I86.1
Uretheritis, nonspecific	N34.1
Syphilis	
Primary, genital	A51.0
Primary, anal	A51.1
Primary, other sites	A51.2
Infections- By Organism & Anatomy	
Candidiasis, acute vulvovaginitis or thrush Female	B37.31
Cystitis and urethritis Female/Male	B37.41
Chlamydial Infection, vulvovaginitis FE	A56.02
Cystitis and urethritis FE/M	A56.01
Cervicitis FE	A56.09
Anus and rectum FE/M	A56.3
Lower GU tract, anatomy unspecified FE/M	A56.00
Other chlamydial infect. (eg, epididymitis/orchitis)	A56.19
Gonorrheal Infection, vulvovaginitis	A54.02
Cystitis and urethritis Female/Male	A54.01
Cervicitis FE	A54.03
Anus FE/M	A54.6
Lower GU tract, anatomy unspecified FE/M	A54.00

FAMILY PLANNING AND STIs

Infections- By Organism & Anatomy - Cont.		Code
Herpesviral, anogenital [h simplex] vaginitis I		A60.04
Cervicitis FE		A60.03
Perianal skin and rectum FE/M		A60.1
Penis M		A60.01
Male genital organs, other than penis M		A60.02
Herpes, urogenic, unspecified FE/M		A60.00
Hepatitis A, acute		B15.9
Hepatitis B, acute		B16.9
Hepatitis C, chronic	*HCC*	B18.2
HIV *positive & asymptomatic* *(not AIDS)*	*HCC*	Z21
HIV/AIDS	*HCC*	B20
HPV, *Human papillomavirus*		A63.0
Trichomoniasis Infection, vulvovaginitis FE		A59.01
Cystitis and urethritis FE/M		A59.03
Cervicitis FE		A59.09
PID, acute *pelvic inflammatory disease*		N73.0
PID, chronic		N73.1
Counseling		
Counseling re: STI/STD		Z71.89
Counseling re: HIV *negative or positive*		Z71.7
Exposure as a Dx		
Infection, primarily sexual transmission		Z20.2
HIV, *exposure to*		Z20.6
History Of		
Personal hx of infection (e.g., STD)		Z86.19
Procreation Dx		
Procreative counseling		Z31.69
using natural family planning		Z31.61
Infertility, female NOS		N97.9
Infertility, male NOS		N46.9

Report all conditions that require or impact care today. See pg 25 for SDOH impacting care: ie, homelessness

Risk Issues *(carrier/suspected carrier)*		Code
GC carrier or suspected carrier		Z22.4
STI/STD carrier/suspected carrier		Z22.4
Hepatitis B, chronic, viral; carrier	*HCC*	B18.1
Hepatitis C, chronic, viral;carrier	*HCC*	B18.2
High risk sexual behavior		
Heterosexual		Z72.51
Bisexual		Z72.53
Homosexual		Z72.52
Physical Abuse Dx Codes		
Replace dash (-) with; A = initial (active tx); D = FU (healing); or S = sequela		
Suspected abuse; physical abuse of an adult		T76.11x-
sexual abuse of adult		T76.21x-
physical abuse of a child		T76.12x-
sexual abuse of a child		T76.22x-
Confirmed abuse; physical abuse of adult		T74.11x-
sexual abuse of adult		T74.21x-
physical abuse of a child		T74.12x-
sexual abuse of a child		T74.22x-
Abuse (physical) of adult has now been ruled-out		Z04.71
Abuse (physical) of child has now been ruled-out		Z04.72
Underdosing of Prescribed Medication by Patient		
Code first, underdosing of medication (T36-T50) with fifth or sixth character of "6", then code intent and reason (below)		
Replace dash (-) with; A = initial (active tx); D = FU (healing); or S = sequela		
1. Underdosing, oral contraceptives		T38.4x6-
2. Then code also intent and reason from below.		
INTENTIONAL underdosing of med(s) by patie		
due to financial hardship		Z91.120
for any other reason		Z91.128
UNINTENTIONAL underdosing of med(s) by pt		
due to age-related debility		Z91.130
for any other reason		Z91.138

PEDIATRIC CONDITIONS

Preventive Visits *(Primary-only dxs)*	Code
Routine infant or child check	Z00.129
with abnormal findings *(code findings)*	Z00.121
Newborn < 8 days old *(e.g., weight/color che*	Z00.110
8-28 days old	Z00.111
Exam of the ears and hearing *(normal exam)*	Z01.10
following failed hearing screening	Z01.110
with other abnormal findings *(code finding*	Z01.118
Exam of the eyes/vision *(normal exam)*	Z01.00
with abnormal findings *(code findings)*	Z01.01
Sports physical	Z02.5
Adoption exam	Z02.82
Child welfare exam	Z02.84
Screenings	
Screening; unspecified developmental delays	Z13.40
autism	Z13.41
for global developmental delays (milestones)	Z13.42
Immunizations	
Encounter for immunizations	Z23
Immunization not carried; caregiver refusal	Z28.82
Encounter for prophylactic immunotherapy fc	Z29.11
Otitis and Other Ear Infections	
OM, nonsuppurative, serous & acute; RIGHT	H65.01
left ear	H65.02
bilateral	H65.03
recurrent right ear	H65.04
recurrent left ear	H65.05
recurrent bilateral	H65.06
OM, nonsuppurative, serous & CHRONIC; RIGHT	H65.21
left ear	H65.22
bilateral	H65.23
OM, suppurative & acute & TM intact RIGHT	H66.001
left ear	H66.002
bilateral	H66.003
recurrent right ear	H66.004
recurrent left ear	H66.005
recurrent bilateral	H66.006
OM, suppurative & acute TM rupture, RIGHT	H66.011
left ear	H66.012
bilateral	H66.013
recurrent right ear	H66.014
recurrent left ear	H66.015
recurrent bilateral	H66.016
OM, suppurative, tubotympanic, chronic, RIGHT	H66.11
left ear	H66.12
bilateral	H66.13
Otitis externa, acute Right ear	H60.501
left ear	H60.502
bilateral	H60.503
Otitis externa, chronic Right ear	H60.61
left ear	H60.62
bilateral	H60.63

ADHD	Code
predominately inattentive type	F90.0
predominately hyperactive type	F90.1
combined	F90.2
Asthma	**Code**
Asthma, mild & intermittent	
uncomplicated	J45.20
with acute exacerbation	J45.21
with status asthmaticus	J45.22
Asthma, mild & persistent	
uncomplicated	J45.30
w/acute exacerbation	J45.31
with status asthmaticus	J45.32
Asthma, moderate & persistent	
uncomplicated	J45.40
with acute exacerbation	J45.41
with status asthmaticus	J45.42
Asthma, severe & persistent	
uncomplicated	J45.50
with acute exacerbation	J45.51
with status asthmaticus	J45.52
Asthma, severity not stated	J45.909
with acute exacerbation	J45.901
with status asthmaticus	J45.902
Asthma, exercise induced	J45.990
Asthma, cough variant	J45.991
Family history of asthma	Z82.5
Conjunctivitis	
Conjunctivitis, mucopurulent	H10.9
Acute Follicular	
right eye	H10.011
left eye	H10.012
bilateral	H10.013
Other mucopurulent	
right eye	H10.021
left eye	H10.022
bilateral	H10.023
Acute atopic	
right eye	H10.11
left eye	H10.12
bilateral	H10.13
Serous, except viral	
right eye	H10.231
left eye	H10.232
bilateral	H10.233
Viral	B30.9
Other Respiratory and ENT Dx	
Bronchitis, acute	J20.9
Ceruman impaction, Right ear	H61.21
left ear	H61.22
bilateral	H61.23
Cough, acute	R05.1

PEDIATRIC CONDITIONS

Rhinitis - *Code tobacco exposure*	Code
acute	J00
allergic	J30.9
chronic	J31.0
Laryngitis, acute w/o obstruction	J04.0
with obstruction (croup)	J05.0
chronic	J37.0
Pharyngitis, acute	J02.9
Sinusitis - *Code tobacco exposure*	
ethmoidal: acute	J01.20
recurrent	J01.21
chronic	J32.2
frontal: acute	J01.10
recurrent	J01.11
chronic	J32.1
maxillary: acute	J01.00
recurrent	J01.01
chronic	J32.0
pansinusitis: acute	J01.40
recurrent	J01.41
chronic	J32.4
sphenoid: acute	J01.30
recurrent	J01.31
chronic	J32.3
Weight Management	
Failure to Thrive child	R62.51
Newborn	P92.6
Delayed milestones (childhood)	R62.0
Short stature	R62.52
Sprain *7th character - A=initial, D=subsequent, S=sequela*	
RIGHT ankle, unspecified ligament	S93.401-
LEFT ankle, unspecified ligament	S93.402-
RIGHT ankle, deltoid ligament	S93.421-
LEFT ankle, deltoid ligament	S93.422-
Underdosing by Patient Also code drug from T36-T50	
intentional NEC	Z91.128
due to financial hardship	Z91.120
unintentional NEC	Z91.138
Physical Abuse Dx Codes	
Replace dash (-) with; A = initial (active tx);	
D = FU (healing); or S = sequela	
Suspected abuse; physical abuse of a child	T76.12x-
sexual abuse of a child	T76.22x-
Confirmed abuse; physical abuse of child	T74.12x-
sexual abuse of a child	T74.22x-
Abuse (physical) of child has now been ruled-out	Z04.72
Counseling For:	
Alcohol abuse (code also alcohol abuse/dep F10.-)	Z71.41
Contraception	Z30.09
Dietary (Add code: BMI & underlying condition)	Z71.3
Tobacco (code also nicotine dependence F17.2-)	Z71.6
Peds - Misc	
Zika virus	A92.5
Family history of SIDS	Z84.82
Maternal Use Drugs Affecting Newborn	
Newborn affected by maternal use; opiates	P04.14
antidepressants	P04.15
amphetamines	P04.16
sedative-hypnotics	P04.17

Condition	Code
Epistaxis	R04.0
Gastroenteritis	K52.9
Otalgia, Right ear	H92.01
left ear	H92.02
Pneumonia	J18.9
Swimmer's ear, Right ear	H60.331
left ear	H60.332
bilateral	H60.333
Tonsillitis, acute	J03.90
chronic	J35.01
Adenoiditis, chronic	J35.02
Tonsillitis with adenoiditis, chronic	J35.03
URI	J06.9
Viral syndrome	B97.89
FOREIGN BODY *(7th - A=initial, D= FU, S=sequela)*	
Nostril	T17.1XX-
Ear; RIGHT	T16.1XX-
LEFT	T16.2XX-
Dermatology	
Acne	L70.8
Eczema	L30.9
Impetigo	L01.00
LICE; Head	B85.0
Body	B85.1
Rash	R21
Plantar wart	B07.0
Sunburn; First degree	L55.0
Second degree	L55.1
Urticaria	L50.9
GI/GU Dx	
Abdominal Pain, acute	R10.0
RUQ	R10.11
LUQ	R10.12
RLQ	R10.31
LLQ	R10.32
Epigastric	R10.13
Periumbilical	R10.33
Generalized	R10.84
Dental caries, unspecified	K02.9
Diarrhea	R19.7
UTI	N39.0
Constipation	K59.00
GERD	K21.9
Dysuria	R30.0
Nausea	R11.0
with vomiting	R11.2
Vomiting alone	R11.11
Signs/Symptoms	
Chest pain	R07.9
Dizziness	R42
Fatigue	R53.83
Fever	R50.9
Headache, unspecified	R51.9
TB Study: Contact or exposure to T	Z20.1
Nonspec. Reac. to TB skin test w	R76.11
Screening respiratory tuberculo	Z11.1
Syncope	R55

Report **Nicotine influence**: ie, 2nd hand tobacco smoke exposure Z77.22, when impacting care or healing.

RESPIRATORY CONDITIONS

Bronchitis J20 & J44	Risk?	Code
Bronchitis, acute; *organism unknown*		J20.9
Organism known, *but no code exists it.*		J20.8
Bronchitis, acute; *choose based on organism*		
mycoplasma pneumonia		J20.0
hemophilus influenzae		J20.1
streptococcus		J20.2
coxsackievirus		J20.3
parainfluenza virus		J20.4
respiratory syncytial virus (RSV)		J20.5
rhinovirus		J20.6
echovirus		J20.7
Bronchitis, (**acute**) **w/COPD** *codes to COPD*	*Yes*	J44.0
Bronchitis, chronic; *choose from below*		
simple and chronic	*Yes*	J41.0
obstructive ***without*** exacerbation	*Yes*	J44.9
obstructive ***with*** (acute) exacerbation	*Yes*	J44.1
mucopurulent	*Yes*	J41.1
mixed simple & mucopurulent	*Yes*	J41.8
with (acute) lower resp infection *(code also infection)*	*Yes*	J44.0
with acute exacerbation of asthma	*Yes*	J44.1
COPD J44		
Chronic Obstructive Pulmonary Disease	*Yes*	J44.9
with acute exacerbation	*Yes*	J44.1
with (acute) lower resp infection (code also infect	*Yes*	J44.0
with asthma *(code also Asthma type J45-)*	*Yes*	J44.9
with asthma exacerbation *(code also asthma)*	*Yes*	J44.1
Pneumonia J12, J14, J15 & J18		
Pneumonia, no organism specified		J18.9
Pneumonia, viral, *choose from below -*		
adenovirus		J12.0
respiratory syncytial virus (RSV)		J12.1
parainfluenza virus		J12.2
SARS-associated coronavirus		J12.81
viral, unspecified		J12.9
Pneumonia, bacterial, *organism unspecified*		J15.9
Pneumonia, bacterial, *choose from below -*		
hemophilus influenzae	*Yes*	J14
pseudomonas	*Yes*	J15.1
staphylococcus	*Yes*	J15.20
streptococcus, Group A	*Yes*	J15.4
streptococcus, Group B	*Yes*	J15.3
anaerobes	*Yes*	J15.8
E.coli (Escherichia coli)	*Yes*	J15.5
other gram-negative bacteria		J15.69
bacteria, other than above	*Yes*	J15.8
Pneumonia, MRSA	*Yes*	J15.212
Pneumonia, MSSA	*Yes*	J15.211
Pneumonia, idiopathic, interstitial	*Yes*	J84.111
Emphysema J43		
Emphysema, unilateral pulmonary	*Yes*	J43.0
panlobular emphysema	*Yes*	J43.1
centrilobular emphysema	*Yes*	J43.2
other emphysema, *not listed here*	*Yes*	J43.8
unspecified, *(when documentation does not ident*	*Yes*	J43.9
COVID-19		
COVID-19 **See pg 15 for more detail**		U07.1

Asthma J45	Risk?	Code
Asthma, if chronic obstructive, *see COPD w/asthma left*		
Asthma, mild & intermittent		
uncomplicated	*Yes*	J45.20
with acute exacerbation	*Yes*	J45.21
with status asthmaticus	*Yes*	J45.22
Asthma, mild & persistent		
uncomplicated	*Yes*	J45.30
with acute exacerbation	*Yes*	J45.31
with status asthmaticus	*Yes*	J45.32
Asthma, moderate & persistent		
uncomplicated	*Yes*	J45.40
with acute exacerbation	*Yes*	J45.41
with status asthmaticus	*Yes*	J45.42
Asthma, severe & persistent		
uncomplicated	*Yes*	J45.50
with acute exacerbation	*Yes*	J45.51
with status asthmaticus	*Yes*	J45.52
Asthma, severity not stated		J45.909
with acute exacerbation		J45.901
with status asthmaticus		J45.902
Asthma, exercise induced		J45.990
Asthma, cough variant		J45.991
Family hx asthma/lower resp disease		Z82.5
EMR ICD-10 Search Tips *: Search Asthma* ***by severity*** *(e.g., mild, moderate or severe);* ***then by quality*** *(e.g., intermittent or persistent);* ***then today's status*** *(uncomplicated,*		
Respiratory S/S, Status & Hx Codes		
Abnormal; chest sounds/rales		R09.89
x-ray of lung		R91.8
pulmonary function studies		R94.2
Bronchospasm, acute		J98.01
Chest pain on breathing		R07.1
Cough, chronic *(if smoker's cough, use J41.0)*		R05.3
Cyanosis		R23.0
Dyspnea / respiratory distress		R06.00
Fatigue, lethargy, or decreased energy		R53.83
Fever		R50.9
Hyperventilation		R06.4
Hypoxia or Hypoxemia		R09.02
Oxygen dependence *(supplemental)*		Z99.81
Pleural effusion		J90
Respiratory; insufficiency		R06.89
Shortness of breath		R06.02
Sputum, abnormal/excessive		R09.3
Stridor		R06.1
Tightness, chest		R07.89
URI		J06.9
Wheezing		R06.2
Status codes (assign when present)		
Tracheostomy, status	*HCC*	Z93.0
Lung transplant status	*HCC*	Z94.2
Personal history of;		
recurrent pneumonia		Z87.01
other respiratory diseases		Z87.09
Report **Nicotine influence** with respiratory problems: ie, Current cigarette smoker F17.210. See page 18 for other options.		

COVID-19

COVID-19	Code
COVID-19 infection *(confirmed cases only)*	U07.1
Also code associated manifestions	
Encounter for screening for COVID-19	Z11.52
Contact with & (suspected) exposure to COVID-19	Z20.822
Personal history of COVID-19	Z86.16
Multisystem inflammatory syndrome	M35.81
COVID-19 associated coagulopathy	D68.8
Other spec systemic involvement of connective tissue	M35.89
Pneumonia due to coronavirus disease 2019	J12.82
Signs/Symptoms with no COVID-19 Diagnosis	
Acute cough	R05.1
Shortness of breath	R06.02
Fever, unspecified	R50.9
and other signs/symptoms as appropriate	
Pregnancy	
COVID-19 is reason for encounter (first listed)	O98.5-
Also code COVID-19 infection	U07.1
ICD-10 Guidelines: I.C.15.s	
Newborn	
COVID-19 infection (confirmed cases only)	U07.1
Also code associated manifestions	
COVID-10 contracted in utero or during birth process	P35.8
ICD-10 Guidelines: I.C.16.h	
Antibody Testing	
Encounter for antibody response examination	Z01.84
Other COVID-related diagnoses	
Post COVID-19 condition, unspecified	U09.9
Includes Long COVID and Post-acute sequela of COVID-19	
Code first specific condition related to COVID-19, such as:	
chronic respiratory failure	J96.1-
loss of smell	R43.8
loss of taste	R43.8
multi-system inflammatory syndrome	M35.81
pulmonary embolism	I26.-
pulmonary fibrosis	J84.10
Follow up evaluation after COVID-19 resolved (neg test)	Z09
+Personal history of COVID-19	Z86.19

See ICD10CM guidelines section 1.C.g.1 for information of diagnosis reporting for COVID19

Report **Nicotine influence** with Respiratory conditions : ie, Current cigarette smoker F17.210. See page 18 for other nicotine coding options.

COVID-19 Vaccine and Administration CPT Codes	
CPT service codes below are effective 11/1/2023. The current CPT manual contains outdated information.	
Immunization Admin, any COVID-19 vaccination product	**90480**
Novovax Product Code:	
5mcg/0.5mL dose, 12 years and older	91304
Pfizer Product Codes:	
3mcg/0.2mL dose, ages 6 months through 4 years	91318
10mcg/0.2mL dose, ages 5-11 years	91319
30mcg/0.3mL dose, ages 12 years and older	91320
Moderna Product Codes:	
25mcg/0.25mL dose, ages 6 months through 11 years	91321
50mcg/0.5mL dose, ages 12 years and older	91322
COVID-19 Vaccine ICD10 Codes	**Code**
Encounter for immz safety counseling *(also code one below)*	Z71.85
Encounter for immunization *(administration today)*	Z23
Vaccine not given d/t Patient's refusal	Z28.21
Vaccine not given d/t Patient's decision for other reason	Z28.29
Vaccine not given d/t caregiver refusal	Z28.82
Vaccine not given d/t unavailability of vaccine	**Z28.83**
Vaccine not given for other reason	Z28.89
Underimmunization Status	
Unvaccinated for COVID-19	Z28.310
Partially vaccinated for COVID-19	Z28.311
Other underimmunized status (lapsed/delinquent schedule)	Z28.39
Exposure to COVID-19	
Contact with &(suspected) exposure to other viral communicable diseases	Z20.822

CHRONIC PAIN AND SUBSTANCE USE DISORDERS

Chronic Pain & Medication Management	Risk?	Code
Coding chronic pain management: List 1st the chronic pain Dx, then the clinical reason Dx, followed by "Therapeutic monitoring" Dx, and finally High-risk medication Dx, if appropriate. See 1-4 below.		
1. Chronic Pain Syndrome		G89.4
Chronic Pain, unspecified		G89.29
due to; trauma		G89.21
neoplasm related		G89.3
2. Common conditions causing chronic pain		
Arthropathy, unspecified site		M12.9
Fibromyalgia		M79.7
Lumbago		M54.50
Rheumatoid arthritis, unspecified site	*Yes*	M06.9
Pain disorder with related psychological factors		F45.42
Medication Management *(detailed documentation)*		
3. Therapeutic drug monitoring *(code also #4 and/or #5)*		Z51.81
4. ✚ Long term (current) use of opiate analgesic		Z79.891
5. ✚ Other long term (current) drug therapy		Z79.899
Alcohol Abuse *("mild") See DSM5 pg.490*		
Alcohol abuse; uncomplicated		F10.10
Alcohol abuse; in remission		F10.11
with alcohol-induced; with anxiety disorder	*Yes*	F10.180
with mood disorder	*Yes*	F10.14
with psychotic disorder with delusions	*Yes*	F10.150
with psychotic disorder with hallucinations	*Yes*	F10.151
with sexual dysfunction	*Yes*	F10.181
with sleep disorder	*Yes*	F10.182
Alcohol abuse with intoxication; uncomplicated (t	*Yes*	F10.120
with delirium	*Yes*	F10.121
Alcohol abuse with withdrawal; uncomplicated	*Yes*	F10.130
unspecified	*Yes*	F10.139
Alcohol Dependence *(DSM "moderate / severe")*		
Alcohol dependence; uncomplicated	*Yes*	F10.20
Alcohol dependence; in remission	*Yes*	F10.21
with withdrawal; uncomplicated	*Yes*	F10.230
with delirium	*Yes*	F10.231
with perceptual disturbance	*Yes*	F10.232
with alcohol-induced; with anxiety disorder	*Yes*	F10.280
with mood disorder	*Yes*	F10.24
with persisting amnesic disorder	*Yes*	F10.26
with persisting dementia	*Yes*	F10.27
with psychotic disorder delusions	*Yes*	F10.250
with psychotic disorder hallucinations	*Yes*	F10.251
with sexual dysfunction	*Yes*	F10.281
with sleep disorder	*Yes*	F10.282
Alcohol dependence with intoxication; uncomplic	*Yes*	F10.220
with delirium	*Yes*	F10.221
Alcohol Use (w/o abuse or dependence) **& Alcohol Poisoning**		
Alcohol use, unspec. with withdrawal; uncomplic	*Yes*	F10.930
unspecified	*Yes*	F10.939
Alcohol use unspec w/ unspec alcohol-induced disorder *See F10.9x for other alcohol "use" diagnoses*	*Yes*	F10.99
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Alcohol poisoning - *intent undetermined*		T51.0x4 -

Blood alcohol level codes			
< 20 mg/100 ml	Y90.0	100-119 mg/100 ml	Y90.5
20-39 mg/100 ml	Y90.1	120-199 mg/100 ml	Y90.6
40-59 mg/100 ml	Y90.2	200-239 mg/100 ml	Y90.7
60-79 mg/100 ml	Y90.3	240mg/100 ml or >	Y90.8
80-99 mg/100 ml	Y90.4	Level not specified	Y90.9

Cannabis Dependence *("moderate / severe")*	Risk?	Code
Cannabis dependence; uncomplicated	*Yes*	F12.20
Cannabis dependence; in remission	*Yes*	F12.21
Cannabis dependence; with withdrawal	**Yes**	F12.23
with cannabis-induced; with anxiety disorder	*Yes*	F12.280
with psychotic disorder with delusions	*Yes*	F12.250
with psychotic disorder with hallucinations	*Yes*	F12.251
Cannabis dependence w/intoxication; uncomplica	*Yes*	F12.220
with delirium	*Yes*	F12.221
with perceptual disturbance	*Yes*	F12.222
Cannabis Use *(w/o abuse or dependence)* **& Cannabis Poisoning**		
Cannabis use, unspecified & uncomplicated *See F12.9x for other cannabis "use" diagnoses*		F12.90
Cannabis poisoning - *intent undetermined*		T40.714 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Cocaine Abuse *("mild") See DSM5 pg. 561*		
Cocaine abuse; uncomplicated	Yes	F14.10
Cocaine abuse; in remission	Yes	F14.11
Cocaine abuse; with other cocaine-induced disord	*Yes*	F14.188
with cocaine-induced; with anxiety disorder	*Yes*	F14.180
with mood disorder	*Yes*	F14.14
with psychotic disorder with delusions	*Yes*	F14.150
with psychotic disorder with hallucinations	*Yes*	F14.151
with sexual dysfunction	*Yes*	F14.181
with sleep disorder	*Yes*	F14.182
Cocaine abuse with intoxication; uncomplicated	*Yes*	F14.120
with delirium	*Yes*	F14.121
with perceptual disturbance	*Yes*	F14.122
Cocaine Dependence *(DSM "moderate / severe")*		
Cocaine dependence; uncomplicated	*Yes*	F14.20
Cocaine dependence; in remission	*Yes*	F14.21
with withdrawal;	*Yes*	F14.23
with cocaine-induced; with anxiety disorder	*Yes*	F14.280
with mood disorder	*Yes*	F14.24
with psychotic disorder with delusions	*Yes*	F14.250
with psychotic disorder with hallucinations	*Yes*	F14.251
with sexual dysfunction	*Yes*	F14.281
with sleep disorder	*Yes*	F14.282
Cocaine dependence with intoxication; uncomplic	*Yes*	F14.220
with delirium	*Yes*	F14.221
with perceptual disturbances	*Yes*	F14.222
Cocaine abuse, unspecified with withdrawal	*Yes*	F14.13
Cocaine Use *(w/o abuse or dependence)* **& Cocaine Poisoning**		
Cocaine use unspecified & uncomplicated *See F14.9x for other cocaine "use" diagnoses*		F14.90
Cocaine poisoning *-intent undetermined*		T40.5x4 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Cocaine use, unspecified with withdrawal	*Yes*	F14.93
Opioid Abuse *("mild") See DSM5 pg. 540*		
Opioid abuse; uncomplicated	Yes	F11.10
Opioid abuse; in remission	Yes	F11.11
with opioid-induced; with mood disorder	*Yes*	F11.14
with psychotic disorder with delusions	*Yes*	F11.150
with psychotic disorder with hallucinations	*Yes*	F11.151
with sexual dysfunction	*Yes*	F11.181
with sleep disorder	*Yes*	F11.182
Opioid abuse with other induced disorder	*Yes*	F11.188
Opioid abuse with intoxication; uncomplicated	*Yes*	F11.120
with delirium	*Yes*	F11.121
with perceptual disturbance	*Yes*	F11.122

SUBSTANCE USE DISORDERS

Cannabis Abuse *("mild") See DSM5 pg. 509*	**Risk?**	
Cannabis abuse; uncomplicated		F12.10
Cannabis abuse; in remission		F12.11
with cannabis-induced; with anxiety disorder	*Yes*	F12.180
with psychotic disorder with delusions	*Yes*	F12.150
with psychotic disorder with hallucinations	*Yes*	F12.151
Cannabis abuse with intoxication; uncomplicated	*Yes*	F12.120
with delirium	*Yes*	F12.121
with perceptual disturbance	*Yes*	F12.122
Cannabis abuse with withdrawal	*Yes*	F12.13
Opioid Dependence *continued from prev. page*		**Code**
Opioid dependence with other induced disorder	*Yes*	F11.288
Opioid dependence with intoxication; uncomplica	*Yes*	F11.220
with delirium	*Yes*	F11.221
with perceptual disturbances	*Yes*	F11.222
Opioid Use *(w/o abuse or dependence)* **& Opioid Poisoning**		
Opioid use unspecified & uncomplicated		F11.90
See F11.9x for other opioid "use" diagnoses		
Opioid poisoning - *Intent undetermined*		T40.2x4 -
Fentanyl poisoning - *Intent undetermined*		T40.414 -
Tramadol poisoning - *Intent undetermined*		T40.424 -
Other synthetic narcotic poisoning - *Intent undetermined*		T40.494 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Stimulant Abuse *("mild") See DSM5 pg. 561*		
Stimulant abuse; uncomplicated	Yes	F15.10
Other stimulant abuse; in remission.	*Yes*	F15.11
with stimulant induced; with anxiety disorder	*Yes*	F15.180
with mood disorder	*Yes*	F15.14
with psychotic disorder with delusions	*Yes*	F15.150
with psychotic disorder with hallucinations	*Yes*	F15.151
with sexual dysfunction	*Yes*	F15.181
with sleep disorder	*Yes*	F15.182
Stimulant abuse with intoxication; uncomplicated	*Yes*	F15.120
with delirium	*Yes*	F15.121
with perceptual disturbance	*Yes*	F15.122
Other stimulant abuse with withdrawal	*Yes*	F15.13
Stimulant Dependence		
Stimulant dependence; uncomplicated	*Yes*	F15.20
Stimulant dependence; in remission	*Yes*	F15.21
with withdrawal	*Yes*	F15.23
with stimulant-induced; anxiety disorder	*Yes*	F15.280
with mood disorder	*Yes*	F15.24
with psychotic disorder with delusions	*Yes*	F15.250
with psychotic disorder with hallucinations	*Yes*	F15.251
with sexual dysfunction	*Yes*	F15.281
with sleep disorder	*Yes*	F15.282
Stimulant dependence with intoxication; uncomp	*Yes*	F15.220
with delirium	*Yes*	F15.221
with perceptual disturbances	*Yes*	F15.222
Stimulant Use *(w/o abuse or dependence)* & Stimulant Poisoning		
Stimulant use unspecified/uncomplicated		F15.90
See F15.9x for other stimulant "use" diagnoses		
Stimulant poisoning - *Intent undetermined*	*Yes*	T43.604 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Psychoactive Abuse *("mild") See DSM5 pg. 577*		
Psychoactive abuse; uncomplicated	*Yes*	F19.10
Other psychoactive substance abuse; in remission	*Yes*	F19.11
with psychoactive-induced; anxiety disorder	*Yes*	F19.180
with mood disorder	*Yes*	F19.14
with persisting amnestic disorder	*Yes*	F19.16

Opioid abuse with withdrawal	*Yes*	F11.13
Opioid Dependence *(DSM "moderate / severe")*		
Opioid dependence; uncomplicated	*Yes*	F11.20
Opioid dependence; in remission	*Yes*	F11.21
with withdrawal	*Yes*	F11.23
with opioid-induced; with mood disorder	*Yes*	F11.24
with psychotic disorder with delusions	*Yes*	F11.250
with psychotic disorder with hallucinations	*Yes*	F11.251
with sexual dysfunction	*Yes*	F11.281
with sleep disorder	*Yes*	F11.282
Psychoactive Use *(not abuse)* **& Poisoning**		**Code**
Psychoactive use unspecified & uncomplicated		F19.90
See F19.9x for other psychoactive "use" diagnoses		
Psychoactive poisoning *-intent undetermined*		T43.94x -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Sedative/hypnotic/anxiolytic Abuse *("mild") See DSM5 pg. 550*		
Sedative abuse; uncomplicated	*Yes*	F13.10
Sedative, hypnotic or anxiolytic abuse; in remissic	*Yes*	F13.11
with sedative-induced; with anxiety disorder	*Yes*	F13.180
with mood disorder	*Yes*	F13.14
with psychotic disorder with delusions	*Yes*	F13.150
with psychotic disorder with hallucinations	*Yes*	F13.151
with sexual dysfunction	*Yes*	F13.181
with sleep disorder	*Yes*	F13.182
Sedative abuse with other induced disorder	*Yes*	F13.188
Sedative abuse with intoxication; uncomplicated	*Yes*	F13.120
with delirium	*Yes*	F13.121
Sedative abuse with withdrawal; uncomplicated	*Yes*	F13.130
unspecified	*Yes*	F13.139
Sedative Dependence *(DSM "moderate / severe")*		
Sedative dependence; uncomplicated	*Yes*	F13.20
Sedative dependence; in remission	*Yes*	F13.21
with withdrawal; uncomplicated	*Yes*	F13.230
with delirium	*Yes*	F13.231
with perceptual disturbance	*Yes*	F13.232
with sedative-induced; with anxiety disorder	*Yes*	F13.280
with mood disorder	*Yes*	F13.24
with persisting amnestic disorder	*Yes*	F13.26
with persisting dementia	*Yes*	F13.27
with psychotic disorder delusions	*Yes*	F13.250
with psychotic disorder hallucinations	*Yes*	F13.251
with sexual dysfunction	*Yes*	F13.281
with sleep disorder	*Yes*	F13.282
Sedative dependence with other induced disorde	*Yes*	F13.288
Sedative dependence with intoxication; uncompli	*Yes*	F13.220
with delirium	*Yes*	F13.221
Sedative Use *(w/o abuse or dependence)* & Sedative Poisoning		
Sedative use unspecified & uncomplicated		F13.90
See F13.9x for other sedative "use" diagnoses		
Sedative poisoning - *intent undetermined*		T42.74x -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Hallucinogen Related Abuse *("mild") See DSM5 pg. 520*		
Hallucinogen abuse; uncomplicated	*Yes*	F16.10
Hallucinogen abuse; in remission	*Yes*	F16.11
with Hallucinogen-induced; with anxiety disorder	*Yes*	F16.180
with induced mood disorder	*Yes*	F16.14
with persisting perception disorder (flashbacks)	*Yes*	F16.183
with psychotic disorder with delusions	*Yes*	F16.150
with psychotic disorder with hallucinations	*Yes*	F16.151
Hallucinogen abuse with other induced disorder	*Yes*	F16.188

SUBSTANCE USE DISORDERS

Psychoactive Abuse *(DSM "mild")*	**Risk?**	
with persisting dementia	*Yes*	F19.17
with psychotic disorder with delusions	*Yes*	F19.150
with psychotic disorder with hallucinations	*Yes*	F19.151
with sexual dysfunction	*Yes*	F19.181
with sleep disorder	*Yes*	F19.182
Psychoactive abuse with other induced disorder	*Yes*	F19.188
Psychoactive abuse with intoxication; uncomplica	*Yes*	F19.120
with delirium	*Yes*	F19.121
with perceptual disturbance	*Yes*	F19.122
Psychoactive abuse with withdrawal; uncomp	*Yes*	F19.130
Psychoactive Dependence *(DSM "moderate / severe")*		
Psychoactive dependence; uncomplicated	*Yes*	F19.20
Psychoactive dependence; in remission	*Yes*	F19.21
with withdrawal; uncomplicated	*Yes*	F19.230
with delirium	*Yes*	F19.231
with perceptual disturbance	*Yes*	F19.232
with Psychoactive-induced; with anxiety disorder	*Yes*	F19.280
with mood disorder	*Yes*	F19.24
with psychotic disorder with delusions	*Yes*	F19.250
with psychotic disorder with hallucinations	*Yes*	F19.251
with sexual dysfunction	*Yes*	F19.281
with sleep disorder	*Yes*	F19.282
Psychoactive dependence with other induced disc	*Yes*	F19.288
Psychoactive dependence with intoxication; unco	*Yes*	F19.220
with delirium	*Yes*	F19.221
with perceptual disturbances	*Yes*	F19.222

Nicotine Dependence & Exposure *See DSM5 pg. 571*	**Code**
Cigarette; uncomplicated (current smoker) *(no related illness)*	F17.210
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of tobacco dependence	Z87.891
Tobacco use, *[no dependence]*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Screening for	
Alcoholism	Z13.39
Behavioral disorder	Z13.30
Depression	Z13.31
Neurologic disorder	Z13.89
HIV	Z11.4
STD/STI	Z11.3
HPV	Z11.51
Developmental delays, unspecified	Z13.40
Malnutrition	Z13.29
Medication Management *Code also clinical condition(s)*	
Code 1st: Therapeutic drug level monitoring	Z51.81
Code ✚: Other long term (current) drug therapy	Z79.899

Hallucinogen abuse with intoxication; uncomplica	*Yes*	F16.120
with delirium	*Yes*	F16.121
with perceptual disturbance	*Yes*	F16.122
Hallucinogen Dependence *(DSM "moderate / severe")*		
Hallucinogen dependence; uncomplicated	*Yes*	F16.20
Hallucinogen dependence; in remission	*Yes*	F16.21
with Hallucinogen-induced; with anxiety disorder	*Yes*	F16.280
with mood disorder	*Yes*	F16.24
with persisting perception disorder (flashbacks)	*Yes*	F16.283
with psychotic disorder with delusions	*Yes*	F16.250
with psychotic disorder with hallucinations	*Yes*	F16.251
Hallucinogen dependence with other induced disc	*Yes*	F16.288
Hallucinogen dependence with intoxication; unco	*Yes*	F16.220
with delirium	*Yes*	F16.221
Hallucinogen Use (w/o abuse or dependence) & Poisoning		
Hallucinogen use unspecified & uncomplicated		F16.90
See F16.9x for other sedative "use" diagnoses		
Hallucinogen poisoning; *intent undetermined*		T40.904 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		

Substance Use In Pregnancy (see ICD Chapter 15)	**Code**
Use additional code(s) from F10 to identify manifestations of alcohol use	
Alcohol use complicating pregnancy; 1st trimester	O99.311
2nd trimester	O99.312
3rd trimester	O99.313
Use additional code(s) from F11-F16 to identify manifestations of the drug use	
Drug use complicating pregnancy; 1st trimester	O99.321
2nd trimester	O99.322
3rd trimester	O99.323
Use additional code(s) from F17 to identify type of tobacco nicotine dependence	
Smoking complicating pregnancy: 1st trimester	O99.331
2nd trimester	O99.332
3rd trimester	O99.333

Miscellaneous and Signs/Symptoms		
Noncompliance with medical treatment, unspecifi		Z91.199
Abnormal involuntary movements		R25.9
Abnormal weight gain		R63.5
Abnormal weight loss		R63.4
Underweight		R63.6
BMI of 19 or less		Z68.1
Malnourished; moderate	*Yes*	E44.0
Abnormality of gait		R26.9
Altered mental status		R41.82
Decreased libido		R68.82
Dizziness/giddiness		R42
Excessive crying		R45.83
Fatigue		R53.83
Generalized pain		R52
Headache, unspecified		R51.9
Hepatitis C, chronic, viral; carrier	*Yes*	B18.2
Hepatitis C, acute		B17.10
Insomnia		G47.00
Memory loss		R41.3
Nausea		R11.0
Senility w/o mention psychosis		R41.81
Sleep disturbance		G47.9

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SUBSTANCE USE DISORDERS

Patient Medication Noncompliance by Self Underdosing of;	
*Replace dash (-) w/ **A** =initial (active tx); **D** = FU (healing); or **S** =sequela*	
tetracyclic antidepressants	T43.026 -
tricyclic antidepressants	T43.016 -
other antidepressant	T43.296 -
antipsychotics (phenothiazine)	T43.3x6 -
amphetamines	T43.626 -
other psychostimulant	T43.696 -
antipsychotics and neuroleptics	T43.596 -
barbiturates	T42.3x6 -
benzodiazepines	T42.4x6 -
butyrophenone & thiothixene neuroleptics	T43.4x6 -
cannabis	T40.716 -
MAOIs	T43.1x6 -
methadone	T40.3x6 -
methyphenidate (ADD)	T43.636 -
narcotics (synthetic)	T40.496 -
opium	T40.0x6 -
other opioid	T40.2x6 -
psychotrophic (other)	T43.8x6 -
SSRIs	T43.226 -
Code also PATIENT'S INTENT of underdosing	
INTENTIONAL underdosing of med(s) by patient;	
due to financial hardship	Z91.120
for any other reason	Z91.128
UNINTENTIONAL underdosing by patient;	
due to age-related debility	Z91.130
for any other reason	Z91.138
Other Patient Noncompliance Diagnoses	
Noncomp. w/other medical tx d/t financial hardship	Z91.190
Noncomp. w/other medical tx for other reason	Z91.198
Patient's noncomp. with dietary regimen, other reason	Z91.118

Lab Studies - Search for additionals in EMR		
[Urine drug screen] Encounter other specified exa		Z01.89
Finding, abnormal substance in urine		R82.998
Blood test for alcohol/drugs *Code results*		Z02.83
Codes for results listed below, assign if known		
Abnormal findings in blood study		
Opiate drug in blood		R78.1
Cocaine in blood		R78.2
Hallucinogen in blood		R78.3
Psychotropic in blood		R78.5
Other addictive substance in blood		R78.4
Other substance in blood		R78.9
Physical Abuse Diagnosis Codes		
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela		
Suspected abuse; physical abuse/adult		T76.11x -
sexual abuse of adult		T76.21x -
physical abuse of a child		T76.12x -
sexual abuse of a child		T76.22x -
Confirmed abuse; physical abuse/adult		T74.11x -
sexual abuse of adult		T74.21x -
physical abuse of a child		T74.12x -
sexual abuse of a child		T74.22x -
Personal History and Family History Diagnosis Codes		
Personal History of; Alcoholism	*Yes*	F10.21
Combat and operational stress		Z86.51
Other Mental & Behavioral Disorders		Z86.59
Family History of psychiatric condition		Z81.8
Family History of substance abuse or dependence		Z81.3

PSYCHIATRIC AND RELATED CONDITIONS

ADHD - *Features are predominately...(choose)*	Risk?	Code
ADHD; inattentive type		F90.0
ADHD; hyperactive type		F90.1
ADHD; combined (inattentive and hyperactive types)		F90.2
ADHD; other type, *other than above three types*		F90.8
Anxiety and Related		
Anxiety; generalized		F41.1
Anxiety, mixed (*with prominent features of other d*		F41.3
Panic disorder; *w/o agoraphobia (panic attack) DEF in note*		F41.0
with agoraphobia		F40.01
Separation anxiety (*of childhood*)		F93.0
Other specified anxiety disorder (*doc in record, but no code)*		F41.8
Social phobia (anxiety) disorder, generalized		F40.11
Acute stress reaction		F43.0
Post-traumatic Stress Disorder		
PTSD; acute		F43.11
PTSD; chronic		F43.12
Anxiety; unspecified	*avoid*	F41.9
Adjustment Disorders F43.2		
Adjustment disorder; with depressed mood (*grief reactior*		F43.21
with anxiety		F43.22
with mixed mood *(anxiety & depression)*		F43.23
with disturbance of conduct		F43.24
with mixed disturbance *(emotion/conduct)*		F43.25
with other symptoms *not noted in available codes*		F43.29
Adjustment disorder unspecified	*avoid*	F43.20
Bipolar Disorders F31		
Consider: manic, depressed or mixed, & mild, moderate or severe. If "severe" select code based on presence/absence of psychosis.		
Bipolar, current episode is **manic & mild**	*Yes*	F31.11
Bipolar; current episode is; **manic & moderate**	*Yes*	F31.12
manic & severe *WITHOUT* psychotic features	*Yes*	F31.13
manic & severe and *WITH psychotic features*	*Yes*	F31.2
Bipolar, current episode **depressed & mild**	*Yes*	F31.31
current episode depressed & moderate	*Yes*	F31.32
depressed *but WITHOUT* psychotic features	*Yes*	F31.4
depressed and WITH psychotic features	*Yes*	F31.5
Bipolar, current episode **mixed** (manic & dep.) **mild**	*Yes*	F31.61
Bipolar; current episode mixed & moderate	*Yes*	F31.62
mixed & severe, *WITHOUT* *psychotic features*	*Yes*	F31.63
mixed & severe, and *WITH psychotic features*	*Yes*	F31.64
Bipolar, current episode **hypomanic**	*Yes*	F31.0

Bipolar Disorders *IN REMISSION* (*Partial or Full Remission)*					
Bipolar PARTIAL remission			Bipolar **FULL** remission		
hypomanic	*Yes*	F31.71	hypoman	*Yes*	F31.72
manic	*Yes*	F31.73	manic	*Yes*	F31.74
depressed	*Yes*	F31.75	depresse	*Yes*	F31.76
mixed	*Yes*	F31.77	mixed	*Yes*	F31.78
Bipolar II disorder				*Yes*	F31.81

Manic Episode F30	Risk?	Code
Manic episode w/o psychotic symptoms **mild**	*Yes*	F30.11
Manic episode w/o psychotic symptoms **moderate**	*Yes*	F30.12
Manic episode w/o psychotic symptoms **severe**	*Yes*	F30.13
Manic episode ***with*** psychotic symptoms **severe**	*Yes*	F30.2
Other manic episodes (like hypomania)	*Yes*	F30.8
Manic episode in PARTIAL remission	*Yes*	F30.3
Manic episode in FULL remission	*Yes*	F30.4
Manic episode, unspecified	*Yes*	F30.9

Major Depressive Disorders (MDD)	Risk?	Code
MDD, single episode code choices		
"Single episode" is the first-ever episode. DSM-5, pg 162: Dx code for MDD based on single vs recurrent and severity.		
MDD, single episode; *(The patient's 1st Dx of MDD - may last mont*		
MDD, single episode; **mild severity**	*Yes*	F32.0
MDD, single episode, **moderate severity**	*Yes*	F32.1
MDD, single; **severe, *w/o*** **psychotic symptoms**	*Yes*	F32.2
MDD, single; **severe, *w/*** **psychotic symptoms**	*Yes*	F32.3
MDD, single episode; **in PARTIAL remission**	*Yes*	F32.4
MDD, single episode; **in FULL remission**	*Yes*	F32.5
Depression, Unspecified (not MDD above)		F32.A
MDD, recurrent episode code choices ***(more common than single episode)***		
An "episode" likely to last many mos/years. DSM-5, pg 162: "recurrent" = interval of ≥ 2 consecutive months between		
MDD, recurrent episode; **mild**	*Yes*	F33.0
MDD, recurrent episode; **moderate severity**	*Yes*	F33.1
MDD, recurrent; severe, *w/o* **psychotic symptoms**	*Yes*	F33.2
MDD, recurrent; severe, w/psychotic symptoms	*Yes*	F33.3
MDD, recurrent episode **in *PARTIAL* remission**	*Yes*	F33.41
MDD, recurrent episode **in *FULL* remission**	*Yes*	F33.42
MDD, other recurrent depressive disorder *(specifiea*	*Yes*	F33.8
MDD, recurrent episode, *unspecified*	*Yes*	F33.9
Other Depressive Episodes		
Premenstrual dysphoric disorder		F32.81
Other specified depressive episode *(specified in reco*		F32.89
Obsessive-compulsive disorder (OCD) F42		
Mixed obsession thoughts and acts		F42.2
Hoarding disorder		F42.3
Excoriation (skin-picking) disorder		F42.4
Other obsessive-compulsive dis. *(documented, but not*		F42.8
Obsessive-compulsive disorder, unspecified	*avoid*	F42.9
Persistent mood (affective) disorders F34		
Cyclothymic disorder		F34.0
Dysthymic disorder *DSM5 = persistent depressive disoi*		F34.1
Disruptive mood dysregulation disorder	*Yes*	F34.81
Other specified persistent mood disorder	*Yes*	F34.89
Mood disorder, unspec. (Active psychosis N	*Yes*	F39
Personality Disorders F60		
Antisocial		F60.2
Avoidant		F60.6
Borderline		F60.3
Dependent		F60.7
Histrionic		F60.4
Narcissistic		F60.81
Obsessive-compulsive		F60.5
Paranoid		F60.0
Schizoid		F60.1
Schizophrenia/Schizoaffective		
Paranoid	*Yes*	F20.0
Disorganized	*Yes*	F20.1
Catatonic	*Yes*	F20.2
Undifferentiated	*Yes*	F20.3
Residual	*Yes*	F20.5
Schizophreniform disorder	*Yes*	F20.81
Schizophrenia *(a documented but no code exist*	*Yes*	F20.89
Schizoaffective disorder, bipolar type	*Yes*	F25.0
depressive type	*Yes*	F25.1

PSYCHIATRIC AND RELATED CONDITIONS

Screening for Mental Health and Behavioral Disorders	
Screening; mental health&behavioral disorders, unspec	Z13.30
depression	Z13.31
maternal depression	Z13.32
other mental health and behavioral disorders	Z13.39
autism	Z13.41
CHILD MALTREATMENT	
*Replace dash with **A** -initial, **D** -FU or **S** -sequela*	
Child physical abuse, confirmed	T74.12X -
Psychological abuse, confirmed	T74.32X -
Sexual abuse, confirmed	T74.22X -
Neglect or abandonment	T74.02X -
Shaken infant syndrome	T74.4XX -
Sexual exploitation, confirmed	T74.52X-
Sexual exploitation, suspected	T76.52X-
Labor exploitation, confirmed	T74.62X-
Labor exploitation, suspected	T76.62X-
Other Child Dxs	
Autistic disorder	F84.0
Heller's syndrome	F84.3
Child psychosis NOS	F84.9
Asperger's syndrome or Schizoid disorder, childhood typ	F84.5
Child Conduct Disorders	
Oppositional defiant disorder	F91.3
Adolescent onset type	F91.2
Childhood onset type	F91.1
Other conduct disorders	F91.8
Unspecified	F91.9
Disorder - Social Functioning Child/Adolescence	
Selective mutism	F94.0
Reactive attachment disorder	F94.1
Disinhibited attachment disorder	F94.2
Other childhood disorder	F94.8
Child - Additional Social Status Dxs	
Parent-biological child conflict	Z62.820
Parent-adopted child conflict	Z62.821
Parent-foster child conflict	Z62.822
Parent-step child conflict	Z62.823
Sibling Rivalry	Z62.891
Runaway (from current living environment)	Z62.892
Alcoholism in family	Z63.72
Substance abuse in family	Z63.72
Other psychosocial circumstances	Z65.8
Acculturation difficulty	Z60.3
Problems r/t legal circumstances	Z65.3
Refusal of tx for religious reasons	Z53.1
Problems r/t unwanted pregnancy	Z64.0
Bereavement, uncomplicated	Z63.4
Counseling victim of parental child abuse	Z69.010
Absence of family member d/t military deployment	Z65.8
Basic services unavailable in physical environmen	Z58.81
Personal History of Mental Disorders *(Any age)*	
Affective disorders	Z86.59
Neurosis	Z86.59
Alcoholism	F10.21
Combat and operational stress	Z86.51

Factitious Disorders	
Factitious disorder imposed on self; unspecified	F68.10
with predominantly psychological sgns and symp	F68.11
with predominantly physical sgns and sympt	F68.12
with combined psychological physical sgns and sym	F68.13
Factitious disorder imposed on another	F68.A
ADULT MALTREATMENT	
*Replace dash with **A** -initial, **D** -FU or **S** -sequela*	**Code**
Adult physical abuse, confirmed	T74.11X -
Psychological abuse, confirmed	T74.31X -
Sexual abuse, confirmed	T74.21X -
Neglect or abandonment	T74.01X -
Financial abuse, confirmed	T74.A1X -
Forced sexual exploitation, confirmed	T74.51X-
Forced sexual exploitation, suspected	T76.51X-
Labor exploitation, confirmed	T74.61X-
Labor exploitation, suspected	T76.61X-
Adult Related Info Dx Codes	
Perpetrator of spousal/partner abuse, MH services	Z69.12
Family counseling	Z71.89
Perpetrator of parental child abuse, MH services	Z69.011
Parent-biological child problem	Z62.820
Parent-adopted child problem	Z62.821
Parent-foster child problem	Z62.822
Parental overprotection	Z62.1
Problems with aged parents or in-laws	Z63.79
Problems r/t alcoholism in family	Z63.72
Problems r/t substance abuse in family	Z63.72
Exposure to disaster, war, and other hostilitie	Z65.5
Absence of family member d/t military deplo	Z63.31
Occupational concerns, unemployment	Z56.0
Change of job	Z56.1
Threat of loss of job	Z56.2
Stressful work schedule	Z56.3
Discord with boss and workmates	Z56.4
Difficult conditions at work	Z56.5
Other physical and mental strain	Z56.6
Acculturation difficulty	Z60.3
Problems r/t legal circumstances	Z65.3
Refusal of tx for religious reasons	Z53.1
Bereavement (disappearance/death)	Z63.4
Religious or spiritual problem	Z65.8
Problems r/t release from prison	Z65.2
Person awaiting admission to facility	Z75.1
Exploitation Dx Codes *(Any age)*	
Exam and observation; following forced sexual expl	Z04.81
following forced labor exploitation	Z04.82
Forced labor or sexual exploitation in childhc	Z62.813
Forced labor or sexual exploitation	Z91.42
Emotional State Dx Codes *(Any age)*	
Nervousness	R45.0
Irritability & Anger	R45.4
Impulsiveness	R45.87
Emotional Liability	R45.86
Demoralization/Apathy	R45.3
Other emotional state (e.g., flat affect, loneliness)	R45.89

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PSYCHIATRIC AND RELATED CONDITIONS

Other/Miscellaneous Dxs *(Any Age)*	
Insomnia, unspecified	G47.00
Hypersomnia *Several codes available Check F51.0 - F51.9*	F51.11
Non-suicidal self-harm (personal hx)	Z91.52
Anorexia nervosa, restricting type	F50.01
Anorexia nervosa, binge eating/purging	F50.02
Bulimia nervosa	F50.2
Intellectual Disabilities; mild	F70
moderate	F71
severe	F72
profound	F73

PSYCHIATRIC AND RELATED CONDITIONS Signs and Symptoms *(Any age)*	Code
Memory loss	R41.3
Excessive crying	R45.83
Altered mental status	R41.82
Impulsiveness	R45.87
Irritability and anger	R45.4
Abnormal weight gain	R63.5
Abnormal weight loss	R63.4
Other speech disturbance	R47.89
Senility w/o mention psychosis	R41.81
Headache, unspec	R51.9
Sleep disturbance	G47.9
Hallucinations	R44.3
Dizziness/giddiness	R42
Decreased libido	R68.82
Fatigue	R53.83
Low self-esteem	R45.81
Night terrors (child)	F51.4

"PROVISIONAL DX" / "RULE OUT DX" TODAY??	
ICD-10 Guidelines prohibit assignment of a diagnosis when that Dx. is only being "considered" at this time. Report Signs/Symptomes when definite DX is absent. One might consider assignment of R69 in cases where a definitive diagnosis cannot yet be assigned. R69 May or may not represent reimbursement problems, Coder/biller should monitor.	
Mental illness, NOS	F99
Illness, unspecified	R69

Personal History of Abuse in Childhood *(Excludes Current)*	
physical and sexual abuse	Z62.810
psychological abuse	Z62.811
neglect	Z62.812
forced labor or sexual exploitation	Z62.813
financial abuse	Z62.814
intimate partner abuse	Z62.815
unspecificed abuse	Z62.819
Use additional code(s) to identify manifestations of vaping-related disorders	

Other Patient Noncompliance Diagnoses	
Other med. noncompliance *(e.g., self overdosing)*	Z91.14
Noncompliance, ***other than*** meds d/t financial hardship	Z91.190
Noncompliance with diet d/t other reason (food desert)	Z91.118

Cognitive Defects *(Any age)*	
Attention/concentration	R41.840
Cognitive communication	R41.841
Visuospatial	R41.842
Psychomotor	R41.843
Frontal lobe/executive function	R41.844
Other cognitive deficits	R41.89
Dementia in disease classified elsewhere	F02.80
Code first, underlying condition	*code first*
with agitation	F02.811

(OB) Puerperium Mental & Behavioral Disorders	
Postpartum depression	F53.0
Peurperal psychosis	F53.1

Underdosing of Prescribed Medication by Patient (requires 2 codes)	
Refer these cases to coder for code assignment	
Code first, underdosing of medication (T36-T50) with fifth or sixth character of "6", then code intent and reason (below)	
1. Look up med or med class in ICD	TXX.XXX -
When assigning the "T" code, the 7th character will be; "A" Initial eval of this med management, "D" FU or "S" Sequala	

Patient Medication Noncompliance by Self Underdosing of;	
*Replace dash (-) w/ **A** =initial (active tx); **D** = FU (healing); or **S** =sequela*	
tetracyclic antidepressants	T43.026 -
tricyclic antidepressants	T43.016 -
other antidepressant	T43.296 -
antipsychotics (phenothiazine)	T43.3x6 -
amphetamines	T43.626 -
other psychostimulant	T43.696 -
antipsychotics and neuroleptics	T43.596 -
barbiturates	T42.3x6 -
benzodiazepines	T42.4x6 -
butyrophenone/thiothixene narcoleptics	T43.4x6 -
cannabis	T40.7x6 -
MAOIs	T43.1x6 -
methadone	T40.3x6 -
methyphenidate (ADD)	T43.636 -
narcotics (synthetic)	T40.4x6 -
opium	T40.0x6 -
other opioid	T40.2x6 -
psychotropic (other)	T43.8x6 -
SSRIs	T43.226 -

2. Code also intent and reason from self underdosing	
INTENTIONAL underdosing of med(s) by patient;	
due to financial hardship	Z91.120
for any other reason	Z91.128
UNINTENTIONAL underdosing by patient;	
due to age-related debility	Z91.130
for any other reason	Z91.138

INJURIES (Fractures, Burns, Lacerations)
(A=Initial/Active treatment. D=Subsequent/Healing. S=Sequela)

UPPER EXTREMITY	RIGHT	LEFT
SHOULDER/HUMERUS: ***Replace dash with 7th character EOC;***		
A=Initial/Active Tx, D=Subseq/healing, S=S	RIGHT	LEFT
Contusion: shoulder	S40.011-	S40.012-
Upper arm	S40.021-	S40.022-
Pain in shoulder	M25.511	M25.512
Stiffness, shoulder	M25.611	M25.612
Sprain, rotator cuff	S43.421-	S43.422-
Strain, rotator cuff	S46.011-	S46.012-
biceps, long head	S46.111-	S46.112-
Swelling (disorder, soft tissue)	M79.89	M79.89
Joint effusion, shoulder	M25.411	M25.412
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Dislocation shoulder [more detail available]	S43.004-	S43.005-
Recurrent dislocation shoulder	M24.411	M24.412
ELBOW: *Replace dash with 7th character EOC*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S50.01X-	S50.02X-
Pain	M25.521	M25.522
Stiffness	M25.621	M25.622
Sprain, elbow [more detail available]	S53.401-	S53.402-
Swelling (soft tissue)	M79.89	M79.89
Elbow joint effusion	M25.421	M25.422
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Nursemaid's elbow	S53.031-	S53.032-
WRIST: *Replace dash with 7th character EOC;*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S60.211-	S60.212-
Pain	M25.531	M25.532
Stiffness	M25.631	M25.632
Sprain, wrist [more detail available]	S63.501-	S63.502-
Swelling (soft tissue)	M79.89	M79.89
Wrist joint effusion	M25.431	M25.432
Carpal tunnel syndrome	G56.01	G56.02
Ganglion cyst	M67.431	M67.432
Laceration, forearm, without foreign body	S51.811-	S51.812-
Burn, forearm, second degree	T22.211-	T22.212-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Fx: distal radius, non-displaced	S52.501-	S52.502-
Fx: Colles'	S52.531-	S52.532-
HAND: *Replace dash with 7th character EOC;*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S60.221-	S60.222-
Pain	M79.641	M79.642
Pain in finger(s)	M79.644	M79.645
Stiffness	M25.641	M25.642
Sprain unspecified part(s) hand/wrist	S63.91X-	S63.92X-
Sprain finger, unspecified finger/region	S63.619-	S63.619-
Hand joint effusion	M25.441	M25.442
Burn, palm, second degree	T23.251-	T23.252-
Burn, palm, third degree	T23.351-	T23.352-
Laceration, hand, without foreign body	S61.411-	S61.412-
Laceration, thumb, without foreign body	S61.011-	S61.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
FX 5th metacarpal shaft, nondisplaced,	S62.356-	S62.357-
FX navicular, w/o specificity [many choices	S62.001-	S62.002-
FX phalanx, index, nondisplaced	S62.600-	S62.601-
Joint effusion, hand	M25.441	M25.442
Joint (wrist) effusion	M25.431	M25.432

LOWER EXTREMITY	RIGHT	LEFT
KNEE: ***Replace dash with 7th character EOC;***		
A=Initial D=FU & S=Sequela	RIGHT	LEFT
Contusion of the knee	S80.01X-	S80.02X-
Pain	M25.561	M25.562
Stiffness	M25.661	M25.662
Sprain, CRUCIATE ligament, unspecified	S83.501-	S83.502-
Sprain, LATERAL collateral ligament	S83.421-	S83.422-
Sprain, MEDIAL collateral ligament	S83.411-	S83.412-
Tear, meniscus, undescribed	S83.206-	S83.207-
Subluxation, lateral patella	S83.011-	S83.012-
Joint effusion knee	M25.461	M25.462
Swelling - soft tissue disorder	M79.89	M79.89
Laceration, knee, without foreign body	S81.011-	S81.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Patella fx	S82.001-	S82.002-
ANKLE: *Replace dash with 7th character EOC;*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S90.01X-	S90.02X-
Pain	M25.571	M25.572
Stiffness	M25.671	M25.672
Sprain; deltoid ligament	S93.421-	S93.422-
calcaneofibular ligament	S93.411-	S93.412-
tibiofibular ligament	S93.431-	S93.432-
other specified ligament (eg., talofibular)	S93.491-	S93.492-
Joint effusion, ankle	M25.471	M25.472
Swelling (soft tissue)	M79.89	M79.89
Burn, lower leg (calf), second degree	T24.231-	T24.232-
Laceration, ankle, without foreign body	S91.011-	S91.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Dislocation	S93.04X-	S93.05X-
FOOT/TOES: *Replace dash with 7th character EOC;*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S90.31X-	S90.32X-
Pain	M25.571	M25.572
Stiffness	M25.674	M25.675
Sprain [more detail available]	S93.601-	S93.602-
Joint effusion, foot	M25.474	M25.475
Swelling, skin and subcutaneous tissue	R22.41	R22.42
Laceration, foot, without foreign body	S91.311-	S91.312-
Laceration, foot, with foreign body	S91.321-	S91.322-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
FX great toe, displaced, unspec phalanx	S92.401-	S92.402-
FX, lesser toe, displaced, unspec phalanx	S92.501-	S92.502-
FX, 1st metatarsal, displaced	S92.311-	S92.312-
CERVICAL SPINE: *Replace dash with 7th character EOC;*		
A=Initial/Active Tx, D=Subseq/healing, S=Sequela		
Contusion	S10.93X-	
Pain - Cervicalgia	M54.2	
Stiffness	M43.6	
Sprain cervical ligament(s)	S13.4XX-	
Strain muscles, fascia and tendons neck	S16.1XX-	
Swelling, skin and subcutaneous tissue	R22.1	
Injury (undefined)	S19.9XX-	
Radiculopathy	M54.12	

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INJURIES (Fractures, Burns, Lacerations)
(A=Initial/Active Treatment. D=Subsequent/Healing. S=Sequela)

LUMBAR SPINE: *Replace dash with 7th character EOC*	
A=Initial/Active Tx, D=Subseq/healing, S=Sequela	
Contusion	S30.0XX-
Pain, low back, w/sciatica, right side	M54.41
Pain, low back, w/sciatica, left side	M54.42
Pain, low back, **without** sciatica	M54.50
Sprain ligament(s)	S33.5XX-
Strain muscles, fascia, tendons, low back	S39.012-
Swelling, soft tissue	M79.89
Fx, vertebra due to osteoporosis	M80.08X-
Radiculopathy, lumbar	M54.16
lumbosacral	M54.17
Burn, lower back, second degree	T21.24X-

PELVIS & FEMUR: *Replace dash with 7th character EOC*		
A=Initial/Active Tx, D=FU/healing, S=Sequ	RIGHT	LEFT
Contusion, pelvis	S30.0XX-	S30.0XX-
Contusion, thigh	S70.11X-	S70.12X-
Pain, thigh	M79.651	M79.652
Strain, thigh [more detail available]	S76.911-	S76.912-
Strain, hip	S76.011-	S76.012-
Burn, thigh, second degree	T24.211-	T24.212-
Sprain, hip [more detail available]	S73.101-	S73.102-
Effusion, hip	M25.451	M25.452

Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC

Burns: EMR Search: burn, second degree, right palm & EOC		
Second degree palm	T23.251-	T23.252-
Code also percent of body surface burned	Code Also	
Less than 10% of body surface burned	T31.0	
10% - 19% of body surface burned	T31.10	
20% - 29% of body surface burned, add	T31.20	

PHYSICAL ABUSE CODES: *Replace dash w/7th character EOC*	
A=Initial/Active Tx, D=FU/healing & S=Sequela	
Suspected abuse;	
physical abuse of an adult	T76.11x-
sexual abuse of adult	T76.21x-
physical abuse of a child	T76.12x-
sexual abuse of a child	T76.22x-
Confirmed abuse;	
physical abuse of adult	T74.11x-
sexual abuse of adult	T74.21x-
physical abuse of a child	T74.12x-
sexual abuse of a child	T74.22x-

LACERATIONS

Lacerations: Generally right/left specific, with or w/o foreign body. Fingers are specific, e.g. index, little, middle, ring; thumb has it's own section. All with or w/o nail damage.

Replace dash with 7th character EOC; A=Initial/Active Tx, D=Subseq/healing, S=Sequela	RIGHT	LEFT
foot, except toes:	S91.311-	S91.312-
with foreign body	S91.321-	S91.322-
forehead	S01.81X-	
with foreign body	S01.82X-	
eyelid w/o foreign body	S01.111-	S01.112-
ear	S09.91X-	
scalp w/o foreign body	S01.01X-	
with foreign body	S01.02X-	
face, unsp	S09.93X-	
hand	S61.411-	S61.412-
with foreign body	S61.421-	S61.422-
knee	S81.011-	S81.012-
with foreign body	S81.021-	S81.022-
thumb	S61.011-	S61.012-
with foreign body	S61.021-	S61.022-
with damage to nail	S61.111-	S61.112-
with foreign body and nail damage	S61.121-	S61.122-

OTHER MISCELLANEOUS INJURIES		
Black Eye NOS	S00.11X-	S00.12X-
Foreign body		
eye	T15.91X-	T15.92X-
ear	T16.1XX-	T16.2XX-
nostril	T17.1XX-	
pharynx, (specify type and if asphyxia)	T17.2 - - -	
Frostbite, superficial		
face	T33.09x -	
hand	T33.521-	T33.522-
foot	T33.821-	T33.822-
Heatstroke	T67.01X-	
Disruption of wound		
internal surgical wound	T81.32X-	
external surgical wound	T81.31X-	

SOCIAL DETERMINANTS OF HEALTH (SDoH)

Education and Literacy	Code
Illiteracy and low-level literacy	Z55.0
Underachievement in school	Z55.3
Edu. maladjustment, discord w/ teachers &	Z55.4
Other problems r/t education and literacy	Z55.8
Problems related to health literacy	Z55.6
Employment and Unemployment	
Unemployment, unspecified	Z56.0
Change of job	Z56.1
Threat of job loss	Z56.2
Stressful work schedule	Z56.3
Discord with boss and workmates	Z56.4
Uncongenial work environment	Z56.5
Other physical and mental strain related to work	Z56.6
Housing and Economic Circumstances	
Homelessness, sheltered	Z59.01
Homelessness, unsheltered	Z59.02
Inadequate housing	
environmental temperature	Z59.11
utilities	Z59.12
other (pest infestation, space restrictions, etc.)	Z59.19
Problems r/t in residential institution	Z59.3
Food insecurity	Z59.41
Other specified lack of adequate food	Z59.48
Extreme poverty	Z59.5
Low income	Z59.6
Insufficient health insurance coverage	Z59.71
Insufficient welfare support	Z59.72
Housing instability	
housed with risk of homelessness	Z59.811
housed, homelessness in past 12 months	Z59.812
Transportation insecurity	Z59.82
Financial insecurity	Z59.86
Materal hardship d/t limited financial resources	Z59.87
Social Environment	
Empty nest syndrome	Z60.0
Problems related to living alone	Z60.2
Acculturation difficulty	Z60.3
Social exclusion and rejection	Z60.4
Other problems related to social environment	Z60.8
Upbringing	
Foster care (status)	Z62.21
Institutional upbringing	Z62.22
Child in custody of non-parental relative	Z62.23
Child in custody of non-relative guardian	Z62.24
Other upbringing away from parents	Z62.29
Parent-child conflict	Z62.820
Parent-step child conflict	Z62.823
Non-parental relative-child conflict	Z62.831
Runaway	Z62.892
Personal history of abuse in childhood *Excludes current*	
physical and sexual abuse	Z62.810
psychological abuse	Z62.811
neglect	Z62.812
forced labor or sexual exploitation	Z62.813
intimate partner abuse in childhood	Z62.815

Primary Support Group,Family Circumstances	Code
Problems in relationship with spouse/partner	Z63.0
Absence of family member due to military deployment	Z63.31
Other absence of family member	Z63.32
Disruption of family by separation and divorce	Z63.5
Stress on family d/t return of family member from military deployment	Z63.71
Alcohol/drug addiction in family	Z63.72
Problem r/t primary support group, unspecified	Z63.9
Other Psychosocial Circumstances	
Conviction civil/criminal proceedings w/o imprisonment	Z65.0
Imprisonment and other incarceration	Z65.1
Problems related to release from prison	Z65.2
Problems related to other legal circumstances	Z65.3
Victim of a crime and terrorism	Z65.4
Lifestyle	
Lack of physical exercise	Z72.3
Inappropriate diet and eating habits	Z72.4
High risk sexual behavior	
heterosexual behavior	Z72.51
homosexual behavior	Z72.52
bisexual behavior	Z72.53
Anti-social behavior	
child and adolescent antisocial behavior	Z72.810
adult antisocial behavior	Z72.811
Problem r/t sleep	
sleep deprivation	Z72.820
inadequate sleep hygiene	Z72.821
Life Management Difficulty	
Burn-out	Z73.0
Type A behavoir pattern	Z73.1
Stress, NEC	Z73.3
Inadequate social skills, NEC	Z73.4
Social role conflict, NEC	Z73.5
Limitation of activites due to disability	Z73.6
Care Provider Dependency	
No household member to render care	Z74.2
Medical Facilities and Other Health Care	
Holiday relief care	Z75.5
Personal Risk Factors, NEC	
Personal history of adult physical and sexual abuse	Z91.410
Personal history of adult psychological abuse	Z91.411
Dependence on Enabling Machines/Devices, NEC	
Wheelchair dependence *Code cause of dependence*	Z99.3
Dependence on supplemental oxygen	Z99.81

Z codes may be used as either a first-listed or secondary code. Some codes may only be used as first-listed. Codes describing social determiniants of health (SDoH) should be assigned when this information is documented by clinicians involved in the care of the patient who are not the patient's provider.

From the American Medical Association ICD-10-CM 2024 The Complete Official Codebook:

Appendix E: Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC)

In the 1970s, Medicare began demonstration projects that contracted with health maintenance organizations (HMOs) to provide care for Medicare beneficiaries in exchange for prospective payments. In 1985, this project changed from demonstration status to a regular part of the Medicare program, Medicare Part C. The Balanced Budget Act (BBA) of 1997 named Medicare's Part C managed care program Medicare+Choice, and the Medicare Modernization Act (MMA) of 2003 again renamed it to Medicare Advantage (MA).

Medicare Is one of the world's largest health Insurance programs, and about one-third of the beneficiaries on Medicare are enrolled In a MA private health care plan. Due to the great variance in the health status of Medicare beneficiaries, risk adjustment provides a means of adequately compensating those plans with large numbers of seriously ill patients while not overburdening other plans that have healthier individuals. Medicare Advantage (MA) plans have been using the Hierarchical Condition Category (HCC) risk adjustment model since 2004.

The Risk Adjustment Model

The primary purpose of a risk adjustment model Is to predict (on average) the future health care costs for specific consortiums enrolled In Medicare Advantage (MA) health plans. CMS is then able to provide capitation payments to these private health plans. Capitation payments are an Incentive for health plans to enroll not only healthier Individuals but those with chronic conditions or who are more seriously ill by removing some of the financial burden.

The MA risk adjustment model uses HCCs to assess the disease burden of its enrollees. HCC diagnostic groupings were created after examining claims data so that enrollees with similar disease processes, and consequently similar health care expenditures, could be pooled into a larger data set in which an average expenditure rate could be determined. The medical conditions included In HCC categories are those that were determined to most predictably affect the health status and health care costs of any Individual. Several important principles to the risk adjustment model and the development of the HCC categories include but are not limited to:

1. The HCC diagnostic categories should be clinically meaningful.
    a. Diagnostic categories are well-defined.
    b. Clinically specific diseases or medical conditions are grouped to each category.
2. The HCC diagnostic categories should predict medical expenditures.
    a. The diagnoses grouped to a specific category should have as close to the same cost burden not only in the current year but also in the future.
3. The HCC diagnostic categories should have adequate sample sizes and discretionary categories excluded to be as accurate and stable in their estimate of costs as possible.
    a. A diagnostic category that groups extremely rare diseases or conditions would not be reliably effective in determining current or future costs.
    b. Codes that are not credible as cost predictors or may be subject to coding variation should be excluded, when possible.
4. The HCC diagnostic categories should be both hierarchical and additive.
    a. Hierarchical measurement is used within a specific disease process.

b. Disease processes that are unrelated to each other are measured additively.

c. The diagnostic classification should encourage specificity and should not reward coding proliferation.

d. More diagnosis codes and vague diagnosis codes do not equal greater diseaseburden.

The model will use more recent data and denominator year and reflect a reclassification by which CMS rebuilt the condition categories to reflect diagnosis coding under the ICD-10-CM diagnosis classification system. CMS assessed conditions that are coded more frequently for Medicare Advantage and as a result the proposed model includes additional constraints and the removal of several HCCs in order to reduce the impact on risk scores of MA coding variation. The 2024 CMS-HCC model has 115 payment HCCs, up from 86 in the current model. This increase in HCCs is due to newly created HCCs added to the model and the splitting of several existing HCCs resulting from changes in the structure and clinical specificity of codes from ICD-9 to ICD-10, as well as changes in clinical concepts for some conditions. The model results in more appropriate relative weights because they reflect more recent utilization, coding and expenditure patterns. Beneficiary risk scores or plan average risk scores may change depending on each individual beneficiary's combination of diagnoses or the clinical profile of a plan's enrollee population.

To guide the reclassification process, CMS applied its longstanding 10 Principles of Risk Adjustment that were used to create the original CMS-HCC diagnosis classification system. Both the panel of clinicians and analyses of cost data informed CMS's creation of the revised condition categories. The new categories reflect more clinical specificity and validity available through ICD-10 coding and better reflects recent cost and utilization patterns. The new categories and updated HCCs also reflect possible changes to physician coding patterns that have developed as a result of the transition to ICD-10 that the current model does not. Changes to the condition categories are based on each condition category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that do not predict costs well or do not have well-specified diagnosis coding are not included in the model.

Risk Adjustment Factors

The CMS-HCC risk adjustment model uses "risk adjustment factors" to calculate a risk score for each member. This score summarizes that particular patient's expected cost of care relative to other members'. Each member's risk score Is based on demographic and health status information and is calculated as the sum of these demographic and health factors weighted by their estimated marginal contributions to total risk. The model also takes into account where the patient resides (community or Institutional), Medicaid eligibility (full or partial benefits), the patient's Medicare enrollment status (new or established), age, disability status, whether the patient is frail or has end-stage renal disease
(ESRD), and even prescription drug use.

No procedure codes, ICD-10-PCS or CPT, are Included In the MA risk adjustment model. The model relies solely on diagnostic and demographic data. Not all ICD-10-CM diagnoses map to an HCC, and there Is no specific code sequencing involved. The CMS-HCC model Is additive as well as hierarchical. The additive functionality allows a patient to have more than one HCC category assigned, providing a more complete clinical picture and prediction of resource consumption. The hierarchical aspect of the model provides a means of ranking diagnoses that are similar in disease process, by severity. The hierarchy of the condition categories ensures the patient's conditions are classified to the most severe condition within the related group. Less severe conditions within a particular hierarchy are superseded by more severe diagnoses within the same group. The hierarchy and additive relationship permits this model to characterize the person's illness level within each disease process, while still allowing the effects of unrelated disease processes to be counted In the patient's overall score.

Certain combinations of coexisting diagnoses for an individual can increase medical costs. The CMS-HCC model adjusts for these higher costs by the addition of disease interaction factors. For each patient, multiple HCCs assigned, along with demographic and disease interaction factors, are used to calculate a single, combined risk adjustment factor (RAF). The RAF

score for an individual member represents all of the HCCs that have been submitted from all sources for that member to CMS during the course of an entire calendar year.

There are separate CMS-HCC models for new enrollees and continuing enrollees. The new enrollee model uses demographic factors only, such as age, sex, and disability status, and is used when the enrollee has less than 12 months of medical history. The community model accounts for age, sex, original reason for Medicare entitlement (age or disability), Medicaid eligibility, and clinical conditions as measured by HCCs. In the second step, expected costs are adjusted for outliers based on the member's risk score and whether the patient has ESRD.

Demographic data (age, sex, eligibility) as well as health status (diagnoses codes submitted on claims to CMS) of an MA population are used to determine the reimbursement to the health plan to care for their members.

CMS considers a RAF score of 1.0 as the benchmark to indicate the score of the average healthy patient with the same demographic and diagnostic factors, these patients are expected to use average or lower-than-average resources. When the RAF score Is higher than 1.0, CMS considers the patient to be sicker than the average patient with the same criteria and expects greater-than-average resource utilization.

A low RAF score may accurately indicate a healthier patient, but it may also falsely indicate a healthier patient due to Incomplete or inaccurate coding, incomplete or Insufficient record documentation, or patients who fail to complete an annual assessment.
A high RAF score may accurately Indicate a sicker patient, or it may be falsely inflated from overcoding due to diagnoses that are reported but not documented, or from copying and pasting from previous encounters or problem lists of resolved conditions.

Documentation Requirements
Payment Is made per HCC category (not per diagnosis code). No matter how many times in the year the diagnosis codes are reported, a single payment Is made to the MA plan each year. Each year the list of HCCs and the RAF for each patient is "reset." This means the annual health assessment is extremely important, and adequate documentation Is critical. Accurate risk adjustment payment relies on complete medical record documentation and diagnosis coding. CMS requires that all applicable diagnosis codes be reported and that all diagnoses be reported to the highest level of specificity and that these be substantiated by the medical record.

CMS's Guiding Principle:
The risk adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter, coded according to the ICD-10-CM Guidelines for Coding and Reporting; assigned based on dates of service within the data collection period, submitted to the MA organization from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source.

A "face-to-face" health service encounter between a patient and healthcare provider describes an encounter between the patient and the provider (MD, DO), Including qualified nonphysician practitioners (NPP) (e.g. nurse practitioner or physician's assistant), which is face-to-face with the patient. CMS provides a current listing of acceptable physician specialty types for risk adjustment data submission within the 2012 Regional Technical Assistance Participant Guide. The only exception to the face-to-face encounter requirement Is pathology services (professional component only). Due to the 2019 coronavirus disease (COVID-19) pandemic, CMS is allowing MA organizations to submit diagnoses from telehealth services that meet the risk adjustment face-to-face requirement when the services are provided using interactive audio and video telecommunications systems that permit real-time interactive communication. Currently, CMS does not provide a listing of all services that are considered face-

to-face visits for risk adjustment data, but does provide guidance on what types of services are not acceptable for risk adjustment In the Participant Guide. For example, diagnostic radiology does not qualify because diagnostic radiologists typically do not document confirmed diagnoses. Other examples of services that are not acceptable include diagnostic reports that have not been interpreted, such as laboratory reports.
It is essential that the medical record documentation show evidence by provider authentication that the direct face-to-face service was personally furnished by the physician or qualified NPP. Examples of these services Include office visits, hospital visits, preoperative anesthesia assessment, and surgical and invasive procedures.

Risk adjustment relies on annual health Information. Each enrollee is assigned an individual risk score based on the health status information obtained from the diagnosis codes on the claims. The CMS-HCC model relies on ICD-10-CM coding specificity for accurate risk adjustment by using the most specific code available that is substantiated by the documentation in the medical record. Providers should fully document and accurately code the evaluation and management of all severe and chronic conditions to ensure a full, complete, and accurate clinical record of the patient's condition and reflect the work involved in caring for the patient, particularly those with complex and challenging health issues. All conditions affecting the treatment or management of the patient's health should be documented at least once a year, as applicable to care provided, to accurately describe the true complexity and severity of the patient's health. If the diagnosis coding on the claim Is not accurate or complete, the claim may Indicate that the provider did much less medical decision-making, evaluation, and management than was actually performed.

Documentation to support or validate risk adjustment conditions may be found anywhere in the note for the face-to-face encounter. It is Important to ensure that the note accurately reflects all chronic conditions that affect the health and care of the patient. Each encounter must be unique and reflect only that visit as it occurred. Insufficient documentation Influences the assignment of diagnosis codes and directly affects the patient's risk score.

Documentation should properly validate all reported conditions. Each page of progress notes should be properly authenticated and include the patient's name and the date.

Providers should document each clinical diagnosis to the highest degree of specificity per encounter, including all complications and/or manifestations, including clear links to causal conditions. Only confirmed conditions should be documented - no rule-out conditions or abnormal findings without clinical significance. All known conditions, including chronic conditions, that affect the care and treatment of the patient at least once per year should be noted.

Providers should specifically document the condition and clinical significance, and pertinent changes using terminology such as decreased, increased, worsening, Improving, or unchanged, or abnormal findings.

Documentation Tips

- Document all cause-and-effect relationships.
- Report the most specific diagnosis code available that is supported by the documentation.
- Include all current diagnoses as part of the current medical decision-making, and document for every visit.
- Identify diagnoses that are current or chronic problems rather than a past medical history or previous resolved condition.
- Document history of heart attack, status codes, etc., that affect the patient's care as "history of" or "PMH" when they no longer exist or are not current conditions.
- Ensure each progress note has the date, signature, and credentials/specialty.
- Document the thought processes used to assess each condition.
- Know high revenue HCCs that are often undiagnosed or undercoded.

- Avoid "unspecified" codes.
- Ensure the codes reported are accurate.
- Ensure each encounter is billed.
- Review rejection reports, and audit reports to assess risks.

Audits

Because reimbursement Is by patient, rather than based on an average of the entire population, and is based upon documentation, there is the potential for upcoding. Audits are conducted by the MA plan and CMS recovery auditors.

Initial Validation Audit (IVA)

CMS requires that the MA plan validate HCCs. This is usually performed by an Independent auditor working with the plan or a contracted vendor to validate the MA plan's data submitted to CMS. The MA plan submits the one best medical record that supports each HCC identified for the beneficiary.

Risk Adjustment Data Validation Audit

Risk adjustment data validation (RADV) audits were introduced in 2011 and updated for 2015. They are performed by CMS to validate the integrity and accuracy of risk-adjusted payments by verifying that the diagnosis codes the MA plans submit are supported by the medical record documentation for a member. On March 30, 2020, CMS announced it was suspending RADV activities related to the payment year 2015 audit and will not initiate any additional contract-level audits until after the 2019 coronavirus public health emergency (PHE) has ended, at which time CMS will make an announcement when normal audit activities will resume.

MA plans can be selected by CMS for RADV audits annually and If chosen are required to submit their members' medical records to CMS. Providers are required to assist the MA plan by providing the medical record documentation included in the audit. Even though each diagnosis needs to be reported only once in a calendar year, during a RADV audit up to five dates of service may be submitted to support any one HCC.

To be validated, medical record documentation must meet certain criteria and standards. Even if the diagnosis is documented and coded correctly, any deficiency in the documentation can make the encounter and the HCC invalid. Diagnoses that cannot be validated are considered payment errors. The results of the audit are communicated to the MA plan, which then communicates these results to the provider. Under- and overpayments are subject to payment adjustment. The results of RADV audits can be extrapolated over the MA plan population to calculate potential payment errors and overpayments/ recoupments. Regulations include a RADV appeal process, a document dispute process, and a procedure for obtaining physician-signature attestations.

The following items are reviewed during the validation process:

- The record Is for the correct enrollee.
- The record Is from the correct calendar year for the payment year being audited.
- The record is legible.
- The date of service is present on the records and is for a face-to-face visit.
- The record Is from a valid provider type.
- Valid credentials and/or a valid physician specialty are documented on the record.
- The record contains a signature from an acceptable type of physician.
- There Is a diagnosis on the record.

- The diagnosis supports an HCC.
- The diagnosis supports the submitted HCC.

Mitigate audit risk by coding each reportable diagnosis each time it meets reporting guidelines. Audit regularly to assess areas of risk and in need of improvement and to capture conditions documented but not coded. Check for additional qualifying HCCs. Ensure claims are submitted and that corrected claims are submitted when indicated. There are three claims submission deadlines: January, March, and September. CMS adjusts each member's risk score twice a year, with the final reconciliation in August of the year after the plan year.

If providers emphasize correct coding and documentation and perform Internal audits to determine where the risks are and prepare for audits, incorrect payment Is less likely. For additional Information on risk adjustment coding, see Optum's Risk Adjustment Coding and HCC Guide.