An Overview of HCC Risk Adjustment-Documentation and ICD-10-CM Coding

Presented by: Kathy Kuntz, CPC, CRC, CPCD
## HCC Risk Adjustment Overview

<table>
<thead>
<tr>
<th>Fee for Service</th>
<th>HCC Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providers are paid based on services performed.</td>
<td>• Concentrates on patient’s current conditions.</td>
</tr>
<tr>
<td>• Payment is based on CPT code accuracy.</td>
<td>• Payment is based on the overall complexity of the patient’s conditions over a year’s period.</td>
</tr>
<tr>
<td>• Critical that documentation support the level of service and procedures performed.</td>
<td>• Uses patient demographics and diagnosis codes to establish payment.</td>
</tr>
<tr>
<td>• ICD-10-CM codes reported to support the medical necessity of the service provided.</td>
<td></td>
</tr>
</tbody>
</table>
HCC Risk Adjustment Overview (cont’d)

- CMS HCC Model
- HHS HCC Model
- Medicaid CDPS Model
- Hybrid Model
HCC Risk Adjustment
Overview (cont’d)

CMS Model HCC Requirements

• Services must be reported by an acceptable provider type
• There must be a face-to-face encounter with the patient
• Provider signature, credential, and date signed must be on record
• Documentation must clearly show the condition is current
• Each page of the patient’s medical record must have two identifiers:
  ✓ Member’s name
  ✓ Member’s date of birth
  ✓ Medical record number
  ✓ Account number
<table>
<thead>
<tr>
<th>CODE</th>
<th>SPECIALTY</th>
<th>CODE</th>
<th>SPECIALTY</th>
<th>CODE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>79</td>
<td>Addiction Medicine</td>
<td>40</td>
<td>Hand Surgery</td>
<td>20</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>C7</td>
<td>Advanced Heart Failure and Transplant Cardiology</td>
<td>82</td>
<td>Hematology</td>
<td>12</td>
<td>Osteopathic Manipulative Therapy</td>
</tr>
<tr>
<td>3</td>
<td>Allergy/Immunology</td>
<td>83</td>
<td>Hematology/Oncology</td>
<td>4</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>5</td>
<td>Anesthesiology</td>
<td>C9</td>
<td>Hematopoietic Cell Transplantation and Cellular</td>
<td>72</td>
<td>Pain Management</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist</td>
<td>17</td>
<td>Hospice and Palliative Care</td>
<td>22</td>
<td>Pathology</td>
</tr>
<tr>
<td>21</td>
<td>Cardiac Electrophysiology</td>
<td>C6</td>
<td>Hospitalist</td>
<td>37</td>
<td>Pediatric Medicine</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac Surgery</td>
<td>44</td>
<td>Infectious Disease</td>
<td>76</td>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>6</td>
<td>Cardiology</td>
<td>11</td>
<td>Internal Medicine</td>
<td>25</td>
<td>Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>89</td>
<td>Certified Clinical Nurse Specialist</td>
<td>C3</td>
<td>Interventional Cardiology</td>
<td>65</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>42</td>
<td>Certified Nurse Midwife</td>
<td>9</td>
<td>Interventional Pain Management (IPM)</td>
<td>97</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>43</td>
<td>Certified Registered Nurse Anesthetist</td>
<td>94</td>
<td>Interventional Radiology</td>
<td>24</td>
<td>Plastic and Reconstructive Surgery</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractic</td>
<td>80</td>
<td>Licensed Clinical Social Worker</td>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>68</td>
<td>Clinical Psychologist</td>
<td>85</td>
<td>Maxillofacial Surgery</td>
<td>84</td>
<td>Preventive Medicine</td>
</tr>
<tr>
<td>28</td>
<td>Colorectal Surgery</td>
<td>90</td>
<td>Medical Oncology</td>
<td>26</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>81</td>
<td>Critical Care (Intensivists)</td>
<td>C8</td>
<td>Medical Toxicology</td>
<td>62</td>
<td>Psychologist</td>
</tr>
<tr>
<td>C5</td>
<td>Dentist</td>
<td>39</td>
<td>Nephrology</td>
<td>29</td>
<td>Pulmonary Disease</td>
</tr>
<tr>
<td>7</td>
<td>Dermatology</td>
<td>13</td>
<td>Neurology</td>
<td>92</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>93</td>
<td>Emergency Medicine</td>
<td>86</td>
<td>Neuropsychiatry</td>
<td>66</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>46</td>
<td>Endocrinology</td>
<td>14</td>
<td>Neurosurgery</td>
<td>C0</td>
<td>Sleep Medicine</td>
</tr>
<tr>
<td>8</td>
<td>Family Practice</td>
<td>36</td>
<td>Nuclear Medicine</td>
<td>15</td>
<td>Speech Language Pathologist</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
<td>50</td>
<td>Nurse Practitioner</td>
<td>23</td>
<td>Sports Medicine</td>
</tr>
<tr>
<td>1</td>
<td>General Practice</td>
<td>16</td>
<td>Obstetrics/Gynecology</td>
<td>91</td>
<td>Surgical Oncology</td>
</tr>
<tr>
<td>2</td>
<td>General Surgery</td>
<td>67</td>
<td>Occupational Therapist</td>
<td>33</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>38</td>
<td>Geriatric Medicine</td>
<td>18</td>
<td>Ophthalmology</td>
<td>99</td>
<td>Unknown Physician Specialty</td>
</tr>
<tr>
<td>27</td>
<td>Geriatric Psychiatry</td>
<td>41</td>
<td>Optometry</td>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>98</td>
<td>Gynecologist/Oncologist</td>
<td>19</td>
<td>Oral Surgery</td>
<td>77</td>
<td>Vascular Surgery</td>
</tr>
</tbody>
</table>
What is CMS HCC Risk Adjustment?

✓ A process that CMS uses to reimburse Medicare Advantage plans based on the demographics and health status of members.

✓ Is a prospective model—uses this information from the prior year to predict the costs for a beneficiary for the following year.

✓ It identifies individuals with serious or chronic illness and assigns them a Risk Adjustment Factor Score, or RAF, based on his or her disease burden, as well as demographic factors.
The RAF is used to predict future healthcare costs for the patient.

Demographics

Health Status
(Reported Diagnosis Codes)

RAF Score
HCC Risk Adjustment
Overview (cont’d)

Demographic Factors that Contribute to RAF Score

- Age
- Sex
- Disabled status
- Original reason for entitlement
- Medicaid eligibility
- Patient’s housing status
  - Community
  - Institution
- Long term care
- ESRD
HCC Risk Adjustment Overview (cont’d)

Diagnosis Factors that Contribute to RAF Score

- Reported CMS HCC diagnosis codes for chronic and acute conditions
- Disease Interactions
- Multiple reported HCC Payment Conditions (Alternative Payment Condition Count (APCC))
• ICD-10-CM diagnosis codes reported over a year’s period contribute to a patient’s RAF score.
• The reported diagnosis codes are mapped to a hierarchical conditional category (HCC).

*HCC's are groupings of clinically similar diagnoses.*
HCC Risk Adjustment
Overview (cont’d)

- Diabetes without Complications HCC 19
- Schizophrenia HCC 57
- COPD HCC 111
- Amputation Status, Lower Limb/Complications HCC 189
- Diabetes with Complications HCC 18
- CKD Multiple HCCs
- Severe Head Injury HCC 166
- Major Depression Bipolar and Paranoid Disorders HCC 59
- Cancers Multiple HCCs
- CHF HCC 85
- HIV AIDS HCC 1
- Substance Use Disorders Moderate/Severe or with Complications HCC 55
- Morbid Obesity HCC 22
- Vascular Disease HCC 108
- Vascular Disease with Complications HCC 107
### Chronic Obstructive Pulmonary Disease

**CMS HCC Category 111**

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J410</td>
<td>Simple chronic bronchitis</td>
</tr>
<tr>
<td>J411</td>
<td>Mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J418</td>
<td>Mixed simple and mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J42</td>
<td>Unspecified chronic bronchitis</td>
</tr>
<tr>
<td>J430</td>
<td>Unilateral pulmonary emphysema [MacLeod's syndrome]</td>
</tr>
<tr>
<td>J431</td>
<td>Panlobular emphysema</td>
</tr>
<tr>
<td>J432</td>
<td>Centrilobular emphysema</td>
</tr>
<tr>
<td>J438</td>
<td>Other emphysema</td>
</tr>
<tr>
<td>J439</td>
<td>Emphysema, unspecified</td>
</tr>
<tr>
<td>J440</td>
<td>Chronic obstructive pulmonary disease with acute lower respiratory infection</td>
</tr>
<tr>
<td>J441</td>
<td>Chronic obstructive pulmonary disease with (acute) exacerbation</td>
</tr>
<tr>
<td>J449</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
</tr>
<tr>
<td>J982</td>
<td>Interstitial emphysema</td>
</tr>
<tr>
<td>J983</td>
<td>Compensatory emphysema</td>
</tr>
</tbody>
</table>
HCC Risk Adjustment Overview (cont’d)

Disease Hierarchy

- Addresses situations when multiple levels of severity for a disease, with varying levels of associated costs, have been reported for a beneficiary within the same calendar year.
- Conditions are categorized hierarchically and the highest severity takes precedence over other conditions in the hierarchy.
- Some categories supersede other categories.
Disease Hierarchy (cont’d)

Example:
• Patient at beginning of the year with DM without complications.
• Over the year, the patient’s condition progresses to DM with neuropathy.
Disease Hierarchy (cont’d)

Only the **DM with complications** will be considered towards the Risk Score. The HCC for the diabetes without complication will be dropped.

*Only the most severe HCC is counted in the calculation of the RAF score.*
HCC Risk Adjustment
Overview (cont'd)

Disease Interactions
Additional value/weight is given for some disease interactions/combinations due to the two conditions, when occurring together, require more resources than the value/weight for each condition alone would suggest.

Example: A patient with CHF in addition to Diabetes

The combination of these two diseases adds additional value/weight to the patient’s overall RAF score.
Multiple Payment HCCs

Additional value/weight may be given for patient’s who have at least four payment HCCs.

Example:

<table>
<thead>
<tr>
<th># Payment HCCs</th>
<th>Example Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>0.006</td>
</tr>
<tr>
<td>5</td>
<td>0.042</td>
</tr>
<tr>
<td>6</td>
<td>0.077</td>
</tr>
<tr>
<td>7</td>
<td>0.126</td>
</tr>
<tr>
<td>8</td>
<td>0.214</td>
</tr>
<tr>
<td>9</td>
<td>0.258</td>
</tr>
<tr>
<td>10 or more</td>
<td>0.505</td>
</tr>
</tbody>
</table>
Not all ICD-10-CM codes CMS HCC Risk Adjust.

There are more than 10,000 ICD-10-CM codes that map to over 80 HCC categories in the CMS HCC Risk Adjustment model.
HCC Risk Adjustment Overview (cont’d)

How is a Risk Factor Score Determined Based on Diagnosis Codes?

• ICD-10-CM codes are submitted with claims
• The ICD-10-CM codes are mapped to a Hierarchical Conditional Category (HCC)
• Each HCC is assigned a value/weight.
• The HCCs are cumulative—the more HCCs—the higher the patient’s Risk Factor Score (RAF)
How is a Risk Factor Score Determined?

- The Risk Score, or **RAF**, is then used by CMS to determine the payment made to Medicare Advantage Plans.
- The higher the **RAF**, the more resources are projected to be needed to manage the patient’s health—which results in higher payment.
# HCC Risk Adjustment Overview (cont’d)

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>HCC</th>
<th>Value/Weight</th>
<th>RAF Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/out complications E11.9</td>
<td>HCC19 Diabetes w/out complications E11.9</td>
<td>.106</td>
<td>XXXX</td>
</tr>
<tr>
<td>Diabetes with Complications E11.40</td>
<td>HCC18 Diabetes with Complications E11.40</td>
<td>.307</td>
<td>+</td>
</tr>
<tr>
<td>Acute Gastric Ulcer with Perforation K25.1</td>
<td>HCC 33 Intestinal Obstruction Perforation K25.1</td>
<td>.243</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Total:</td>
<td>.550</td>
<td></td>
</tr>
</tbody>
</table>

**HCC - Hierarchical Condition Category**  
**RAF - Risk Adjustment Factor**
HCC Risk Adjustment Overview (cont’d)

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>HCC</th>
<th>Value/Weight</th>
<th>RAF Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/out Complications E11.9</td>
<td>HCC19 Diabetes w/out Complications</td>
<td>.106</td>
<td>+ .106</td>
</tr>
<tr>
<td>Diabetes w/ Complications E11.39</td>
<td>HCC18 Diabetes w/ Complication</td>
<td>.307</td>
<td>+ .307</td>
</tr>
<tr>
<td>Congestive Heart Failure I50.9</td>
<td>HCC85 Congestive Heart Failure</td>
<td>.310</td>
<td>+ .310</td>
</tr>
<tr>
<td>Disease Interaction</td>
<td>Total:</td>
<td>.152</td>
<td>+ .152</td>
</tr>
<tr>
<td></td>
<td>Total:</td>
<td>.769</td>
<td></td>
</tr>
</tbody>
</table>

HCC - Hierarchical Condition Category
RAF – Risk Adjustment Factor
<table>
<thead>
<tr>
<th>Demographics</th>
<th>HCC</th>
<th>No Conditions Coded</th>
<th>Some Conditions Coded</th>
<th>All Conditions Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 Year Old Female</td>
<td>-</td>
<td>0.442</td>
<td>0.442</td>
<td>0.442</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>-</td>
<td>0.151</td>
<td>0.151</td>
<td>0.151</td>
</tr>
<tr>
<td>DM without Complications</td>
<td>19</td>
<td>X</td>
<td>0.106</td>
<td>X</td>
</tr>
<tr>
<td>DM with Complications</td>
<td>18</td>
<td>X</td>
<td>X</td>
<td>0.307</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>22</td>
<td>X</td>
<td>0.262</td>
<td>0.262</td>
</tr>
<tr>
<td>CHF</td>
<td>85</td>
<td>X</td>
<td>X</td>
<td>0.310</td>
</tr>
<tr>
<td>Intestinal Obstruct/Perfor</td>
<td>33</td>
<td>X</td>
<td>X</td>
<td>0.243</td>
</tr>
<tr>
<td>Disease Interactions</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>0.152</td>
</tr>
<tr>
<td>Multiple Payment HCC (4)</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>0.0006</td>
</tr>
<tr>
<td><strong>Total RAF Score</strong></td>
<td>-</td>
<td>0.593</td>
<td>0.961</td>
<td>3.241</td>
</tr>
</tbody>
</table>
Documentation and Coding for HCC Risk Adjustment

• HCC Risk Adjustment reimbursement depends on complete and accurate reporting of patient diagnoses.

• Thorough documentation and accurate ICD-10-CM code assignment is critical to predicting the risk and future cost associated with a patient’s care.

• All reported ICD-10-CM diagnoses and the plan of care related to the diagnoses must be documented in the patient’s medical record at least once every calendar year.
Documentation in the medical record must:

✓ Support **all diagnosis codes reported**-including specificity.

✓ Should accurately reflect the acuity of the patient’s condition.

✓ Must stand alone for each date of service.
When coding for CMS HCC Risk Adjustment it is appropriate to code for current/active conditions regardless of where they are documented in a progress note.

✓ HPI
✓ ROS
✓ Exam
✓ Assessment
✓ Plan
Example:
Documentation in the **Exam portion** of a note states:

August 7, 2013, the patient underwent a small bowel resection due to small bowel obstruction.

*Augmentation ileostomy with loop ileostomy.*

**ICD-10-CM Code:** Z93.2 Ileostomy status

*This Diagnosis Code CMS HCC Risk Adjusts (maps to HCC 188 – Artificial Openings for Feeding or Elimination)*
Documentation of each condition should be supported.

**MEAT**

**Documentation should support at least one of the following:**

- **Monitor** – signs, symptoms, disease progression, and disease regression
- **Evaluate** – tests results, medications, response to treatment
- **Assess** – order tests, discussion, records reviewed, and counseling
- **Treat** – medications, therapies, other modalities
• ICD-10-CM Coding Guidelines should be followed when coding for services performed.
• AHA Coding Clinic Guidelines should also be followed/referenced.

All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
ICD-10-CM Guidelines-Section IV – Diagnostic Coding and Reporting Guidelines for Outpatient Services

Code all Documented Conditions

J. Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (category Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
➢ It is not necessary for a provider to be in charge of a patient’s comorbidity in order for it to be coded.
➢ The comorbidity simply needs to affect decision-making or treatment in the current encounter.
ICD-10-CM Guidelines-Section IV
Diagnostic Coding and Reporting Guidelines for Outpatient Services

I. Chronic diseases-chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
Do Not Code/Rule Out or Working Diagnoses

*ICD-10-CM Guidelines - Section IV - Diagnostic Coding and Reporting Guidelines for Outpatient Services*

**H. Uncertain diagnosis** - Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, “compatible with”, “consistent with,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

*Submitting a rule/out or working diagnosis-as an established diagnosis-can result in an inaccurate RAF score*
Per ICD-10-CM Guidelines

Chapter 21 Specific Guidelines:

3.) Status codes indicate a patient is either a carrier of a disease or has the sequela or residual of a past disease or condition.

A status code is informative because the status may impact the course of treatment and its outcome.

Status diagnosis codes are often not coded, resulting in missed diagnosis codes that

CMS HCC Risk Adjust.
Current/Active Conditions vs. PMH

- Often documented as past medical history
- Diagnoses documented as past medical history should not be coded as a current condition
- Providers should be educated in regards to appropriate documentation for current active condition vs conditions that are historical
Diabetes

• Often coded as *without* complications when the documentation supports *with* complications.

• Documentation should always include:
  ✓ Type (1, 2, or secondary)
  ✓ Complications and body system affected
  ✓ Control status
  ✓ Long term use of insulin

*Per ICD-10-CM Coding Guidelines, the word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List.*
Morbid Obesity/BMI

- Often not documented and/or coded.
- Both Morbid Obesity and BMI 40 and over CMS-HCC Risk Adjust.
- A diagnosis for Morbid Obesity requires the provider expressly document the condition.
- BMI should not be reported without an associated diagnosis.
Major Depressive Disorder

- Documentation is often not sufficient to code this condition to the highest level of specificity.
- Providers often document as “MDD” or “Depression”
- Often coded with a more specific ICD-10-CM code than supported by the documentation.
- Documentation should include:
  ✓ Episode
  ✓ Severity
  ✓ Remission Status

The specificity of the diagnosis must be supported by the documentation.
Malignant Neoplasms

• Significant source of error in regards to CMS HCC Risk Adjustment.

• Documentation often is not sufficient to code to highest level of specificity and/or if current or history of.

• History of malignancies are often coded as a current malignancy.

• Can only be coded as active when current treatment is being directed to the malignancy, or if the cancer is active and treatment has been refused or currently contraindicated.
Chronic Kidney Disease

✓ Underlying cause
✓ Stage
✓ Dialysis Dependence
✓ Associated diagnoses/conditions
✓ Transplant status

It is important that providers document the stage

✓ Stage 1, 2, and unspecified do not CMS HCC Risk Adjust
✓ Stage 3, 4, and 5 do CMS HCC Risk Adjust.
HCC Recapture

• A patient’s risk score is re-calculated each year.
• It is critical to recapture all chronic and acute conditions that CMS HCC Risk Adjust as well as report any new diagnoses that CMS HCC Risk Adjust annually.
• Reports can assist in identifying missed historical HCC’s to assist with provider documentation and coding education.
### Example:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Missing HCCs Current Year vs. Reported Historically</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Smith</td>
<td>(22) Morbid Obesity (59) Major Depression, Bipolar and Paranoid Disorders</td>
</tr>
<tr>
<td>B. Jones</td>
<td>(189) Amputation Status, Lower Limb/Complications</td>
</tr>
<tr>
<td>C. West</td>
<td>(18) Diabetes with complications (111) COPD</td>
</tr>
<tr>
<td>D. South</td>
<td>(18 Diabetes with Complications (85) CHF (111) COPD</td>
</tr>
</tbody>
</table>
✓ Document all of a patient’s chronic and acute conditions that were monitored, evaluated, assessed and/or treated to the highest level of specificity at every visit.

✓ Capture all patient’s documented conditions, by reporting ICD-10-CM codes at the highest level of specificity at least once each calendar year.

✓ Ensure all ICD-10-CM diagnosis codes reported are supported by the documentation.
Documentation and Coding for HCC Risk Adjustment (cont’d)

CMS Risk Adjustment Information

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

CMS Medical Record Reviewer Guidance

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/Medical-Record-Reviewer-Guidance.pdf

Medicare Managed Care Manual-Chapter 7- Risk Adjustment

Thank you for participating!
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Sources: 2019/2020 CD-10-CM, CMS Medicare Managed Care Manual Chapter 7, CMS.Gov. Risk Adjustment, CMS Medical Record Reviewer Guidance