



Medicaid Risk Adjustment Provider Toolkit, Orientation, and Resources



Aetna Better Health®

Index

Key Terms	3
Risk Adjustment Preparedness Tasks: A Checklist	4
Risk Adjustment – An Overview	5
Documentation to Billing Workflow	6
Coding Guidelines	8
Documentation	10
Healthy Home Visit	11
Condition Guides	
Major Depressive Disorder	13
Pregnancy	16
Diabetes	25
Chronic Kidney Disease	29
Congestive Heart Failure	32
Chronic Obstructive Pulmonary Disease	36
Asthma	41
Coronary Artery Disease / Heart Disease	44
End Stage Liver Disease	47
Substance Use Disorder	51
Pulmonary Fibrosis	54
Telehealth	56
2023 E/M Changes	57
2024 E/M Changes	60
Resource	61

Key Terms

Term:	Definition:
ABD	Aged, Blind, and Disabled: Often qualify for Medicaid as part of the SSI category. However, some states set requirements for this group that may differ from the general SSI guidelines.
CDPS+RX	Chronic Illness and Disability Payment System and Prescription claims are utilized for risk adjustment in Medicaid.
CHIP	Children's Health Insurance Program, expansion program introduced in the 1997. This program provides health insurance coverage to children whose parents make too much money to qualify for Medicaid.
CMS	Centers for Medicare and Medicaid Services. Designated by the Department of Health and Human Services.
DD	Developmental Disability: Children and adults who are diagnosed early in life with a severe chronic condition that is due to a mental and/or physical impairment that results in substantial functional limitations.
FFS	Fee for Service. Payment structure based on services performed but not tied to quality or outcome measures. Lacks coordination of care element.
HHS	U.S. Department of Health and Human Services.
Issuers	Insurance company, service, or organization.
LTSS	Long Term Services and Support: This group involves older individuals or those with disabilities who cannot perform activities of daily living on their own.
MCO	Managed Care Organizations. Includes quality and care coordination elements. Process the claims and pay providers as well as track and manage quality initiatives.
RFP	Request for Proposal. Many states require Managed Care Organizations (MCOs) to bid for their business utilizing an RFP process.
SSI	Supplemental Security Income: Cash assistance primarily for Aged, Blind, and Disabled (ABD) individuals who have little or no income.
State Medicaid Agency	Regulators, such as the state Medicaid agency, choose what benefits will be offered, length of contract, delivery systems, provider rates, and other factors.
TANF	Temporary Assistance for Needy Families. Families with one or more dependent children and pregnant women who are receiving financial assistance from the state.

Risk Adjustment Preparedness Tasks: A Checklist

☑	Item:	Item Description:
☐	Risk Adjustment – An Overview	Read through the information provided to understand the concepts of risk adjustment and factors utilized by state regulators to determine a member's Risk Score (e.g. demographic, disease, etc.)
☐	All Diagnosis codes are received by Aetna	Using the Documentation to Billing Workflow, verify all documented diagnosis codes are added to the claim form and successfully submitted and received by Aetna. Helpful resources: Documentation to Billing Workflow
☐	Coding Assessment	Using the Aetna Coding Guidelines, verify M.E.A.T.; Coexisting conditions; Problem List; History of...; Unspecified Diagnoses; and other Coding Guidelines are being followed. Helpful resources: Coding Guidelines*, Condition Specific Guides
☐	Documentation Assessment	Using the Aetna Top 10 Documentation tips, verify that all recommended “DOs” are being followed and the “Don’ts” are being avoided. Helpful resources: Documentation*, Condition Specific Guides
☐	Healthy Home Visit (HHV)	Using the Aetna Healthy Home Visit Program materials, review the benefits to Members and Providers. Recognize the role HHVs play in improving overall care and in documenting Social Determinants of Health. Helpful resources: Healthy Home Visits Program*
☐	TeleHealth	Check state guidelines to see if TeleHealth is an allowed benefit for managing patient care. Helpful resources: TeleHealth Handout*
☐	Continuing Education	Aetna provides continuing education opportunities on a variety of risk adjustment related topics. For a full list of our library of resources or to learn more, contact us at RiskAdjustment@aetna.com

*Aetna has education presentations on this topic, including some webinars with the potential to earn CEU credits.

To obtain a schedule or to request a private presentation for your practice, please contact us at RiskAdjustment@aetna.com

Risk Adjustment

“A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.”

- healthcare.gov

Aetna risk adjustment programs are vital to making sure we are collectively serving our members in a comprehensive and effective manner. Complete, timely, and accurate information is critical for coordination of care and resources. Regulators, such as the state Medicaid agency, calculate risk score using a combination of factors. Please read through the information below to learn more.

Demographics Factors

Factors include age, gender, disability, original reason for entitlement, Medicare status, and institutional status.

Disease Data

- Risk score calculation considers diagnoses reported on claims from physicians, hospitals, and certain non-hospital providers.
- Regulators rely on encounter data

Implications of Risk Adjustment for Providers

Diagnoses reported to state regulators as part of the risk adjustment process must be supported in the medical record and coded according to *ICD-10-CM Official Guidelines for Coding and Reporting*.

A provider should submit accurate medical record documentation and coding of diagnoses and conditions because it:

- Helps to ensure data submitted is correct, truthful, and complete; and
- Promotes quality and integrity of the information Aetna receives about its members
- Allows identification of members in need of additional support services such as case management, etc.
- Enables an annual population assessment of member characteristics, health needs, and social determinants

of health. This profile is used to review and update member programs and resources with the goal of improving health and reducing health care disparities.

Regulatory Environment

The Medicaid industry is highly regulated. Providers must:

- Submit accurate, complete, and truthful claims
- Adhere to ICD-10-CM Official Guidelines for Coding and Reporting
- Code all documented conditions that co-exist at the time of the encounter and require or affect patient care treatment or management
- Maintain medical records in accordance with state requirements
- Comply with requests for medical records from plans and governmental agencies

We can't do it without you

Chart requests and reviews are completed for the following reasons:

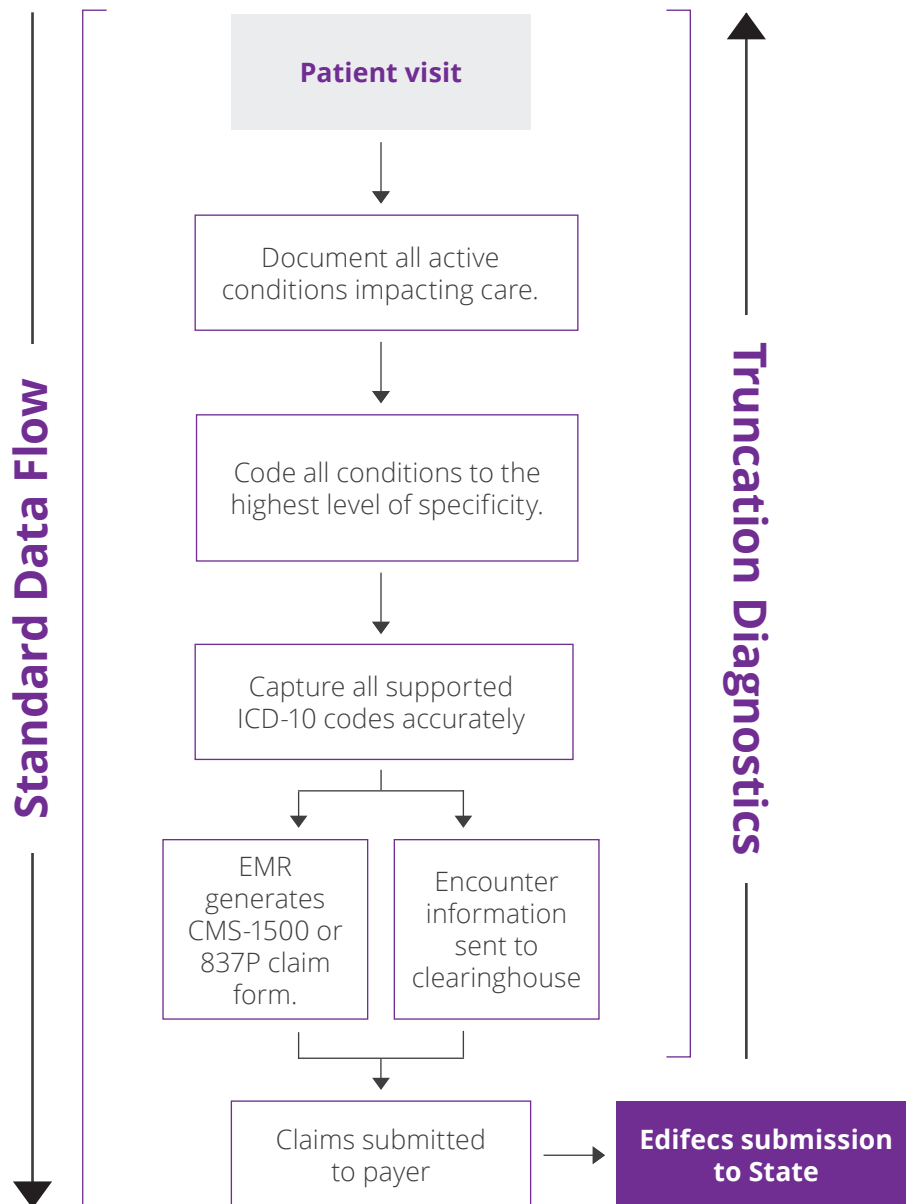
- Review for coding accuracy and trends to identify need for education
- Review to ensure accurate reimbursement
- Quality reviews to identify gaps in care

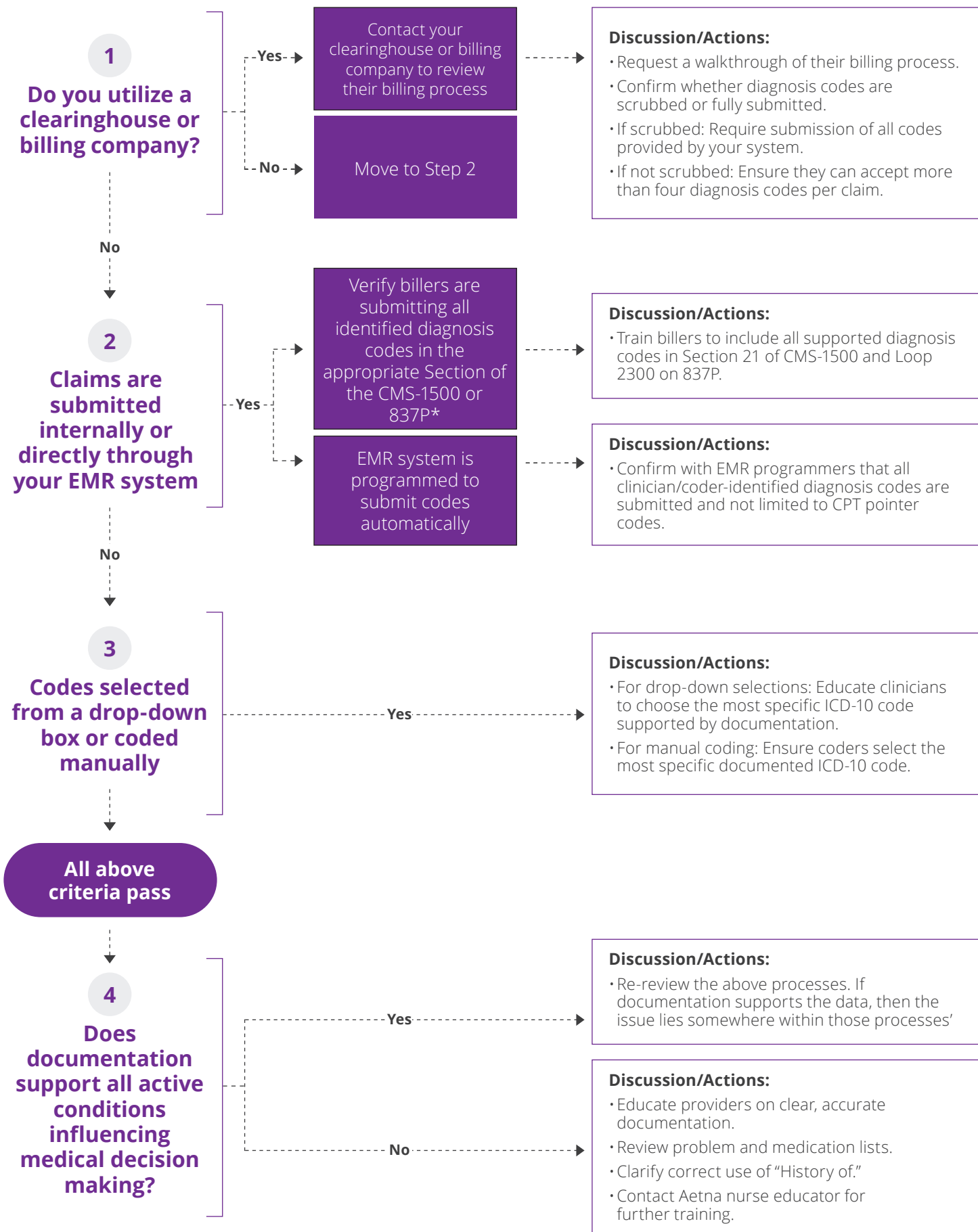
Documentation to Billing Workflow

Diagnostics Steps

Diagnosis code field truncation refers to the removal—whether by stripping, scrubbing, or dropping—of diagnosis code data from a claim that was originally documented by the provider for a specific date of service.

The steps below are designed to help providers identify obstacles within the submission process and offer practical troubleshooting strategies.





Risk Adjustment

General Outpatient Coding Guidelines

Coding Guidelines – Why They Matter

- Supports making sure members receive adequate and appropriate resources, coordination, and care for the whole person.
- More complete identification of population health needs
- Coding personnel must follow specific guidelines to report accurate ICD-10-CM codes based on a physician's documentation.
- Accurate and complete documentation and coding allows state regulators to adequately assess and measure a Medicaid beneficiary's diseases and conditions.

M.E.A.T.



Monitor signs, symptoms, disease progression, disease regression



Evaluate test results, medication effectiveness, response to treatment



Assess/Address ordering tests, discussion, review records, counseling



Treat using medications, therapies, other modalities

Coexisting Conditions Impacting Patient Care

Consider all medical record components when documenting an encounter:

- Chief complaint, HPI, ROS
- Exam
- Consult or diagnostic reports available since last visit
- Past medical history
- Problem list
- Current or active problem list

Keep problem lists current:

- Review problem list with the patient at least once per calendar year and update accordingly.
- Document the status of the condition such as being active or resolved.
- Show supporting documentation in your note if the condition is active.

ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.J

History Of vs. Past Medical History

It is important to document historical conditions that impact the overall decision making by using the appropriate Z-codes. In addition, continue to code any previous diagnoses that remain in treatment.

It is not appropriate to document a condition as “history of” simply due to that condition being diagnosed months or even years ago. If you are currently monitoring s/s related to a disease, evaluating the disease progression or regression, and/or prescribing medications to manage the disease, the current diagnosis should be carried to the assessment.

In addition to the patient's personal history, family history can be coded if it pertains to management of a patient's current and future care. Please include family history when clinically meaningful.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I. C.21.c.4

Unspecified Diagnoses

The ICD-10-CM includes “unspecified” codes in cases where the medical record documentation does not include enough information to use a more specific code. However, it remains important that a provider documents to the highest level of specificity. Doing so allows a coder to assign the code that most accurately reflects the patient’s true condition. Here are a few examples:

Unspecified Diagnosis	Specified Diagnosis
PVD	<ul style="list-style-type: none">• Carotid artery stenosis• Atherosclerosis of the left leg with rest pain
Lupus	<ul style="list-style-type: none">• Discoid lupus• Systemic erythematosus lupus (SLE)

Etiology/Manifestation

Manifestation codes can never be used as first-listed or principal diagnosis codes. Rather, the etiology must always be documented as the cause of the manifestation. In other words, providers should always list both the etiology and manifestation of the condition, even in cases where the provider is solely addressing the manifestation during a visit with the patient.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.13

Sequela (Late Effects)

- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.
- There is no time limit on when a sequela code can be used. The residual may be apparent early or it may occur months or years later.
- The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

ICD-10-CM Official Guidelines for Coding and Reporting, Sections I.A.12., I.B.10., I.C.13.b, I.C.9.d., I.C.19.c.

Supporting Assessments from Ancillary Staff

Providers may rely on support staff to document specificity, but without a diagnostic statement from the patient’s physician, a coder may not be able to capture information from the support staff documentation.

For example, ancillary staff may record a BMI of 48, but it is the physician that must establish a diagnosis of severe or morbid obesity. While ancillary staff may be qualified to provide dietary instructions, the physician must order that education.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I. C.21.c.4

Documenting a Definitive Diagnosis

Providers should avoid using the terms included in the list below in cases where he/she is certain of a diagnosis. The coding guidelines indicate that one can only code the known signs and symptoms related to an uncertain diagnosis.

• Probable	• Suspected
• Working Diagnosis	• Likely
• Compatible with	• Indicative of
• Rule out	• Concern for
• Questionable	• Consistent with
• Suggestive of	• Comparable to

ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.H

Documentation

Top 10 Documentation Tips

	Dos	Don'ts	
10	Sign, credential, and maintain the record	Encounter signed off by Dr. Cindy Lou Who, MD 1/1/2019 	
9	Consistency, consistency, consistency	CC: Pt here today for f/u on Diabetes HPI: Type 2 Diabetes diagnosis 2 weeks ago by Dr. Van Helsing Assessment and Plan: Diabetes Type 2 w/o complications	CC: Pt here today for f/u on DM HPI: Type 1 DM diagnosis 2 weeks ago by Dr. Van Helsing Assessment and Plan: DM Type 2 w/o complications
8	Spell it out	Assessment: Elevated blood pressure, Major depressive disorder and Mitral insufficiency	Assessment: ↑ BP; MDD; MI BP elevated??; Major depressive disorder or Manic Depressive disorder; Myocardial infarction or Mitral insufficiency???
7	When did it all happen?	"Patient was discharged from Gray Fox hospital on 10/01/2019 after inpatient admission for acute myocardial infarction."	"Follow-up visit for recent myocardial infarction."
6	Confirmed Dx or Working Dx	Assessment: "Mary May has CAD and is stable on her atenolol." OR Assessment: "I suspect coronary artery disease, ordering EKG and Stress Test to confirm."	Assessment: "I suspect Mary May has coronary heart disease."
5	Active vs. resolved	Active problem list (reviewed 10/01/2019): Hypertension – active/stable, Allergic rhinitis – active/stable, Acute respiratory failure – resolved 2/2015 A/P: Patient remains on medication and enjoyed playing golf this weekend.	Active problem list: Hypertension, Allergic Rhinitis, Acute Respiratory failure A/P: Patient remains on medication and enjoyed playing golf this weekend.
4	Link your medications/date of review	Medication List (reviewed 10/01/2019): Atenolol 25 mg for Hypertension – Continue med, Ceftin 250mg for Sinus infection – Discontinue 1/24/2018, Lasix – 20mg twice a day for Congestive heart failure – continue as prescribed, Coumadin 10mg for history of Pulmonary embolism – Continue as prescribed	Medication list: Atenolol, Ceftin, Lasix, Coumadin
3	Stable, or complications?	Assessment: Chronic Kidney Disease from Diabetes – with elevated potassium levels and edema Hypertension – stable Diabetes Type 2 with active foot ulcer requiring debridement	Assessment: CKD, HTN, DM
2	Review & update active Conditions	Active problem List (Reviewed 10/01/2019)Diabetes – Stable on Insulin, Acute Myocardial Infarction – Resolved from inpatient stay on 3/2015, Chronic Kidney disease – StableHepatitis C – In remission since 8/2014, Deep Vein Thrombosis – Prophylaxis treatment since 12/2017	Active Problem List: DM, AMI, CKD, Hepatitis C, DVT
1	Link manifestations and complications	Assessment: Diabetic gangrene of the big toe, culture positive for MRSA	Assessment: Diabetes, Gangrene of big toe, Staph infection

Healthy Home Visit Program

How It Helps You and Your Patients

About the Healthy Home Visit Program

- An in-home visit by a licensed Nurse Practitioner (NP) or physician (who is contracted through an Aetna vendor), available to Medicaid members.
- A “whole-person” assessment that evaluates not only medical needs like medication and care gaps, but also non-medical needs like safety and nutrition.
- Through a visit summary, the HHV NP/Physician provides insight and information to the PCP that may have not otherwise been identified.
- Members who have had an assessment are more likely to be engaged with their PCP compared to members who have not had an assessment.
- **An in-home assessment is not intended to take the place of a primary care visit, nor an annual wellness visit. It is intended to complement the primary care provider’s care efforts.**
- Enables proactive intervention for at-risk and high-risk members and helps to drive quality improvement.

How Healthy Home Visits Help Members

Identify and discuss:

- Personal health goals
- Care gaps
- Barriers to care

Facilitate access to care

- Primary care
- Urgent or emergent care
- Case management support
 - Comorbid condition management
- Additional health plan resources

Answer general health questions

How Healthy Home Visits Help Care Partners

Reinforce the importance of primary care

oversight, annual wellness visits and annual physicals.

Gather and share information on members’ home environments and social determinants of health such as:

- Poor nutrition
- Drug diversion or noncompliance
- Poor living conditions

Arrange for case management support

Identify and facilitate closing gaps

Assessments Improve Care Quality

Below are examples of programs & quality measures impacted by HHV results.



Medication

Ensure medication safety and compliance

- Renin-angiotensin system antagonist adherence*
- Diabetes adherence*
- Statin adherence*
- Blood pressure control*



SDOH

Social Determinants of Health

- Poor nutrition
- Fall risk
- Poor living conditions
- Drug diversion or noncompliance
- Lack of transportation

* For example purposes, not all-inclusive.

How Providers Can Help

Support our outreach:

- **Encourage members** to accept the in-home assessment.
- **Utilize the information** we provide in the PCP summary to update your care plan.
- **Provide us with feedback.**

Healthy Home Visit Partner



Major Depressive Disorder (MDD)

Disease Overview

Major depressive disorder, also known as clinical depression, is a common and serious mood disorder. According to the National Institutes of Mental Health, symptoms must be present for at least two weeks to be considered major depressive disorder.¹ Patients must exhibit five to nine of the symptoms outlined in the Diagnostic and Statistical Manual of Mental Health Disorders V (DSM-V)² in order to meet the definition of major depressive disorder.

DSM-V Criteria¹:

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly attributed to another medical condition.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Markedly diminished interest or pleasure to all, or almost all activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day.

- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode. A+B+C must be present without a better explanation such as schizoaffective disorder, other psychotic disorder or manic episode also present.

Note: Please see the DSM-V manual for the full criteria.

Documentation Tips

Avoid the use of abbreviations

Best practice is to document major depressive disorder by spelling out the diagnosis in full. The abbreviation of MDD could have more than one meaning (major depressive disorder or manic-depressive disorder).

- If you choose to abbreviate a word, please spell it out the first time you use it to ensure clarity of the abbreviation.
Example: major depressive disorder (MDD).

Include depression screening results with the notes for the encounter. Some commonly used screening tools are:

- Geriatric Depression Scale – GDS
- PRIME-MD Screening
- Patient Health Questionnaire (PHQ-9)

Clinical documentation should support the qualifying diagnosis of major depression through careful consideration of the following:

Episode:

- Single: lasts for more than two weeks and can continue for years; if no break then would be one continuous episode.
- Recurrent: must have interval of at least two months between episodes for criteria.

Severity:

- Mild: few, if any symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational function.
- Moderate: the number of symptoms, intensity of symptoms and/or functional impairment are between those specified for “mild” and “severe.”
- Severe: the number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

Psychosis (presence or absence of)

- Documentation should support if psychosis symptoms are present or absent.

Remission status:

- Partial: up to two months free of depression symptoms.
- Full: greater than two months free of depression symptoms.

Document a diagnostic statement that supports ICD-10 specificity.

Do not use “history of” to describe a current or active diagnosis of MDD.

- “History of” for coding purposes conveys that the condition is historical and no longer exists.

Document the treatment plan to include:

- Medications linked to condition
- Therapy/counseling
- Referrals
- Date of next follow-up appointment

Coding Guidance for Major Depression

The following are categories for coding major depression. Fourth and fifth character provides further specificity (e.g., mild, moderate or severe; with or without psychotic features; partial or full remission).

F32	Depressive Episode
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8_	Other depressive episodes
F32.81	Premenstrual dysphoric disorder
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified (includes major depression NOS)
F32.A	Depression, unspecified (includes depression NOS and depressive disorder NOS)

F33	Major Depressive Disorder, recurrent
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent, severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic features
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission, unspecified
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

Pregnancy

Overview

Pregnancy, also known as gestation, is the time during which one or more offspring develops inside of a woman, culminating in birth. While most pregnancies can be considered “routine”, there are several complications that could arise. Risk factors may include:

- **Existing health conditions:** Pregnant women with high blood pressure, diabetes or who are HIV-positive may experience complicated pregnancies.
- **Overweight and obesity:** Being obese raises the risk of cardiac problems, sleep apnea, pre-eclampsia, gestational diabetes and venous thromboembolism.
- **Multiple births:** Women with more than one fetus run a higher risk of complications. Typical issues include pre-eclampsia, premature labor and preterm birth.
- **Young or old maternal age:** Women in their teens or age 35 or over have a higher risk of pre-eclampsia and gestational high blood pressure.
- **Previous fetal loss:** Previous fetal death poses a risk for subsequent pregnancy.
- **History of complications with previous pregnancies:** Women who have experienced complications during a previous pregnancy are more likely to have complications reoccur.

Documentation Tips

Avoid the use of abbreviations

Best practice is to document pregnancy by spelling out the diagnosis in full.

- Spell out the initial notation of the condition in full with the abbreviation in parentheses. Subsequent documentation within the same note can use the abbreviation only.

For example: Pregnancy (PG), Hypertension (HTN)

Prenatal Care

- Documentation should reflect the date when prenatal care was initiated.

- Evidence of at least one of the following needs to be documented:
 - A basic physical obstetrical exam (fetal heart tone (FHT) auscultation, pelvic exam with obstetrical findings and measurement of fundus height)
 - Screening tests including an obstetrical blood panel, Rubella testing alone or a TORCH panel (Toxoplasmosis, Rubella, Cytomegalovirus, Herpes simplex virus), Rh incompatibility testing and an ultrasound/echography of a pregnant uterus
 - Last menstrual period or estimated due date with either prenatal risk assessment and counseling/ education or a complete obstetrical history

Postpartum care

- The postpartum visit should be performed on or between 21 and 56 days after delivery. Documentation should include the date and at least one of the following:
 - Pelvic exam
 - Evaluation of weight, blood pressure, breasts (notation of breastfeeding is acceptable) and abdomen
 - Notation of postpartum care (six-week checkup, postpartum care, etc.)

Tips for providers

- The American College of Obstetricians and Gynecologists (ACOG) recommends a minimum of 14 prenatal visits for a 40-week* pregnancy. Members should receive reminders to schedule all required visits including:
 - One visit every four weeks until 28 weeks gestation (at least six visits)

*Note: for completed weeks of gestation refers to full weeks. For example, if the provider documents gestation at 39 weeks, 6 days, the code for 39 weeks of gestation should be used because the patient has not yet reached 40 completed weeks.

Coding Tips for Pregnancy

The ICD-10 codes listed below are intended for educational purposes only and may not consist of the full listing of ICD-10 codes for this condition category. For the full listing, please refer to the ICD-10 manual that also outlines any Includes and/or Excludes Notes.

ICD-10-CM: General tips for coding

- Conditions that affect the management of pregnancy, childbirth and the puerperium are classified in categories O00 through O9A in Chapter 15 of the ICD-10-CM.
- If pregnancy is incidental to an encounter for a different reason, code Z33.1 (pregnant state, incidental) is assigned in place of any Chapter 15 codes.
- When treating the pregnant member, the codes in chapter 15 are applied before codes from other chapters. Codes from other chapters may be used to report additional conditions when needed to provide more specificity.
- Codes from Chapter 15 refer to the mother only and are assigned only to the mother's record. They are never assigned on the newborn's record.
- If known, use an additional code from category Z3A Weeks of gestation to identify the specific week of pregnancy.
- **EXCLUDES1:** supervision of normal pregnancy (Z34.-)
- **EXCLUDES2:** mental and behavioral disorders associated with the puerperium (F53.-), obstetrical tetanus (A34), postpartum necrosis of pituitary gland (E23.0), puerperal osteomalacia (M83.0)

- One visit every two weeks until 36 weeks gestation (at least four visits)
- One visit every week after 36 weeks until delivery
- If the patient comes in one or two weeks after delivery for an incision check, another visit for 21-56 days after discharge from the hospital should be scheduled for the postpartum visit. Education and explanation should be given to the patient.
- A follow-up cesarean section postoperative visit 1-2 weeks after delivery DOES NOT count as a postpartum visit.
- Patients should get phone calls about scheduling the postpartum visit and should also get reminders about the date and time of the appointment.
- Missed appointments need to be rescheduled.
- All services should be documented appropriately.

Final character for trimester

Most codes in Chapter 15 of ICD-10-CM have a final character indicating the trimester of pregnancy. The trimesters are at the beginning of Chapter 15 and are defined as:

Trimester	Length in Weeks
First trimester	Less than 14 weeks 0 days
Second trimester	14 weeks 0 days to less than 28 weeks 0 days
Third trimester	28 weeks 0 days to delivery

Assignment of the final character for trimester is based on the provider's documentation for the current encounter. Not every code in Chapter 15 has a trimester component. If the trimester component does not occur, it is because the condition is specific to a certain trimester or the concept of trimester is not applicable to the condition.

Seventh character

Many of the codes from O31-O69 require a seventh character to distinguish the fetus in a single or multiple gestation. 7th character 0 is for a single gestation or unspecified fetus in a multiple gestation. 7th characters 1-9 are for multiple gestations to identify the fetus for which the code applies. A code from O30 (multiple gestation) must also be assigned when assigning a code that has a 7th character from 1-9.

Example:

- O36.61X3 – Maternal care for excessive fetal growth, first trimester (3rd fetus)

Normal pregnancy

When coding for a routine visit for a pregnant member who has no complications, Z codes are assigned from Chapter 21 of the ICD-10-CM. These codes are only chosen when a healthy, pregnant woman has no current illness or injury.

Examples:

- Z34.01 – Encounter for supervision of normal first pregnancy, first trimester
- Z34.82 – Encounter for supervision of other normal pregnancy, second trimester

Supervision of high-risk pregnancy

Codes from Category O09 (Supervision of high-risk pregnancy) are intended for use only during the prenatal period.

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09 (Supervision of high-risk pregnancy) should be reported as the first listed diagnosis on the claim. Secondary Chapter 15 codes may be used in conjunction with this code if appropriate.

ICD-10-CM	Description
O09. 00 – O09. 03	Pregnancy with history of infertility
O09. 10 – O09. 13	Pregnancy with history of ectopic pregnancy
O09. A0 – O09. A3	Pregnancy with history of molar pregnancy
O09. 211 – O09. 299	Pregnancy with other poor reproductive or obstetric history
O09. 30 – O09. 33	Pregnancy with insufficient antenatal care

O09.40 – O09.43	Pregnancy with grand multiparity
O09.511 – O09.529	Elderly primigravida and multigravida (35 years or older at expected delivery date)
O09.611 – O09.629	Young primigravida and multigravida (16 years or younger at expected delivery date)
O09.70 – O09.73	High-risk pregnancy due to social problems
O09.811 – O09.899	Other high-risk pregnancy – including pregnancy resulting from assisted reproductive technology (O09.81-) and pregnancy with a history of in-utero procedure during previous pregnancy (O09.82-)
O09.90 – O09.93	High-risk pregnancy, unspecified

Fetal conditions affecting management of pregnancy

Codes from categories O35 (Maternal care for known or suspected fetal abnormality and damage) and O36 (Maternal care for other fetal problems) are assigned only when the fetal condition is actually responsible for modifying the mother's care. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

In cases when surgery is performed on the fetus, a diagnosis code from category O35 should be assigned identifying the fetal condition. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

Other conditions complicating pregnancy, childbirth or the puerperium

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy and those that are a direct result of the pregnancy:

- Conditions such as edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium are classified in categories O10 – O16
- Other maternal disorders—such as hemorrhage, hyperemesis gravidarum, venous complications, genitourinary infections, diabetes mellitus, malnutrition, weight loss/gain, liver disorders, etc.—are classified in categories O20 – O29
- Certain infectious diseases—such as HIV, viral hepatitis, viral diseases (i.e., Zika infection), tuberculosis and venereal disease—are classified in category O98

Hypertension

Pre-existing hypertension is classified in category O10 as follows:

ICD-10-CM	Conditions
O10.01 – O10.03	Essential hypertension
O10.111 – O10.13	Hypertensive heart disease
O10.211 – O10.23	Hypertensive chronic kidney disease
O10.311 – O10.33	Hypertensive heart and chronic kidney disease
O10.411 – O10.43	Secondary hypertension
O10.911 – O10.93	Unspecified

When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of hypertensive heart disease (category I11), heart failure (category I50), chronic kidney disease (category I12) or hypertensive heart and chronic kidney disease (category I13).

Gestational or pregnancy-induced hypertension is coded to category O13 (gestational, pregnancy induced, hypertension without significant proteinuria).

Diabetes

Pre-existing diabetes mellitus (type 1, type 2, other, unspecified), gestational diabetes and unspecified diabetes are coded using category O24 as follows:

ICD-10-CM	Conditions
O24.011 – O24.03	Pre-existing type 1 diabetes mellitus; use additional code from category E10 to further identify any manifestation.
O24.111 – O24.13	Pre-existing type 2 diabetes mellitus; use additional code from category E11 to further identify any manifestation.
O24.311 – O24.33	Unspecified pre-existing diabetes mellitus; use additional code from category E11 to further identify any manifestation.
O24.410 – O24.439	Gestational diabetes mellitus
O24.811 – O24.83	Other pre-existing diabetes mellitus; use additional code from categories E08, E09, and E13 to further identify any manifestation.
O24.911 – O24.93	Unspecified diabetes mellitus

Gestational diabetes mellitus can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Codes for gestational diabetes are in subcategory O24.4 (Gestational diabetes mellitus). No other code from category O24 should be used with the code from O24.4.

If the pre-existing or unspecified diabetes mellitus is being treated with insulin, code Z79.4 (Long-term current use of insulin) should be coded. Use code Z79.85 if being treated with an injectable, non-insulin anti-diabetic drug. Neither code Z79.4 or Z79.84 should be assigned with codes from subcategory O24.4 (Gestational diabetes).

Intrahepatic Cholestasis of Pregnancy

Liver and biliary tract disorders in pregnancy, childbirth, and the puerperium are coded using subcategory O26.6

ICD-10-CM	Conditions
O26.64_	Intrahepatic cholestasis of pregnancy
O26.641	Intrahepatic cholestasis of pregnancy, first trimester - O26.642 -Intrahepatic cholestasis of pregnancy, second trimester
O26.643	Intrahepatic cholestasis of pregnancy, third trimester
O26.649	Intrahepatic cholestasis of pregnancy, unspecified trimester

Intrahepatic cholestasis of pregnancy (ICP) is the most common liver disease related to pregnancy. Classically, ICP presents in the late second trimester to the early third trimester.

HIV infection

During pregnancy, childbirth or the puerperium, a patient with an HIV-related illness presenting for a health care encounter should receive a principal diagnosis code of O98.7 - (Human immunodeficiency virus (HIV) complicating disease complicating pregnancy, childbirth and the puerperium) followed by B20 and the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status presenting for a health care encounter during pregnancy, childbirth or the puerperium should receive codes of O98.7- and Z21.

Codes from Chapter 15 always take sequencing priority.

Examples:

- O98.711 + B20 + Z3A.00 – First trimester pregnant female with AIDS
- O98.713 + Z21 + Z3A.30 – 30-week pregnant female with complicating asymptomatic HIV status

Alcohol, drug and tobacco use

Codes under subcategory O99.31 - (Alcohol use complicating pregnancy, childbirth and puerperium) should be assigned for any pregnancy case when a mother uses alcohol during the pregnancy or postpartum. A secondary code from category F10 (Alcohol-related disorders) should also be assigned to identify manifestations of the alcohol use.

Example:

- O99.311 + F10.130 – Alcohol use complicating pregnancy, first trimester with alcohol abuse with withdrawal, uncomplicated

Codes under subcategory O99.32 (Drug use complicating pregnancy, childbirth and puerperium) should be assigned when a pregnant patient uses drugs during the pregnancy or postpartum. This can involve illegal drugs or inappropriate use or abuse of prescription drugs. Secondary codes from categories F11-F16 and F18-F19 should also be assigned to identify manifestations of the drug use.

Example:

- O99.322 + F11.20 – Drug use complicating pregnancy, second trimester with opioid dependence, uncomplicated

Subcategory O99.33 (Smoking tobacco complicating pregnancy, childbirth and the puerperium) should be assigned when the mother uses any type of tobacco product during the pregnancy or postpartum. A secondary code from category F17 (Nicotine dependence) should also be assigned to identify the nicotine dependence.

Example:

- O99.333 + F17.210 – Tobacco use disorder complicating pregnancy, third trimester with nicotine dependence, cigarettes, uncomplicated

Other maternal diseases

Category O99 is provided to describe other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium:

ICD-10-CM	Conditions
O99.0-	Anemia
O99.1-	Other diseases of the blood and blood-forming organs, and certain disorders involving the immune mechanism
O99.2-	Endocrine, nutritional, and metabolic disorders
O99.3-	Mental disorders and diseases of the nervous system
O99.4-	Diseases of the circulatory system
O99.5-	Diseases of the respiratory system
O99.6-	Diseases of the digestive system
O99.7-	Diseases of the skin and subcutaneous tissue
O99.8-	Other specified diseases and conditions

Malignant neoplasms

When a pregnant woman has a malignant neoplasm, a code from subcategory O9A.1- (Malignant neoplasm complicating pregnancy, childbirth and the puerperium) should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

Example:

- O9A.111 + C50.411 – Malignant neoplasm complicating pregnancy, first trimester with malignant neoplasm of upper outer quadrant of right female breast

Injury, poisoning and other external causes

A code from subcategory O9A.2- should be sequenced first, followed by the appropriate code for the injury, poisoning, toxic effect, adverse effect or underdosing. If appropriate, an additional code specifying the condition caused by the poisoning, adverse effect or underdosing should be included.

Example:

- O9A.213 + T37.8X5_ + R06.02 – Injury, poisoning and other consequences complicating pregnancy, third trimester with shortness of breath caused by adverse effect of Macrobid

Physical, sexual or psychological abuse

For suspected or confirmed cases of abuse of a pregnant patient, a code from subcategories O9A.3 - (Physical abuse complicating pregnancy, childbirth or the puerperium), O9A.4- (Sexual abuse complicating pregnancy, childbirth or the puerperium), and O9A.5 - (Psychological abuse complicating pregnancy, childbirth or the puerperium) should be sequenced first. Followed, if appropriate, by the code(s) to identify any associated current injury due to the abuse and the code (Y07.-) to identify the perpetrator of the abuse.

Example:

- O9A.313 + S00.12_ + Y07.03_ – Physical abuse complicating pregnancy, third trimester with a left black eye caused by the male partner

Normal delivery

Code O80 (Encounter for full term uncomplicated delivery) should be assigned when the delivery is full term (37+ weeks). This is a normal delivery of a single healthy infant without any complications antepartum, during delivery or postpartum during the delivery. O80_ is always a principal diagnosis; it is not used if any other code from Chapter 15 is needed to describe a current complication. Additional codes from other chapters may be used with code O80 if they are not related to or in any way complicating the pregnancy.

Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of delivery.

Outcome of delivery codes are found under subcategory Z30.-. Z37.0 (Single live birth) is the only outcome of delivery code appropriate for use with O80_.

Complications of labor and delivery

Complications of labor and delivery are classified to categories O60-O77:

ICD-10-CM	Conditions
O60.-	Preterm labor (onset of spontaneous labor before 37 weeks) with and without delivery
O61.-	Failed induction of labor (medical, instrumental, other)
O62.-	Abnormalities of forces of labor
O63.-	Long labor
O64.-	Obstructed labor due to malposition and malpresentation of fetus
O65.-	Obstructed labor due to maternal pelvic abnormality
O66.-	Other obstructed labor
O67.-	Intrapartum hemorrhage
O68.-	Abnormality of fetal acid-base balance
O69.-	Umbilical cord complications
O70.-	Perineal laceration during delivery
O71.-	Other obstetric trauma (e.g., uterine rupture or inversion; cervix or high vaginal laceration; damage to pelvic organs, joints, ligaments; other obstetric trauma)
O72.-	Postpartum hemorrhage
O73.-	Retained placenta and membranes
O74.-	Complications of anesthesia
O75.-	Other complications of labor (maternal distress, sepsis, delayed delivery, exhaustion, other)

Fetal stress

ICD-10 provides codes related to fetal problems complicating labor and delivery, such as:

- O68 – (Labor and delivery complicated by abnormality of fetal acid-base balance) - used to describe fetal acidemia, fetal acidosis, fetal alkalosis and fetal metabolic acidemia when these conditions complicate labor and delivery
- O76 – (Abnormality in fetal heart rate and rhythm complicating labor and delivery) - includes fetal bradycardia, decelerations, irregular heart rate, tachycardia and depressed heart tones
- O77 – (Other fetal stress complicating labor and delivery) - includes fetal distress related to meconium in amniotic fluid, drug administration, and other evidence of fetal stress

Complications of the puerperium

Postpartum complications--including acute kidney failure, hematoma, cardiomyopathy, thyroiditis, mood disturbance, and other complications--are classified to category O90.

*O90.4 Post partum acute kidney failure Excludes1: non-anuria and oliguria (R34).

Sequelae of complication

Code O94 (Sequelae of complication of pregnancy, childbirth and the puerperium) is assigned when an initial complication of a pregnancy develops a sequela that requires care or treatment at a later date. For example:

- A patient presents with fatigue and cold intolerance. Her history indicates that she had a severe hemorrhage during delivery of a normal live-born infant seven months earlier. She was diagnosed with Sheehan's syndrome and treated with replacement hormones. Code E23.0 (Hypopituitarism) is assigned for Sheehan's syndrome, followed by code O94 (Sequelae of complication of pregnancy, childbirth and the puerperium).

Abortive outcomes

Abortive outcome is classified by type in ICD-10 as follows:

- O03.- Spontaneous abortion
- O04.- Complications following (induced) termination of pregnancy
 - *Hemorrhage following elective abortion: Assign code O04.6 - Delayed or excessive hemorrhage following (induced) termination of pregnancy. Do not assign code O72.1 - Other immediate postpartum hemorrhage as this code should not be assigned for post abortion.
- O07.- Failed attempted termination of pregnancy
- O08.- Complication following ectopic and molar pregnancy

Category Z3A codes (Weeks of gestation) should not be assigned for pregnancies with abortive outcomes.

*Do not assign code Z33.2 - Encounter for elective termination of pregnancy when the patient experiences a complication post elective abortion.

Ectopic and molar pregnancies

Ectopic and molar pregnancies—as well as other abnormal products of conception—are classified to the following categories:

- O00.- Ectopic pregnancy
- O01.- Hydatidiform mole
- O02.- Other abnormal product of conception

Use an additional code from category O08.- (Complication following ectopic and molar pregnancy) to identify any associated complication.

Diabetes Mellitus (DM)

Disease Overview

Diabetes mellitus (DM) is a chronic, lifelong condition that results when the individual is unable to either produce enough insulin or properly use insulin. It involves impaired metabolism of carbohydrates, proteins and fats, and is associated with abnormally high levels of glucose in the blood. Diabetes mellitus can be due to an absolute decrease in the amount of insulin secreted by the pancreas or to a reduction in the biologic effectiveness of the insulin secreted.

Type of Diabetes

Type 1 diabetes mellitus

Usually diagnosed in childhood, the pancreas is unable to produce or produces very little insulin. Daily insulin injections or insulin pumps are required.

Latent autoimmune diabetes in adults (LADA)

Sometimes referred to as diabetes type 1.5, it is an uncommon slow progressive variation of type 1 diabetes and often not diagnosed until later in age. This often results in a misdiagnosis of type 2 diabetes. LADA is characterized by age, a gradual increase in insulin requirements, no family history of type 2 diabetes and positive antibodies.

Type 2 diabetes mellitus

Typically diagnosed in adulthood, type 2 diabetes mellitus is the most common form of diabetes. With this type of diabetes, the pancreas does not produce enough insulin to maintain normal glucose levels, often because the body tissues do not respond well to insulin.

Secondary diabetes mellitus

Caused by another condition—such as pancreatectomy, malignant neoplasm of the pancreas, adverse effect of drug or poisoning.

Documentation Tips

Avoid the use of abbreviations

Best practice is to document diabetes mellitus by spelling out the diagnosis in full. While “DM” is a commonly accepted abbreviation for diabetes mellitus, other conditions can be represented (i.e., diastolic murmur or distal metastasis).

- Spell out the initial notation of the condition in full with the abbreviation in parentheses. Subsequent documentation within the same note can use the abbreviation only.

Example: diabetes mellitus (DM)

Clinical documentation should support the diagnosis of diabetes mellitus through careful consideration of the following:

• Type or Cause

- Type 1, type 2 due to other disease or condition (specify disease)

• Complications or manifestations

- Describe all complications or manifestations with clear cause and effect documented
 - Describe each complication with the descriptor Diabetes or Diabetic
- Example: Diabetes mellitus type 2 with peripheral neuropathy, type 1 diabetes with diabetic foot ulcer

• Current status of diabetes control

- If uncontrolled, document whether patient is hyperglycemic or hypoglycemic (certified coders cannot assume one or the other)
- Avoid vague descriptions of current status (i.e., terms such as “inadequately controlled”, “out of control” or “poorly controlled”)
- Documenting why the diabetes is uncontrolled is critical in coding accurately

• Insulin and oral hypoglycemic use

- Carry insulin down from medication list into the assessment and plan to ensure the capture of insulin use and correct status code Z79.4

Document symptoms

Document the presence or absence of current symptoms associated with or related to diabetes mellitus

Document exam findings

Document exam findings related to diabetes mellitus or any of its manifestations

Documentation of unrelated conditions

- Some additional conditions may or may not be directly related to diabetes
Example: cataracts or skin ulcers
- In cases where conditions are not a direct cause from the diabetes, documentation must state the condition is not related to the diabetes
 - Actual non-diabetes related condition
 - Cause is not diabetes
 - Cause is unknown
 - Diabetes is without complications

Document a concise treatment plan

- Include the patient’s date of next visit, lab testing, diabetic education referrals and recommendations for diet and exercise

Coding Guidance for Diabetes Mellitus

The ICD-10 codes listed below are intended for educational purposes only and may not consist of the full listing of ICD-10 codes for this condition category. For the full listing, please refer to the ICD-10 manual that also outlines any Includes and/or Excludes Notes.

ICD-10-CM codes for diabetes are found in Chapter 4: Endocrine, Nutritional and Metabolic Disease. Diabetes codes are combination codes that identify:

- The type of diabetes mellitus
- The body system affected
- The complications that affect each system

Diabetes mellitus is divided into 5 categories identified below:

ICD-10-CM	Description
E08.-	Diabetes mellitus due to underlying causes Use additional codes for injectable non-insulin antidiabetic drugs (Z79.85)
E09.-	Drug or chemical-induced diabetes mellitus Use additional codes for injectable non-insulin antidiabetic drugs (Z79.85)
E10.-	Type 1 diabetes mellitus
E11.-	Type 2 diabetes mellitus Use additional codes for injectable non-insulin antidiabetic drugs (Z79.85)
E13.-	Other specified diabetes mellitus Use additional codes for injectable non-insulin antidiabetic drugs (Z79.85)

Additional 4th, 5th, 6th and, in some cases, 7th characters are required to further describe the diabetic condition to the highest specificity

“Code first” and “Use additional codes” notes

“Code first” or “Use additional code” notes are present with some diabetes mellitus categories and subcategories. Please see your ICD-10 manual for specifics after subcategories.

- For “code first,” sequence first the underlying condition followed by the by the complication or manifestation

Type of diabetes mellitus

When the type of diabetes mellitus is not documented in the medical record, coding default is type 2 diabetes mellitus (E11.-).

Diabetic Complications & Manifestations

Diabetic patients will often experience complications related to their diabetes. These complications particularly affect the feet, kidneys, eyes, circulatory system and nervous system.

- A patient may have multiple complications that affect more than one body system; when this occurs, use as many codes as needed to fully describe all of the diabetic complications
 - Codes are sequenced based on reason for encounter
- For diabetic complications that are not clearly linked in the documentation, review the alphabetic index in the ICD 10-CM coding guide to determine if condition can be assumed as linked
- Avoid coding for diabetes with unspecified complications when you indeed know the complications

Treatment with both/multiple drug classifications

If the documentation in a medical record does not indicate the type of diabetes, but does indicate that the patient uses insulin, code E11-. Type 2 diabetes mellitus should be assigned. Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs or injectable non-insulin antidiabetic as follows:

- If the patient is treated with both oral medications and insulin – both code Z79.4, Long-term (current) use of insulin and code Z79.84 – Long-term (current) use of oral hypoglycemic drugs, should be assigned
- If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4 – Long-term (current) use of insulin and Z79.85 – Long term current use of injectable non insulin antidiabetic drugs
- If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84 – Long-term (current) use of oral hypoglycemic drugs and Z79.85 – Long-term (current) use of injectable non-insulin antidiabetic drug

Use additional code(s) to identify control using:

- Oral antidiabetic drugs (Z79.84) Z79.4, Long term current use of insulin and Z79.85, Long term current use of injectable non-insulin antidiabetic drugs
- Oral hypoglycemic drugs (Z79.84)
- Other long-term (current) drug therapy (Z79.899) Z79.85- Long-term (current) use of injectable non-insulin antidiabetic drug
- If the patient is treated with both oral hypoglycemic drugs and injectable non-insulin antidiabetic drugs, assign codes Z79.84, Long term current use of oral hypoglycemic drugs and Z79.85, Long-term current use of injectable non insulin antidiabetic drug
- If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes

Common Diabetes ICD-10 Diagnosis Codes

Type 1 Diabetes Mellitus (E10)

ICD-10-CM	Description
E10.9	Type 1 Diabetes Mellitus without complications
E10.8	Type 1 Diabetes Mellitus with unspecified complications
E10.10 – E10.65	Type 1 Diabetes Mellitus with specified complications
E10.69	Type 1 Diabetes Mellitus with other specified complications

Type 2 Diabetes Mellitus (E11)

ICD-10-CM	Description
E11.9	Type 2 Diabetes Mellitus without complications
E11.8	Type 2 Diabetes Mellitus with unspecified complications
E11.10 – E11.65	Type 2 Diabetes Mellitus with specified complications
E11.69	Type 2 Diabetes Mellitus with other specified complications
E11.A	Type 2 diabetes mellitus without complications in remission

Chronic Kidney Disease (CKD)

Disease Overview

Gradual loss of kidney function, known as chronic kidney disease (CKD) or chronic renal failure (CRF) is caused by the kidneys inability to filter and excrete waste and extra fluid from the blood stream. Dangerous levels of these fluids and waste can build up in the body. CKD is divided into Stage 1-5 and end stage renal disease (ESRD) which can cause death if not treated with dialysis or a kidney transplant. Treatment of CKD is focused on slowing the progression of the disease and controlling the underlying cause.

Definition/Diagnostic Criteria

Chronic kidney disease (CKD) is defined as “abnormalities of kidney structure or function, present for greater than three months, with implications for health.” The glomerular filtration rate (GFR) determines the stage of the CKD. Calculation of the GFR includes the patient’s age, weight, gender and serum creatinine.

Common Causes of Chronic Kidney Disease (CKD)

- Type 1 or Type 2 diabetes
- High blood pressure
- Glomerulonephritis
- Interstitial nephritis
- Polycystic kidney disease
- Prolonged obstruction of the urinary tract, from conditions such as enlarged prostate, kidney stones and some cancers
- Vesicoureteral reflux
- Recurrent kidney infection
- Certain medications can cause renal damage such as aspirin, aminoglycosides and intravenous contrast, and NSAIDs (non-steroidal anti-inflammatory drugs)

Documentation Tips

• Avoid the use of abbreviations

Best practice is to document chronic kidney disease by spelling out the diagnosis in full

- If you choose to abbreviate, spell out the initial notation of the condition in full with the abbreviation in parentheses. Subsequent documentation, within the same note, can use the abbreviation only. For example: Chronic kidney disease (CKD)

- Calculate and state the specific stage, avoid the use of range
- Document acute or chronic renal failure
- Document the underlying cause
- Specify if the patient is on dialysis
- Chronic renal insufficiency, chronic renal failure, or chronic renal disease are equivalent terms for CKD
- All chronic kidney diseases must be staged if known

Coding Guidance for Chronic Kidney Disease

Chronic Kidney Disease is classified based on severity

- CKD is designated by Stages 1-5

ICD-10-CM	Description
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3_	Chronic kidney disease, stage 3 (moderate)
N18.30	Chronic kidney disease, stage 3, unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease (ESRD)
N18.9	Chronic kidney disease, unspecified
Z91.15	Patient's noncompliance with renal dialysis
Z99.2	Dependence on renal dialysis

- If both CKD and ESRD are documented, only assign code N18.6. CKD 5 could refer to imminent dialysis which has not yet been started. Once dialysis is started (and likely to be long-term), CKD stage 5 should no longer be used.

Coding CKD Along With Other Conditions

Chronic Kidney Disease and Diabetes Mellitus

- In ICD 10, more than one code is required to capture Diabetic CKD - one combination code that indicates the type of diabetes with CKD and another separate code that indicates the stage of CKD
 - Under the subcategory of N18 Chronic Kidney Disease, there is a note that directs the user to “code first any associated diabetic CKD (E08.22, E09.22, E10.22, E11.22 and E13.22)
 - A second code after the diabetic code specifies the stage of CKD (N18.1-N18.6 or N18.9)
- If appropriate, use an additional code to identify dialysis status (Z99.2)

Hypertensive Chronic Kidney Disease

- According to the ICD-10-CM Official Coding Guidelines, a presumed causal relationship between hypertension and CKD
 - Thus, these two conditions are linked unless the provider explicitly states that they are not
 - Chronic kidney disease will not be coded as hypertensive if the physician specifies the two conditions are not related
- Assign codes from Category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to Category N18 Chronic kidney disease are present

Hypertensive Heart and Chronic Kidney Disease

- Assign codes from Category I13, Hypertensive heart and chronic kidney disease, when there is hypertension along with both heart and kidney involvement
- The appropriate code from category N18, chronic kidney disease, should be used as a secondary code to identify the stage of chronic kidney disease
- Use additional code to identify type of heart failure (I50._), if applicable
- For patients with both acute renal failure and chronic kidney disease, the acute renal failure should also be coded. Sequence according to the circumstances of the admission encounter.

Chronic Kidney Disease and Kidney Transplant Status

- Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the transplant may not have fully restored kidney function. The presence of CKD alone does not constitute a transplant complication.
- Assign the appropriate N18 code for the patient's stage of CKD and code Z94.0, kidney transplant status. If there is a transplant complication documented, see section I.C.19.g for information on coding complications of a kidney transplant.

Anemia in CKD

- When assigning code D63.1, Anemia in CKD, it is also necessary to assign a code from category N18 to indicate the stage of the CKD
 - Anemia is not presumed linked to CKD unless D63.1 is specifically assigned

Heart Failure

Disease Overview

Heart failure is a condition where the heart muscle is unable to pump enough blood through the heart to provide the body with oxygenated blood. When heart failure develops, the heart is no longer able to pump blood effectively. During the early stages of heart failure, the heart has the ability to compensate in various ways. These include a.) chambers enlarge and the heart develops increased muscle mass, b.) the heart begins to pump faster, c.) starts to divert blood away from less important areas of the body to the brain and heart and/or d.) blood vessels narrow in order to keep blood pressure up. Eventually, signs and symptoms of heart failure become apparent because the heart is no longer able to compensate.

Types of Heart Failure

Left-sided

The cause of left-sided heart failure is the inability of the left ventricle to effectively pump blood out to the rest of the body. A common symptom is shortness of breath due to fluid backing up into the lungs.

Right-sided

The right side of the heart is no longer able to pump effectively, so blood begins to back up in the body's veins. This causes swelling in the tissues (peripheral edema).

Systolic

The left ventricle loses its ability to contract normally during systole and can no longer effectively pump blood out of the heart to the body.

Diastolic

The left ventricle loses its ability to relax normally, losing the ability to fill with blood during the resting period between beats (diastole).

Congestive Heart Failure (CHF)

The slowing of blood flow out of the heart caused from this heart failure can also cause blood returning to the heart to slow and back up. This slowing causes congestion on the tissues of the body that are trying to return blood to the heart. This leads to edema in the lower extremities and congestion in the lungs. In extreme cases, anasarca (total body fluid overload) can occur.

Documentation Tips

Avoid the use of abbreviations

- Best practice is to document heart failure or congestive heart failure by spelling out the diagnosis in full. While “CHF” is a commonly accepted abbreviation for congestive heart failure, “HF” can have multiple other meanings.
- Spell out the initial notation of the condition in full with the abbreviation in parentheses. Subsequent documentation within the same note can use the abbreviation only.
 - Example: Congestive Heart Failure (CHF)/Heart Failure (HF)

Objective documentation

- Physical exam findings should include any current associated signs and symptoms—such as edema, weight gain, shortness of breath, cyanosis, etc. Also document the results of any related diagnostic tests.

Current vs. historical/transient

- Do not document “history of” to describe current heart failure. This implies the condition is no longer present.
- Temporary or transient heart failure that is no longer present should not be documented as current.

Do not document suspected heart failure as if it is a confirmed diagnosis

- Instead, document the signs and symptoms noted during the exam of the patient.

Document heart failure to the highest level of specificity by using all appropriate descriptors

- These can include, but are not limited to: congestive, post-operative, diastolic, systolic, acute or chronic.

Document the cause of the Heart failure by using cause and effect terms such as “associated with,” “due to,” and/or “hypertensive”

- Example: Chronic diastolic congestive heart failure (CHF) due to hypertension

Clearly document the status of the heart failure by using the appropriate terms—such as stable, worsening, in remission, compensated, etc.

Document the treatment plan to include:

- Medication linked to condition
- Referrals for consultations
- Date of next appointment

Coding Guidance for Heart Failure

ICD-10-CM Category I50 Heart failure has “Code First” instructional notes that include:

- Heart failure due to hypertension (I11.0)
- Heart failure due to hypertension with chronic kidney disease (I13._)
- Heart failure following surgery (I97.13_)
- Rheumatic heart failure (I09.81)
- Heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
- Obstetric surgery and procedures (O75.4)

ICD-10-CM	Description
I50.1	Left ventricular failure, unspecified Excludes 1: • Edema of lung without heart disease or heart failure (J81.-) • Pulmonary edema without heart disease or failure (J81,-)
I50.2_	Systolic (congestive) heart failure Excludes 1: • Combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
I50.3_	Diastolic (congestive) heart failure Excludes 1: • Combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
I50.4_	Combined systolic and diastolic (congestive) heart failure
I50.8_	Other heart failure
I50.9_	Heart failure, unspecified

- 4th character (noted above) specifies the type of heart failure
- 5th character indicates acute, chronic or acute-on-chronic

Excludes 2:

- Cardiac arrest (I46.-)
- Neonatal cardiac failure (P29.0)

Codes categorized to I50.2_ – I50.4_

- Include an instructional note to code also end stage heart failure if applicable (I50.84)
- Include the descriptor “congestive” as a non-essential modifier (an additional word that may be present or absent in the diagnostic statement without affecting the assigned code)
 - When documentation lists congestive heart failure along with either systolic or diastolic heart failure, only code for the type of heart failure noted
 - In ICD-10-CM, heart failure and congestive heart failure are both coded “I50.9 Heart failure, unspecified”

Subcategory I50.8

Other heart failure: Further divided into right, biventricular, high output, end-stage, other and unspecified heart failure.

ICD-10-CM	Description
I50.810	Right heart failure, unspecified
I50.811	Acute right heart failure
I50.812	Chronic right heart failure
I50.813	Acute on chronic right heart failure
I50.814	Right heart failure due to left heart failure <i>Excludes: Right heart failure with but not due to left heart failure (I50.82)[†]</i>
I50.82	Biventricular heart failure
I50.83	High output heart failure
I50.84	End stage heart failure
I50.89	Other heart failure

Codes I50.82 and I50.84

Include an instructional note to code also the type of heart failure as systolic, diastolic or combined, if known (I50.2-I50.43).

Diastolic or Systolic dysfunction with acute or chronic heart failure

There are 12 codes in the I50.1-I50.4 range which allow for specificity of systolic, diastolic or combined heart failure, with further specificity for acute, chronic, acute on chronic or unspecified. Use the default code I50.9 when the documentation does not specify the type.

Excludes 1 notes: A type 1 Excludes note is a pure excludes note: this means “NOT CODED HERE!” An Excludes 1 is used when two conditions should never be used at the same time as the code listed above the note.

Excludes 2 notes: Indicates that the condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time. This means “NOT INCLUDED HERE.” If both conditions are present, it is appropriate to code together.

Chronic Obstructive Pulmonary Disease (COPD)

Disease Overview

Chronic obstructive pulmonary disease, commonly abbreviated as COPD, is a lung disease that causes obstructed airflow to the lungs due to its progressive and inflammatory nature. Frequently reported symptoms of COPD include wheezing, dyspnea, chronic cough and increased mucus production. Cigarette smoking is the leading cause of COPD. However, up to 25% of patients diagnosed with COPD have never smoked. Long-term exposure to air pollutants, lung irritants, certain genetic conditions or dust may also contribute the development of the disease. COPD was the fourth leading cause of death in the United States in 2021 according to the Centers for Disease Control. Although there is currently no cure for COPD, early detection may help to modify the course and progression of the disease.

Types of Chronic Obstructive Pulmonary Disease (COPD)

There are two types of COPD:

Emphysema

A slow, progressive destruction of lung tissue. Over time, the lung tissue loses its elasticity and ability to expand and contract.

Chronic bronchitis

Long-term chronic inflammation, cough and increased mucus production, resulting in a narrowing and blockage of the airways.

Note: Most people with COPD have a combination of both of these conditions.

Documentation Tips

Avoid the use of abbreviations

Best practice is to document "Chronic obstructive pulmonary disease" by spelling out the diagnosis in full, even though "COPD" is a commonly accepted abbreviation for this condition.

- If you choose to abbreviate, spell out the initial notation of the condition in full with the abbreviation in parentheses. Subsequent documentation within the same note can use the abbreviation only.

Example: Chronic obstructive pulmonary disease (COPD)

History of present illness (subjective)

Document the presence and/or absence of any current symptoms associated with Chronic obstructive pulmonary disease (i.e. shortness of breath, cough, fatigue, etc.).

Physical examination (objective)

Document any associated physical findings and related diagnostic test (i.e. decreased breath sounds, wheezing).

Suspected versus confirmed condition

Do not document COPD unless confirmed; instead document the appropriate signs and symptoms noted and any additional work up. Once COPD is confirmed, do not use terms such as “probably,” “likely” or “consistent with.”

Consider documenting COPD during all encounters if clinically meaningful

As COPD is a chronic systemic condition, it is never fully resolved. Therefore, COPD always affects the patient’s care, treatment and medical management.

Documentation needs to support COPD to the highest specificity

Examples include:

- Chronic obstructive asthma
- Emphysema with chronic bronchitis
- Acute exacerbation of chronic obstructive bronchitis

Document a clear and concise treatment plan that includes, when appropriate:

- Linking of medications
- Referrals or consultations
- Diagnostic tests
- When patient is to be seen again

Coding Guidance for Chronic Obstructive Pulmonary Disease

The information below consists of ICD-10 codes but is not intended to be used in place of the ICD-10 code manual. Please refer to your ICD-10 manual for a comprehensive list and all includes/excludes notes.

COPD and its associated conditions are classified in the following categories:

ICD 10-CM	Description
J43.-	Emphysema
J44.-	Other chronic obstructive pulmonary disease
J45.-	Asthma

Note: Multiple instructional notes accompany these categories.

It is important to read all “excludes” notes, “add additional” notes and “code first” notes.

Excludes2:

- bronchiectasis (J47.-)
- chronic bronchitis NOS (J42)
- chronic simple and mucopurulent bronchitis (J41.-)
- chronic tracheitis (J42)
- emphysema without chronic bronchitis (J43.-)

COPD is coded to category J44, with a fourth character required to provide further specificity.

ICD 10-CM	Description
J44.0	COPD with acute lower respiratory infection * Use additional code to identify infection
J44.1	COPD with acute exacerbation includes: <ul style="list-style-type: none"> • Decompensated COPD • Decompensated COPD with acute exacerbation * Excludes 2: COPD with acute bronchitis (J44.0); lung diseases due to external agents (J60-J70)
J44.8	Other specified chronic obstructive pulmonary disease
J44.81	Bronchiolitis obliterans and bronchiolitis obliterans syndrome Obliterative bronchiolitis <ul style="list-style-type: none"> • Code first, if applicable: <ul style="list-style-type: none"> - complication of bone marrow transplant (T86.09) - complication of stem cell transplant (T86.5) - heart-lung transplant rejection (T86.31) - lung transplant rejection (T86.810) - other complications of heart-lung transplant (T86.39) - other complications of lung transplant (T86.818) • Code also, if applicable, associated conditions, such as: <ul style="list-style-type: none"> - chronic graft-versus-host disease (D89.811) - chronic lung allograft dysfunction (J4A.-) - chronic respiratory conditions due to chemicals, gases, fumes and vapors (J68.4)
J44.89	Other specified chronic obstructive pulmonary disease <ul style="list-style-type: none"> • Chronic asthmatic (obstructive) bronchitis • Chronic emphysematous bronchitis
J44.9	COPD, unspecified

Emphysema is coded to category J43, with a fourth character required to provide further specificity.

ICD 10-CM	Description
J43.0	Unilateral pulmonary emphysema
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified

Use additional codes to identify:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17._)
- Tobacco use (Z72.0)

Emphysema with coexisting chronic bronchitis codes to category J44.

COPD with exacerbations and/or acute bronchitis

Exacerbation of COPD is considered a worsening or temporary flare-up of symptoms. Acute exacerbations may or may not be caused by an infectious trigger.

• COPD with (acute) exacerbation is coded:

- **J44.1** – COPD with (acute) exacerbation
- Excludes 2 note: J44.0 COPD with acute bronchitis is not part of the J44.1 code

• COPD with acute bronchitis (acute infection) is coded:

- **J44.0** – COPD with acute lower respiratory infection **and**
- **J20.9** – Acute bronchitis, unspecified

COPD with coexisting bronchiectasis

COPD and bronchiectasis are different conditions. However, ICD-10-CM classification indicates when documentation supports both of these conditions, only **code from category J47**.

- Category J44 – COPD
 - Excludes 1 note: COPD with bronchiectasis directs coding to category J47
- Category J47 – Bronchiectasis has multiple instructional notes and fourth characters to provide greater specificity

COPD with coexisting asthma

- Category J44 – Other chronic obstructive pulmonary disease has an instructional note to code also type of asthma if applicable, J45.--
 - **When COPD and specified asthma coexist, assign codes from J44 and J45**
 - Asthma classifies to category J45 with an additional 4th, 5th and 6th character to specify the particular type
 - Unspecified asthma is not coded with COPD

Other specified chronic obstructive pulmonary disease:

- **J44.81** – Bronchiolitis obliterans and bronchiolitis obliterans syndrome
 - Obliterative bronchiolitis
- **Code first**, if applicable:
 - complication of bone marrow transplant (T86.09)
 - complication of stem cell transplant (T86.5)
 - heart-lung transplant rejection (T86.31)
 - lung transplant rejection (T86.810)
 - other complications of heart-lung transplant (T86.39)
 - other complications of lung transplant (T86.818)

- **Code also**, if applicable, associated conditions, such as:
 - chronic graft-versus-host disease (D89.811)
 - chronic lung allograft dysfunction (J4A.-)
 - chronic respiratory conditions due to chemicals, gases, fumes and vapors (J68.4)
- **J44.8** – Other specified chronic obstructive pulmonary disease
- **J44.89** – Other specified chronic obstructive pulmonary disease, chronic asthmatic (obstructive) bronchitis, Chronic emphysematous bronchitis

Asthma

Disease Overview

Asthma is a chronic disease that affects the airways in the lungs. During an asthma attack, airways become inflamed, restricting the flow of air and making it difficult to breathe. Asthma attacks are classified as mild, moderate, severe or even life threatening. Asthma has multiple causes, including but not limited to exercise, allergens and airway infections. Symptoms typically include coughing, shortness of breath, wheezing and tightness or pain in the chest.

Documentation Tips

Document the severity level of presenting Asthma

- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe persistent

Note: We recommend incorporating Asthma severity classification scales available From The National Heart, Lung, and Blood Institute (NHLBI)¹ into your templates and or queries

Clarify if there is any co-existing COPD, bronchitis, bronchiectasis, etc.

Documentation should support asthma case as one of the following:

- Uncomplicated
- Acute exacerbation
- Status asthmaticus

Add additional documentation to describe tobacco use/abuse, or history and any environmental exposures that impact the diagnosis and treatment

Plan/Treatment

Clearly state the following, if applicable:

- Diagnostic tests
- Long term Asthma control plans
- Referrals or consultation to specialist
- Patient's date of next appointment

Coding Guidance for Asthma

ICD-10-CM category J45 codes are used to report Asthma.

This category includes the following conditions:

- Allergic asthma
- Allergic bronchitis (NOS)
- Allergic rhinitis with asthma
- Atopic asthma
- Extrinsic allergic asthma
- Hay fever with asthma
- Idiosyncratic asthma
- Intrinsic nonallergic asthma
- Nonallergic asthma

Category J45 is further classified into the following subcategories based on severity:

ICD-10-CM	Description
J45.2-	Mild intermittent asthma
J45.3-	Mild persistent asthma
J45.4-	Moderate persistent asthma
J45.5-	Severe persistent asthma

Additional characters support specificity:

• 5th digit character supports the following:

- 0 - uncomplicated
- 1 - with (acute) exacerbation
- 2 - with status asthmaticus

Asthma - Other unspecified

Other unspecified asthma is classified as J45.90- and includes:

- Asthmatic bronchitis
- Childhood asthma
- Late onset asthma

6th digit character supports the following:

- 1 - with (acute) exacerbation
- 2 - with status asthmaticus
- 9 - uncomplicated

Other Asthma

The other asthmas are classified as J45.99_ and include:

ICD-10-CM	Description
J45.990	Exercise induced bronchospasms
J45.991	Cough variant asthma
J45.998	Other asthma

Excludes 1 Note

The category J45 specifically states it excludes certain conditions.

These conditions **would not be** reported with a code from category J45.

Excludes 1 note:

- Detergent asthma (J69.8)
- Eosinophilic asthma (J82)
- Lung diseases due to external agents (J60 – J70)
- Miner's asthma (J60)
- Wheezing NOS (R06.2)
- Wood asthma (J67.8)

Excludes 2 Note

J45 also has an Excludes 2 note indicating these conditions can also be reported if the provider documents the conditions in addition to the type of asthma

Excludes 2 note:

- Asthma with chronic obstructive pulmonary disease (J44.9)
- Chronic asthmatic (obstructive) bronchitis (J44.9)
- Chronic obstructive asthma (J44.9)

Coronary Artery Disease & Atherosclerosis

Disease Overview

According to the Centers of Disease Control and Prevention (CDC), coronary artery disease (CAD) is the most common type of heart disease in the United States. Coronary artery disease is due to plaque buildup in the walls of the arteries that supply oxygen-rich blood to the heart. These arteries are called the coronary arteries. The plaque that forms in these coronary arteries is predominantly composed of cholesterol, fibrin, calcium and fat. Over time, the buildup of plaque causes the inside of the arteries to narrow; a process called atherosclerosis. Excessive plaque buildup and the subsequent narrowing of the arterial walls makes it harder for blood to flow. Coronary artery disease can weaken the heart muscle due to poor blood supply, potentially leading to heart failure.

Documentation Tips

Clinical documentation should support the active condition has been monitored, evaluated, assessed/addressed and/or treated (MEAT).

Avoid the use of abbreviations.

- Best practice is to document “coronary artery disease” by spelling out the diagnosis in full. The abbreviation of CAD could have more than one meaning (Coronary artery disease or chronic actinic dermatitis).
- If you choose to abbreviate a word, please spell it out the first time you use it to ensure clarity of the abbreviation.
 - **For example** – coronary artery disease (CAD)

Coronary Artery Disease

- Document the cause, if known:
 - Lipid rich plaque or
 - Chronic total occlusion

- Documentation should clarify whether the condition involves native coronary artery, bypass graft or transplanted heart.
- If noted to be a bypass graft, documentation should identify the type of graft:
 - Autologous artery
 - Autologous vein
 - Nonautologous biological
 - Other specified type
- Specify whether the coronary artery disease is accompanied by angina pectoris, spasms or instability:
 - With and without angina pectoris
 - Unstable angina pectoris
 - Angina with documented spasm
 - Other forms of angina pectoris
- Document tobacco status, if applicable.

Diagnostic Tests

Many diagnostic tests include computer algorithms that generate a diagnostic interpretation. However, this interpretation is not acceptable by a coder until a physician's interpretation of the test is documented.

Final Assessment

In your final assessment, coronary artery disease should be spelled out in full. Include the full description of the coronary artery disease to include, if known:

- Type of vessel
- Type of bypass graft
- Associated with angina pectoris

Coding Guidance

A causal relationship can be assumed if a patient has both atherosclerosis of coronary arteries and angina pectoris, unless the documentation indicates the angina is due to something other than atherosclerosis

Coronary Artery Disease (CAD)

• ICD-10-CM subcategory I25 - Chronic ischemic heart disease

ICD-10-CM	Description
I25.1	Atherosclerotic heart disease of native coronary artery
I25.7	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
I25.8	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified

Additional character supports specificity

• Codes in categories I25.1, I25.7, and I25.8 require a 5th and sometimes a 6th character to fully explain the specificity. Please see your manual for the full listing of codes.

Example:

- I25.10 – Atherosclerotic heart disease of native coronary artery without angina pectoris
- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- Use additional code to identify:
 - Chronic total occlusion of coronary artery (I25.82)
 - Exposure to environmental tobacco smoke (Z77.22)

Plan/Treatment

The treatment plan should clearly state the following, if applicable:

- Diagnostic tests
- Labs
- Medications
- Referrals or consultation to specialist
- Patient's date of next appointment

Do not use personal history of to describe a current or still present or active diagnosis

Personal history of for coding purposes conveys that the condition is historical and no longer exists.

Atherosclerosis

• ICD-10-CM category I70 – Atherosclerosis

ICD-10-CM	Description
I70.0_	Atherosclerosis of aorta
I70.1_	Atherosclerosis of renal artery
I70.2_	Atherosclerosis of native arteries of the extremities
I70.3_	Atherosclerosis of unspecified type of bypass graft(s) of the extremities
I70.4_	Atherosclerosis of autologous view bypass graft(s) of the extremities
I70.5_	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
I70.6_	Atherosclerosis of nonbiological bypass graft(s) of the extremities
I70.7_	Atherosclerosis of other type of bypass graft(s) of the extremities
I70.8_	Atherosclerosis of other arteries
I70.9_	Other and unspecified atherosclerosis

• 5th Character in category specifies additional complications:

- 0 – Unspecified
- 1 – With intermittent claudication
- 2 – With rest pain
- 3 – Right leg with ulceration
- 4 – Left leg with ulceration
- 5 – Other extremities with ulceration
- 6 – With gangrene
- 9 – Other

• 6th Character specifies laterality:

- 1 – Right leg
- 2 – Left leg
- 3 – Bilateral legs
- 8 – Other extremities
- 9 – Unspecified extremities

• Use additional code to identify:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17._)
- Tobacco use (Z72.0)

End Stage Liver Disease

Disease Overview

End stage liver disease (ESLD), also called chronic liver failure, progresses slowly over time as the liver loses its ability to filter blood, detoxify chemicals, metabolize drugs and make protein important for blood clotting and other functions. End stage liver disease is marked by serious complications, such as the buildup of fluid in the abdomen (ascites), bleeding from the rupture of dilated blood vessels (varices) in the abdomen and esophagus, mental confusion (hepatic encephalopathy) or renal impairment. Liver cancer is a serious complication of chronic liver failure as well. The main treatment option for end stage liver disease is transplant.

Stages of Liver Disease

Inflammation

Inflammation of the liver occurs in response to an infection, such as hepatitis or an injury. Left untreated, the inflammation can continue and cause permanent damage. Often time, an inflamed liver does not cause any symptoms.

Fibrosis

Eventually, if the inflammation is not treated the liver will start to scar. The scar tissue replaces healthy tissue. This process is called fibrosis. The scar tissue makes it more difficult for the liver to function properly.

Cirrhosis

Cirrhosis is late stage scarring of the liver. As cirrhosis progresses, the liver will start to fail. Signs and symptoms may start to appear such as fatigue, bleeding or bruising, jaundice, intense itching.

End Stage Liver Disease

End stage liver disease is when the liver shows signs of decompensation. The decompensation includes hepatic encephalopathy, variceal bleed, renal impairment, and ascites. End stage liver disease is usually irreversible and the main treatment is liver transplant.

Causes of End Stage Liver Disease

- Chronic alcohol abuse
- Chronic viral hepatitis (hepatitis B, C and D)
- Fat accumulating in the liver (nonalcoholic fatty liver disease)
- Iron buildup in the body (hemochromatosis)
- Cystic fibrosis
- Copper accumulated in the liver (Wilson’s disease)
- Poorly formed bile ducts (biliary atresia)
- Alpha-1 antitrypsin deficiency
- Inherited disorders of sugar metabolism (galactosemia or glycogen storage disease)
- Medications, including methotrexate or isoniazid

Documentation Tips

Avoid the use of abbreviations

Best practice is to document end stage liver disease by spelling out the diagnosis in full.

- If you choose to abbreviate, spell out the initial notation of the condition the first time it is used. The abbreviation may then be used throughout the remainder of the note. For example: End Stage Liver Disease (ESLD)

Chronic liver failure and hepatic failure are equivalent terms for ESLD

Document the underlying cause of the end stage liver disease, if known

Document alcohol use, abuse or dependence, if applicable

Document the Model of End Stage Liver Disease (MELD) score, if known

Document any complications of the ESLD. Common complications include:

- Ascites
- Variceal bleeding
- Hepatic encephalopathy
- Renal impairment
- Liver cancer
- Portal hypertension

Include results from any laboratory tests, imaging or diagnostic tests, when available, to support current diagnosis

- Coders cannot presume a given condition exists based on any test results. A provider is the only one who can interpret and assign a final diagnosis

Document the transplant status, if applicable

Do not use “history of” to describe a current, still present or active diagnosis:

- History of for coding purposes conveys that the condition is historical and no longer exists

Document the treatment plan to include:

- Medications linked to the condition
- Lab and diagnostic tests or procedures ordered or scheduled
- Referral to a specialist
- Date of next follow-up appointment

Coding Guidance for End Stage Liver Disease

The ICD-10 codes listed below are intended for educational purposes only and may not consist of the full listing of ICD-10 codes for this condition category. For the full listing, please refer to the ICD-10 manual that also outlines any Includes and/or Excludes Notes.

ICD-10-CM Chapter #11: Diseases of the digestive system contains codes for diseases of the liver (K70-K77)

According to the ICD-10-CM coding guidelines:

- Codes for diseases of the liver (**K70-K77**) excludes1:
 - Jaundice NOS (R17)
- Codes **K70- K77** excludes2:
 - Hemochromatosis (E83.11_)
 - Reye's syndrome (G93.7)
 - Viral hepatitis (B15-B19)
 - Wilson's disease (E83.01)

Codes for ESLD fall under category K72, hepatic failure, not elsewhere classified

ICD-10-CM	Description
K72*	Hepatic failure, not elsewhere classified
K72.0_	Acute and subacute hepatic failure <ul style="list-style-type: none">• Acute non-viral hepatitis NOS
K72.00	Acute and subacute hepatic failure without coma
K72.01	Acute and subacute hepatic failure with coma
K72.1_	Chronic hepatic failure
K72.10	Chronic hepatic failure without coma
K72.11	Chronic hepatic failure with coma
K72.9_	Hepatic failure, unspecified
K72.90	Hepatic failure, unspecified without coma
K72.91	Hepatic failure, unspecified with coma <ul style="list-style-type: none">• Hepatic coma NOS

*4th and 5th characters are used for specificity

- Codes in category **K72** include:
 - Fulminant hepatitis NEC, with hepatic failure
 - Liver (cell) necrosis with hepatic failure
 - Malignant hepatitis NEC, with hepatic failure
 - Yellow liver atrophy or dystrophy
- Category **K72** excludes1:
 - Alcoholic hepatic failure (K70.4)
 - Hepatic failure with toxic liver disease (K71.1_)
 - Icterus of newborn (P55-P59)
 - Postprocedural hepatic failure (K91.82)
- Category **K72** excludes2:
 - Hepatic failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
 - Hepatic failure complicating pregnancy, childbirth and the puerperium (O26.6_)
 - Viral hepatitis with hepatic coma (B15-B19)

With or without coma

The 5th character specifies with or without coma. If the documentation does not specify with or without coma, the default is without.

Alcoholic hepatic failure

K70.4_ is the code for alcoholic hepatic failure

ICD-10-CM	Description
K70.4_	Alcoholic hepatic failure <ul style="list-style-type: none"> • Acute alcoholic hepatic failure • Alcoholic hepatic failure NOS • Chronic alcoholic hepatic failure • Subacute alcoholic hepatic failure
K70.40	Alcoholic hepatic failure without coma
K70.41	Alcoholic hepatic failure with coma

- There is a use additional code note to identify alcohol abuse and dependence (F10._)
- The 5th character is used to specify with or without coma

Transplant status

Use code **Z94.4** to capture history of liver transplant status if applicable

Substance Abuse and Dependence

Disease Overview

Substance abuse and dependence are two types of substance use disorders that have distinct meanings. The American Psychiatric Association has defined the standard use of these terms in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This reference provides clinicians with a common language for documenting these disorders. The reference also establishes criteria for diagnosing specific conditions. Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress. Substance dependence is more serious than abuse. According to the DSM-V this maladaptive pattern of substance use includes such features as increased tolerance, resulting in the need for greater amounts of the substance to achieve the intended effect; an obsession with obtaining the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.

Documentation Tips

Documentation should include:

- Type of substance
- Patient's pattern of use
- Associated signs and symptoms
- Complications
- Criteria for making the diagnosis of

Criteria for a DSM-V diagnosis of Substance Use Disorder:

At least two of the following, occurring within a 12-month period:

- Hazardous use
- Social or interpersonal problems related to use
- Neglected major roles to use

- Withdrawal
- Tolerance
- Used larger amounts/longer
- Repeated attempts to control use or quit
- Much time spent using
- Activities given up to use
- Cravings
- Physical or psychological problems related to use

Also include:

- Blood, urine or other lab tests ordered or performed
- Treatment with medications or therapy/counseling
- Referrals to a mental health professional
- Date of next appointment

Coding Guidance

ICD-10-CM codes distinguish between substance use, abuse and dependence. The ICD-10-CM alphabetical index and tabular list now contain entries to incorporate the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

**Excludes notes

ICD-10 Description	DSM-V Description
Use	Use without Substance Use Disorder
Abuse	Mild Substance Use Disorder (2-3 criteria)
Dependence	Moderate (4-5 criteria) or Severe Substance Use Disorder (6+ criteria)

The ICD-10-CM Official guidelines provide a hierarchy of substance use codes. Use the table below to make your selection if use, abuse and dependence of the same substance are documented.

Documentation	Code
Use and Abuse	Abuse
Abuse and Dependence	Dependence
Use, Abuse and Dependence	Dependence
Use and Dependence	Dependence

Codes for Psychoactive substance use disorders, unspecified (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9, F19.9)

- Use only when the psychoactive substance use is associated with a physical, mental or behavioral disorder, and if such a relationship is documented by the provider

“In Remission” codes for categories F10 - F19

- F1_**11 Mild** substance use disorders in early or sustained remission are classified to the appropriate substance code for abuse in remission
- F1_**21 Moderate or severe** substance use disorders in early or sustained remission are classified to the appropriate substance code for dependence in remission

ICD-10-CM	Categories F10 – F19 Mental and behavioral disorders due to psychoactive substance use
F10*	Alcohol -related disorders
F11	Opioid -related disorders
F12	Cannabis -related disorders (includes marijuana)
F13	Sedative, hypnotic or anxiolytic related disorders
F14	Cocaine -related disorders
F15	Other stimulant -related disorders (includes amphetamine-related disorders, caffeine)
F16	Hallucinogen -related disorders (includes ecstasy, phencyclidine/PCP)
F17	Nicotine dependence (do not report with History of tobacco dependence (Z87.891) or Tobacco use, NOS (Z72.0))
F18	Inhalant abuse (includes volatile solvents)
F19	Other psychoactive substance -related disorders (includes polysubstance drug use, indiscriminate drug use)

*A code from category Y90 – Evidence of alcohol involvement determined by blood alcohol level may be assigned when this information is documented and the patient’s provider has documented a condition classifiable to category F10 – Alcohol-related disorders.

**Please refer to the ICD-10 manual for all excludes notes for all coding examples.

4th character supports severity of disorders:

- 1 = abuse
- 2 = dependence
- 9 = unspecified

Additional 5th character supports status or specific type of disorders:

- 0 = **uncomplicated**
- 1 = **in remission**
- 2 = **with intoxication**
- 3 = **with withdrawal**
- 4 = **mood** disorders
- 5 = **psychotic** disorders
- 6 = **persisting amnesic** disorders
- 7 = **persisting dementia**
- 8 = **other** induced disorders
- 9 = **unspecified** induced disorders

Some subcategories also include an additional 6th character to support higher specificity if documented.

Pulmonary Fibrosis

Disease Overview

Pulmonary fibrosis (PF) is a family of more than 200 diseases, and is included within the larger umbrella of interstitial lung diseases. The word pulmonary means “lung” and fibrosis is “scarring.” This scar tissue on the lungs makes it harder for oxygen to get into the blood. The low oxygen levels and the stiffness of the lung scar tissue can cause shortness of breath, fatigue, chest discomfort, cough and unexplained weight loss. The cause of PF can be challenging to determine. It can be drug or radiation-induced, environmental, autoimmune or occupational. Treatment options include oxygen therapy, pulmonary rehabilitation, medications, symptom management and/or lung transplant.¹

Documentation Tips

Avoid the use of abbreviations.

Best practice is to document pulmonary fibrosis by spelling out the diagnosis in full. The abbreviation of (PF) could have more than one meaning (pulmonary fibrosis or pleural fluid).

- If you choose to abbreviate a word, spell it out the first time you use it to ensure clarity of the abbreviation.

Example: pulmonary fibrosis (PF)

Do not use “history of” to describe a current, still present or active diagnosis.

- “History of” for coding purposes conveys that the condition is historical and no longer exists.

Document the cause of the PF, if known.

Document any physical exacerbations of the disease (cough, shortness of breath, etc.).

Document any diagnostic testing—such as blood tests, X-rays, biopsy or pulmonary function tests.

Document a thorough treatment plan to include any medications, therapy or rehabilitation the patient may be receiving.

- Indicate any referral to a specialist.
- The date of the next follow up appointment.

Coding Guidance

Pulmonary fibrosis falls within category J84 - Other interstitial pulmonary diseases.

ICD-10-CM	Other interstitial pulmonary diseases
J84.0_	Alveolar and parieto-alveolar conditions
J84.1_	Other interstitial pulmonary diseases with fibrosis Excludes1: <ul style="list-style-type: none">• Pulmonary fibrosis (chronic) due to inhalation of chemicals, gases, fumes or vapors (J68.4)• Pulmonary fibrosis (chronic) following radiation (J70.1)
J84.10	Pulmonary fibrosis, unspecified Includes: <ul style="list-style-type: none">• Capillary fibrosis of lung• Cirrhosis of lung (chronic) NOS (not otherwise specified)• Fibrosis of lung (atrophic) (chronic) (confluent) (massive) (perialveolar) (peribronchial) NOS• Induration of lung (chronic) NOS• Postinflammatory pulmonary fibrosis
J84.112	Idiopathic pulmonary fibrosis Includes: <ul style="list-style-type: none">• Cryptogenic fibrosing alveolitis• Idiopathic fibrosing alveolitis
J84.2	Lymphoid interstitial pneumonia
J84.8_	Other specified interstitial pulmonary diseases Excludes1: <ul style="list-style-type: none">• Exogenous lipoid pneumonia (J69.1)• Unspecified lipoid pneumonia (J69.1)
J84.9	Interstitial pulmonary disease, unspecified

Note: The J84 category contains:

Excludes1:

- Drug-induced interstitial lung disorders (J70.2-J70.4)
- Interstitial emphysema (J98.2)

Excludes2:

- Lung diseases due to external agents (J60-J70)

Telehealth

Guidelines

- **Telehealth is a benefit for many Medicaid members. Please refer to state guidelines for specific requirements**
- **Best practice for Telehealth is audio and visual, but all providers should follow Aetna's reimbursement policy, available on the Provider Portal, and/or the state Medicaid policies regarding modality.**
- **Document the visit properly**
 - Indicate mode of visit for video conferencing
 - Document date and duration of visit
 - Complete documentation as you would for an in person visit
- **Proper coding for telehealth**
 - E/M codes may require an additional modifier such as GT/95/GQ, review state specific guidelines regarding telehealth modifiers
 - Place of Service for telehealth should follow state specific guidelines
 - Other service such as E/M codes with Modifier 95/ GQ/ GTsit
 - Place of Service Code "10"

2023 E/M Changes

Effective January 1, 2023

Elements of Medical Decision Making (changes in bold)

Level of MDM (Based on 2 of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed <small>*Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below.</small>	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal <ul style="list-style-type: none"> • 1 self-limited or minor problem 	Minimal or None	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low <ul style="list-style-type: none"> • 2 or more self-limited or minor problems or • 1 stable, chronic illness or • 1 acute, uncomplicated illness or injury or • 1 stable, acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care 	Limited (Must meet the requirements of at least 1 out of 2 categories) Category 1: Tests and documents Any combination of 2 from the following: <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see Moderate or High)	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	<p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment or • 2 or more stable, chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury 	<p>Moderate (Must meet the requirements of at least 1 out of 3 categories)</p> <p>Category 1: Tests and documents</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test* • Assessment requiring an independent historian(s) or <p>Category 2: Independent interpretation of tests or</p> <p>Category 3: Discussion of management or test interpretation</p>	<p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p>Examples only:</p> <ul style="list-style-type: none"> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High	<p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	<p>Extensive (Must meet the requirements of at least 2 out of 3 categories)Category 1: Tests and documents, or independent historians(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) or <p>Category 2: Independent interpretation of tests performed by another physician/qualified health professional</p> <p>Category 3: Discussion of management or test interpretation with external physician/other qualified health professional/ appropriate source</p>	<p>High risk of morbidity from additional diagnostic testing or treatment</p> <p>Examples only:</p> <ul style="list-style-type: none"> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level care • Decision not to resuscitate or to deescalate care because of poor prognosis • Parenteral controlled substances

Office or Other Outpatient Consultations

Code	MDM	Time
99242	Straightforward	20 minutes met or exceeded
99243	Low	30 minutes met or exceeded
99244	Moderate	40 minutes met or exceeded
99245	High	55 minutes met or exceeded

If a service is 70 minutes or longer, use prolonged service code 99417.

2024 E/M Changes

Effective January 1, 2024

CPT 2024 removed time ranges from both new and established office/outpatient Evaluation & Management codes. Effective January 1, 2024 a single total time amount “must be met or exceeded”.

For complete details and requirements, please refer to the most current version of the CPT manual.

MDM	Time
<ul style="list-style-type: none">Includes diagnosing, assessing and disease management	<ul style="list-style-type: none">Includes the total time the provider spent (on the DOS only), with the patient as well as time before and after the visit
<ul style="list-style-type: none">Includes complexity and number of diagnoses, reviewed data (i.e. tests) and overall risk of complications	<ul style="list-style-type: none">Includes DOS prep work, the exam, education, documenting, and coordination of care by the provider

Code	Time Requirement*
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes
99212	10 minutes
99213	20 minutes
99214	30 minutes
99215	40 minutes

*Time must meet or exceed the minimum time noted for the respective code.

Resources

Risk Adjustment – An Overview (pg. 5)

CMS Medicare Managed Care Manual Chapter 7: Risk Management

<https://www.cms.gov>

Palmetto GBA – CMS Contractor for RAPS

www.cssoperations.com

CMS Participant Guide: 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organization Participant Guide.

<http://www.hccuniversity.com>

Code of Federal Regulations, 42 CFR 422.504 [d][2][iii] – Record Retention

<https://www.gpo.gov>

Office of the Inspector General’s “Roadmap for New Physician – Avoiding Medicare and Medicaid Fraud and Abuse”:

<https://oig.hhs.gov>

Risk Adjustment (pg. 8 - 9)

2020 Official Guidelines for Coding and Reporting,

valid October 1, 2019 through September 30, 2020, published by NCHS and CMS.

AHA Coding Clinic is published quarterly by the American Hospital Association’s (AHA) Central Office

This publication is approved as the official source of coding information noted in the Federal Register, Vol. 74, No. 165, Thursday, August 27, 2009.

Healthy Home Visit Program (pg. 11 - 12)

If you’d like a copy of the complete 15+ page assessment that was conducted for a patient that concerns you, please see the contact information on the letter included with your PCP Summary.

To request an assessment for a patient that has not already had one in the current calendar year, contact your designated Engagement Manager or Network Management resource.

Major Depressive Disorder (pg. 13 - 15)

¹Diagnostic and Statistical Manual of Mental Disorders, Fifth Addition (Copyright© 2024).

American Psychiatric Association.

National Institutes of Mental Health. (2016, October). Depression: Overview [webpage]. Retrieved from

<https://www.nimh.nih.gov>

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

Pregnancy (pg. 16 - 24)

<https://www.who.int>

<https://www.cdc.gov>

<https://www.ncbi.nlm.nih.gov>

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

Diabetes Mellitus (pg. 25 - 28)

¹ www.mayoclinic.org

² www.diabetes.org

³ www.icd10data.com

⁴ International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

Chronic Kidney Disease (pg. 29 - 31)

www.mayoclinic.org

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

www.icd10data.com

Heart Failure (pg. 32 - 35)

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

American Heart Association

<https://www.heart.org>

Mayo Clinic

<https://www.mayoclinic.org>

American College of Physicians

<https://acphospitalist.org>

Chronic Obstructive Pulmonary Disease (pg. 36 - 40)

www.aapc.com

www.nhlbi.nih.gov/health-topics/copd

www.cdc.gov/copd/basics-about.html

www.mayoclinic.org

International Classifications of Diseases, Eleventh Revision, Clinical Modifications (ICD-10-CM).

Asthma (pg. 41 - 43)

¹<https://www.nlm.nih.gov>

² International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

³ www.aapc.com

Coronary Artery Disease & Atherosclerosis (pg. 44 - 46)

¹ Centers for Disease Control and Prevention

<http://www.cdc.gov/heartdisease>

² American Heart Association

<http://www.heart.org>

³ International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

End Stage Liver Disease (pg. 47 - 50)

U.S. National Library of Medicine, National Institutes of Health

<https://www.niddk.nih.gov>

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

Substance Abuse and Dependence (pg. 51 - 53)

Criteria for a Diagnosis of Substance Abuse and Substance Dependence

<https://www.cdc.gov>

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th Text Revision ed. Washington, DC: American Psychiatric Association.

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

Pulmonary Fibrosis (pg. 54 - 55)

¹ Pulmonary Fibrosis Foundation

<https://www.pulmonaryfibrosis.org>

International Classifications of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM).

2024 E/M Changes (pg. 57-59)

<https://www.ama-assn.org>

We're here to help.
Additional educational
opportunities are available
from Aetna.

Please contact us at
RiskAdjustment@aetna.com
with questions.

If you suspect fraud or abuse related to Medicare or would like to report healthcare fraud-related issues, please call the toll-free hotline, **1-800-338-6361** or email us at **AetnaSIU@aetna.com**.

Fraud involves submission of false information to the Government or a Government contractor to receive money or a benefit. **Waste** includes practices that result in unnecessary costs to the Medicare Program. **Abuse** involves payment for items or services when there is no legal entitlement to payment.



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