## Version Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Modification</th>
<th>Section Name</th>
<th>Version</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/08/16</td>
<td>First technical writer draft</td>
<td></td>
<td>(1.0)</td>
<td>Laura Heintz</td>
</tr>
<tr>
<td>04/30/16</td>
<td>SME edits incorporated.</td>
<td>All</td>
<td>2.0</td>
<td>Laura Heintz</td>
</tr>
</tbody>
</table>

## Reviewers

<table>
<thead>
<tr>
<th>Reviewed by</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dena Castellan</td>
<td></td>
</tr>
<tr>
<td>Lynne Padilla</td>
<td></td>
</tr>
</tbody>
</table>

## Approvers

<table>
<thead>
<tr>
<th>Approved by</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynne Padilla</td>
<td></td>
</tr>
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Contents

Version Control ...................................................................................................................... ii
Reviewers ................................................................................................................................. ii
Approvers ............................................................................................................................... ii
INTRODUCTION ..................................................................................................................... 1
Resources ................................................................................................................................ 1
Acronyms ................................................................................................................................. 1
RISK ADJUSTMENT .................................................................................................................. 3
  Medicare Risk and Commercial Risk .................................................................................. 3
  Altegra Health’s Role in the Risk Adjustment Process ....................................................... 3
DOCUMENTATION REQUIREMENTS ....................................................................................... 3
  Face-to-Face Visit Required ............................................................................................... 3
  Hospital Inpatient Data ....................................................................................................... 4
  Hospital Outpatient Data .................................................................................................... 4
  Physician Services .............................................................................................................. 5
  Acceptable Document Types ............................................................................................. 5
  Unacceptable Document Types ......................................................................................... 5
  Patient Name and Date of Service Must Appear on Each Page ....................................... 5
    Patient Name ..................................................................................................................... 5
    Date of Service .................................................................................................................. 5
    Continuity from Page to Page .......................................................................................... 6
    Letter Format .................................................................................................................... 6
    Missing Pages .................................................................................................................... 6
  Documentation Must Be Legible .......................................................................................... 6
  Diagnoses Must Be Supported by Appropriate Medical Record Documentation ............. 6
    Chronic and/or Life-Long Conditions .............................................................................. 7
  Valid Signature Required ................................................................................................... 9
    Signature Requirements ................................................................................................. 9
    Signature Stamps ............................................................................................................. 9
    Proper Electronic Authentication .................................................................................... 9
  Valid Provider Types .......................................................................................................... 10
  Flagged Event Codes (F Codes) ......................................................................................... 11
CODING REQUIREMENTS .................................................................................................................. 11
TAMPER™ ...................................................................................................................................... 12
Locating Diagnoses within the Documentation .................................................................................. 12
Chief Complaint & History of Present Illness (HPI) ........................................................................ 13
Past Medical History (PMH) and Other Lists .................................................................................... 13
Chronic Diagnoses ............................................................................................................................. 13
Status Codes ..................................................................................................................................... 13
Review of Systems (ROS) .................................................................................................................. 13
Physical Exam (PE) ........................................................................................................................... 14
Assessment & Plan ............................................................................................................................. 14
Uncertain Diagnoses .......................................................................................................................... 14
Code Selection .................................................................................................................................. 15
Additional Coding Guidelines ........................................................................................................... 15
Acute & Chronic ................................................................................................................................. 15
Borderline .......................................................................................................................................... 16
Continue Medication as Treatment Plan ............................................................................................ 17
Evidence of ........................................................................................................................................ 17
ICD Code Documented In Place Of Written Diagnosis ..................................................................... 17
Multiple Diagnoses/Conditions for Same Disease ........................................................................... 17
Linking Diagnoses/Manifestations ....................................................................................................... 17
Stable & Controlled ............................................................................................................................. 18
Prophylactic/Preventative Medication ............................................................................................... 18
Up & Down Arrows ............................................................................................................................ 18
Conditions “With” ............................................................................................................................... 18
COMMON RISK ADJUSTMENT DIAGNOSES .............................................................................. 19
Artificial Openings .............................................................................................................................. 19
Asthma ............................................................................................................................................... 19
Cerebrovascular Accident (CVA) ........................................................................................................ 20
Cancer (CA) ........................................................................................................................................ 20
Depression .......................................................................................................................................... 21
Diabetes (DM) ...................................................................................................................................... 23
Deep Vein Thrombosis (DVT) ........................................................................................................... 23
HIV & AIDS........................................................................................................................................................................... 24
Pregnancy............................................................................................................................................................................... 24
APPENDIX A - FREQUENTLY ASKED QUESTIONS (CODING CLINIC REFERENCES)........................................................................... 26
APPENDIX B – FLAGGED EVENT CODES (F CODES) ................................................................................................................. 32
INTRODUCTION

Altegra Health provides medical record review and coding services. A large part of the coding is focused on risk adjustment coding including retrospective chart review, ICD-9-CM and ICD-10-CM code assignment. This document provides the guidelines by which Altegra Health’s coding specialists perform risk adjustment coding and follows ICD-9-CM/ICD-10-CM Official Guidelines for Coding and Reporting along with any applicable guidance from Coding Clinic, CMS and other federal and state resources to determine accurate code assignment.

Resources

The following resources have been used in the development of these coding guidelines.

- ICD-9-CM/ICD-10-CM Guidelines (both general & chapter specific) published by the World Health Organization (WHO)
- Coding Clinic published by the American Hospital Association (AHA)
- 2008 Risk Adjustment Data Technical Assistance for MA Organizations Resource Guide published by the CMS Customer Service and Support Center (CSSC)
- Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance published by CMS
- Risk Adjustment 101 Participant Guide published by CMS

Acronyms

The following acronyms are common industry terms and are used throughout this document.

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPC</td>
<td>American Academy of Professional Coders</td>
</tr>
<tr>
<td>ACG</td>
<td>Adjusted Clinical Groups (Outpatient)</td>
</tr>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>AH</td>
<td>Altegra Health</td>
</tr>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Authorized Response Team</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgical Centers</td>
</tr>
<tr>
<td>BKA</td>
<td>Below Knee Amputation</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CA</td>
<td>Cancer</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDPS</td>
<td>Chronic Illness and Disability Payment Systems</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive Heart Failure</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>CLL</td>
<td>Chronic Lymphocytic Leukemia</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CRG</td>
<td>Clinical Risk Groups</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CSSC</td>
<td>CMS Customer Service and Support Center</td>
</tr>
<tr>
<td>ACRONYM</td>
<td>MEANING</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular Accident</td>
</tr>
<tr>
<td>DM</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of Service</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>DX</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>DxCG</td>
<td>RxGroups</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>ERG</td>
<td>Episode Risk Groups</td>
</tr>
<tr>
<td>ERSD</td>
<td>End Stage Renal Disease</td>
</tr>
<tr>
<td>FERAS</td>
<td>Front End Risk Adjustment System</td>
</tr>
<tr>
<td>HCC</td>
<td>Hierarchical Condition Category</td>
</tr>
<tr>
<td>HHS</td>
<td>Health and Human Services Hierarchical Condition Category</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPI</td>
<td>History of Present Illness</td>
</tr>
<tr>
<td>HTN</td>
<td>Hypertension</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases, Tenth Revision, Clinical Modification</td>
</tr>
<tr>
<td>LOB</td>
<td>Line of Business</td>
</tr>
<tr>
<td>MAO</td>
<td>Medicare Advantage Organization</td>
</tr>
<tr>
<td>MARx</td>
<td>Medicare Advantage Prescription Drug System</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>MRX</td>
<td>Medicaid Rx</td>
</tr>
<tr>
<td>NCE</td>
<td>Non-Codeable Event</td>
</tr>
<tr>
<td>NOS</td>
<td>Not otherwise specified</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioners</td>
</tr>
<tr>
<td>PMH</td>
<td>Past Medical History</td>
</tr>
<tr>
<td>RA</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>RADV</td>
<td>Risk Adjustment Data Validation</td>
</tr>
<tr>
<td>RAPS</td>
<td>Risk Adjustment Processing System</td>
</tr>
<tr>
<td>RAS</td>
<td>Risk Adjustment System</td>
</tr>
<tr>
<td>ROS</td>
<td>Review of Systems</td>
</tr>
<tr>
<td>Rx</td>
<td>Prescription Drug</td>
</tr>
<tr>
<td>Rx HCC</td>
<td>Prescription Drug Hierarchical Condition Category</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facilities</td>
</tr>
<tr>
<td>TAMPER</td>
<td>Treatment, Assessment, Monitor/Medicate, Plan, Evaluate or Referral</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**RISK ADJUSTMENT**

**Medicare Risk and Commercial Risk**

Risk adjustment is the method used to adjust bidding and payment to health plans based on demographics (e.g. age and sex) as well as actual health status of a plan’s enrollees. Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs, and adjust payment. In contrast, Commercial risk adjustment is concurrent, meaning diagnoses from the current year and demographic information are used to predict current year costs, and adjust payment. Medicaid risk adjustment is very state specific, with the majority of states using a customized, prospective Chronic Illness and Disability Payment Systems (CDPS) model.

Though the diagnosis codes identified for risk adjustment may differ between the Centers for Medicare & Medicaid Services (CMS) model and the Medicaid or Commercial models, they all are used to assist in forecasting the future needs of the member population and where funds may need to be distributed to care for those needs.

**Altegra Health’s Role in the Risk Adjustment Process**

Altegra Health’s role in the Risk Adjustment process is to ensure all active diagnoses supported by acceptable medical record documentation are identified and reported back to the client.

<table>
<thead>
<tr>
<th>Lines of Business</th>
<th>Risk Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>CMS-HCC RxHCC ERSD</td>
</tr>
<tr>
<td>Commercial</td>
<td>HHS-HCC</td>
</tr>
<tr>
<td>Medicaid</td>
<td>CDPS ACG CRG ERG DxCG</td>
</tr>
</tbody>
</table>

**DOCUMENTATION REQUIREMENTS**

For purposes of risk adjustment coding, the following requirements must be present in the medical record documentation or the associated ICD codes will be considered invalid.

**Procedure**

Assign the appropriate Flagged Event (F-Code) when documentation is missing any of these requirements. This will notify the client that further action must be taken (an attestation, amendment, etc.) prior to submitting the identified ICD codes for their risk adjustment calculations. Refer to the *Flagged Event Codes (F Codes)* section of this document for a detailed description of each F Code.

**Face-to-Face Visit Required**

Diagnoses **must** result from a **face-to-face visit** either with an **acceptable physician specialty** or from an **acceptable facility**. If the documentation is not clear that a face-to-face encounter has occurred, do **NOT** code any diagnoses for that encounter.
**Rationale:** This covers the reason for F18, but provides different guidance. We will not code diagnosis from a non-face-to-face encounter/interpreted diagnostic reports. Risk adjustment and RADV guidelines clearly state not to code from these visit types and Altegra Health will not code against official guidelines.

**Note:** The only exception to this requirement is a pathology report. A pathology report is an acceptable document source for risk adjustment coding purposes.

Altegra Health coders are responsible for ensuring that the collected diagnosis data comes from an acceptable source. Acceptable sources include:

- Hospital Inpatient
- Hospital Outpatient
- Physician Services

Acceptable sources are defined below:

**Hospital Inpatient Data**  
Hospital inpatient services occur when a patient is admitted to a facility for at least one (1) overnight stay. Examples of covered and non-covered hospital inpatient facilities are:

**Covered Facilities**
- Short-term (general and specialty) Hospitals
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals Rehabilitation Hospitals
- Children’s Hospitals
- Psychiatric Hospitals
- Medical Assistance Facilities/ Critical Access Hospitals

**Non-Covered Facilities**
- Skilled Nursing Facilities (SNFs) **
- Hospital Inpatient Swing Bed Components
- Intermediate Care Facilities
- Respite Care Hospice

**Hospital Outpatient Data**  
Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization. Examples of covered and non-covered hospital outpatient facilities are:

**Covered Facilities**
- Short-term (general and specialty) Hospitals
- Medical Assistance Facilities/Critical Access Hospitals
- Community Mental Health Centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions

**Non-Covered Facilities**
- Free-standing Ambulatory Surgical Centers (ASCs)
- Home Health Care
- Free-standing Renal Dialysis Facilities Non-Covered Services
- Laboratory Services
- Ambulance

*These are only examples of non-covered facilities and not a comprehensive list.

**Requires additional guidance for coding/health plan specific.*
Covered Facilities (continued)

- Long-term Hospitals
- Rehabilitation Hospitals
- Children’s Hospitals
- Psychiatric Hospitals
- Rural Health Clinic

Non-Covered Facilities*(continued)

- Durable Medical Equipment
- Prosthetics
- Orthotics
- Supplies
- Radiology Services
* These are only examples of non-covered facilities and not a comprehensive list.

Physician Services

Services provided by an individual licensed under state law to practice medicine.

Acceptable and unacceptable document types are defined below:

Acceptable Document Types

The following list includes all acceptable document types:

- Progress Notes (SOAP)
- Consult Notes
- Procedure Notes
- Discharge Summary
- O Notes
- History and Physical (H&P)
- Interpretive Diagnostic Reports (Must be a face to face visit from an approved physician specialty)

Unacceptable Document Types

The following list includes all unacceptable document types:

- Laboratory Reports (except for pathology, which is allowed)
- Radiology reports
- Patient demographic sheets (Used to validate patient demographic data only)
- Clinical Visit Summaries or After Visit Summaries
- Super Bill
- Diagnostic Reports not Interpreted by an Approved Provider Type
- Stand-alone Problem Lists
- Stand-alone Medication Lists
- Hospital Inpatient Coding Summary Sheets
- Nursing Notes

---

**Patient Name and Date of Service Must Appear on Each Page**

**Patient Name**

The heading lists patient name first, followed by the Date of Service (DOS).

**Date of Service**

The Date of Service (DOS) defines when a beneficiary received medical treatment from a physician or medical facility. The DOS is a required element and the service must take place during the measurement period to be valid for risk adjustment purposes.
**Outpatient and Physician Services**

*From Date and Through Date may be identical.*

**Inpatient Services**

*From Date and Through Date are different from each other and indicate the admission date to a facility and discharge date from a facility.*

**Continuity from Page to Page**

If the patient’s name and date of service do not appear on each page, continuity from page to page must be shown.

The example below shows one form of acceptable continuity to use on additional pages when the first page contains the patient name and date of service.

**Example:** Page (1 of 3), (2 of 3), (3 of 3), etc. on each page

**Letter Format**

If the service is documented in a letter format, the letter date cannot be presumed to be the DOS. Providers may at times dictate the encounter the following day or even later, at which time the letter is dated. The DOS must be clearly documented.

**Procedure**

When the DOS is not clearly stated, the date of letter is the date of service and F3 will be assigned as the diagnosis code. Statements such as “I saw your patient today” or “patient seen today for…” confirm that the patient was, in fact, seen on the letter date and F3 will not be assigned.

**Rationale:** This covers the information included in F19.

**Missing Pages**

If pages are missing from the date of service, but you have confirmed the pages are from an acceptable document source, code what is found within the page(s) contained for that date of service.

**Documentation Must Be Legible**

If handwriting in a medical record or on a DOS is difficult to read, do your best and query the Auditor Response Team (ART) for assistance to interpret the indecipherable content. If it is determined the documentation is not legible, do NOT code any questionable diagnoses.

**Diagnoses Must Be Supported by Appropriate Medical Record Documentation**

The guidelines for determining appropriate medical record documentation and support are as follows:

- Code selection follows ICD-10-CM Official Coding Guidelines;
- Diagnoses must be supported as active and relevant during the encounter; Code all coexisting conditions that require or affect patient care, treatment or management;
- Do NOT code conditions that were previously treated and no longer exist;
Permanent/Life-Long chronic conditions are accepted diagnoses. See the table below for recognized conditions. If support for a chronic condition in this list is not found, code the chronic condition and append an F7. Status codes from the list may be assigned without additional support.

### Chronic and/or Life-Long Conditions

- Amputation Status
- Atrial Fibrillation
- Cerebral Palsy
- Cirrhosis of the Liver (Unless diseased liver has been replaced by transplant)
- Chronic Lymphocytic Leukemia (CLL)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Crohn’s Disease
- Cystic Fibrosis
- Diabetes Mellitus
- Emphysema
- End Stage Liver Disease (Unless diseased liver has been replaced by transplant)
- Epilepsy
- Huntington’s Disease
- Major Organ Transplant Status
- Multiple Myeloma
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Paraplegia
- Parkinson’s Disease
- Quadriplegia
- Rheumatoid/Inflammatory Arthritis
- Arthritis
- Systemic Lupus
- Erythematous
- HIV/AIDS

A Medication List may support a documented diagnosis as long as the medication listed is only used for one purpose. If there are multiple uses for a medication, the physician must link the medication to the condition within the documentation. Utilize [www.webmd.com](http://www.webmd.com), [www.mayoclinic.org](http://www.mayoclinic.org), and [World Health Organization (WHO)](http://www.who.int) to research proper uses of a medication.

Rationale: The last bullet previously provided guidance for F8. All ongoing conditions are coded.
**For Example:** Diagnosis of Migraines, medication list includes Topamax. Since Topamax can be used to treat several different conditions, the provider must link the medication with the diagnosis in order to be used for support.

**Rationale:** Formerly coded as F11.
## Valid Signature Required

**Signature Requirements**

All THREE of these signature requirements must be present:

1. **Provider name or initials**
   
   If the signature is not legible or only initials are used, the provider name must be printed under the signature.

2. **Provider credentials**

   For Example: Dr. Bob Smith is not acceptable unless there is evidence that Dr. Smith is an acceptable provider type (MD, DO etc.). Credential such as Bob Smith, MD must be present.

3. **Date signed (Inpatient hospital notes also require a time stamp)**

**Signature Stamps**

Signature stamps are NOT allowed.

**Note:** Some EMR systems affix a JPEG that may look like a signature stamp and these are approved.

### Procedure

Apply F1 if the note is signed by a rubber stamp.

---

### Proper Electronic Authentication

Unacceptable EMR Signatures:

- “Administratively signed”
- “Signed but not read”
- “Dictated but not signed”
- “Dictated but not read”

### Procedure

Apply F1 if one of the unacceptable signatures are noted on the document.

---

### Common EMR signatures approved as acceptable:

- “Accepted by”
- “Finalized by”
- “Completed by”
- “Acknowledged by”
- “Read by”
- “Confirmed by”
- “Approved by”
- “Reviewed by”
- “Electronically approved by”
- “Charted by”
- “Sealed by”
- “Electronically signed by”
- “Closed by”
- “Signature on file”
- “Finalized by”
- “Completed by”
- “Confirmed by”
- “Released by”
- “Approved by”
- “Validated by”
- “Signed by”
- “Charted by”
- “Written by”
- “Signed”
- “Closed by”
- “Date/time signed”
- “Finalized by”
- “Confirmed by”
- “Digitally signed by”
- “Authenticated by”
- “Generated by”
- “Entereed by”
- “Perfomred by”
- “Verified by”
- “Entered data sealed by”
- “Authored by”
- “Authorized by”
- “Authorized by”

**Note:** If you encounter any other variations of signatures, please consult with a Coding Manager before determining whether or not to capture codes from a note.
Valid Provider Types

The collection of provider data for risk adjustment is associated with the provider’s specialty.

**Procedure**
Apply F6 if the document does not clearly state the type of provider. If the provider is not on the acceptable provider list, do not code the encounter.

Acceptable Provider Specialties List:

<table>
<thead>
<tr>
<th>General Practice</th>
<th>Physical Medicine and Rehabilitation</th>
<th>Occupational Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Psychiatry</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>Geriatric Psychiatry</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Colorectal Surgery</td>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Pulmonary Disease</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Thoracic Surgery</td>
<td>Cardiac Surgery</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Urology</td>
<td>Addiction Medicine</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Chiropractic</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>Interventional Pain Management</td>
<td>Nuclear Medicine</td>
<td>Critical Care (intensivists)</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Pediatric Medicine</td>
<td>Hematology</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Geriatric Medicine</td>
<td>Hematology/Oncology</td>
</tr>
<tr>
<td>Osteopathic Manipulative Medicine</td>
<td>Nephrology</td>
<td>Preventive Medicine</td>
</tr>
<tr>
<td>Neurology</td>
<td>Hand Surgery</td>
<td>Maxillofacial Surgery</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Optometry</td>
<td>Neuropsychiatry</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>Certified Nurse Midwife</td>
<td>Certified Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Certified Registered Nurse Anesthetist</td>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Hospice and Palliative Care</td>
<td>Infectious Disease</td>
<td>Surgical Oncology</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Endocrinology</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Podiatry</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>Nurse Practitioner</td>
<td>Interventional Radiology</td>
</tr>
<tr>
<td>Cardiac Electrophysiology</td>
<td>Psychologist</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>Pathology</td>
<td>Audiologist</td>
<td>Gynecologist/Oncologist</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>Physical Therapist</td>
<td>Unknown Physician Specialty</td>
</tr>
<tr>
<td>Plastic And Reconstructive Surgery</td>
<td>Rheumatology</td>
<td>Sleep Medicine</td>
</tr>
</tbody>
</table>

**Note:** Nurses (RN, LPN), Medical Assistants, and Administrative office staff are not approved provider types.

*Effective starting 2015 Dates of Service*
Flagged Event Codes (F Codes)

Altegra Health Flagged Event Codes are used when documentation in the medical record is inadequate, ambiguous, or otherwise unclear for medical coding purposes. The following F Codes should be assigned to flagged events:

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>Signature and Provider Type Deficiencies</td>
<td>Apply F1 to identify all signature deficiencies and/or unconfirmed provider types. Refer to Signature Requirements and Valid Provider Types. The encounter will not be coded if confirmed unacceptable provider.</td>
</tr>
<tr>
<td>F3</td>
<td>DOS Deficiency</td>
<td>Apply F3 to all incomplete or missing DOS. Apply 01/01/2099 to any encounter that has F3 applied for an incomplete/missing DOS. Refer to Date of Service.</td>
</tr>
<tr>
<td>F4</td>
<td>Patient Identifier Deficiency</td>
<td>Apply F4 when patient name is missing from or incomplete in the document.</td>
</tr>
<tr>
<td>F7</td>
<td>Chronic Conditions</td>
<td>Apply F7 when a chronic and or life-long condition is documented without support.</td>
</tr>
<tr>
<td>F11</td>
<td>Medication</td>
<td>Apply F11 when a diagnosis is supported by a medication that was not linked to diagnosis by provider.</td>
</tr>
<tr>
<td>NCE</td>
<td>Non-Codeable Event</td>
<td>Apply NCE when a face-to-face encounter occurred but no risk adjustment diagnoses were documented.</td>
</tr>
</tbody>
</table>

CODING REQUIREMENTS

Diagnoses must be supported by appropriate medical record documentation. Altegra Health follows ICD-9-CM/ICD-10-CM Official Guidelines for Coding and Reporting in addition to any applicable Coding Clinic Articles to determine code selection.

All coders are expected to know and understand the ICD-9-CM/ICD-10-CM Official Guidelines for Coding and Reporting. Coding Clinic articles may be used for guidance on when and how a code should be assigned.

The requirements below are not all-inclusive.
TAMPER™ is an acronym that means ...

- **T**reatment: Surgery, therapy, procedure, counseling, education, DME ordered/given, lab(s) ordered
- **A**ssessment: Acknowledging/giving status/level of condition
- **M**onitoring / **M**edicate: Ordering/referencing labs/other tests/ prescribing medication
- **P**lan: Plan for management or follow-up of condition
- **E**valuate: Examining (as in physical exam) *
- **R**eferral: Referral to specialists for treatment or consultation of a confirmed condition

*An evaluation of normal findings upon review of body system(s) or vital signs that would be done for any member as part of a typical exam is not sufficient alone to support an active diagnosis.

**For Example:** A final diagnosis is Osteoarthritis (OA). Joint exam was done as part of a head to toe physical exam. Provider does not TAMPER™ with Osteoarthritis diagnosis. The joint exam would need to be linked by provider as an evaluation of OA in order for the exam to be used as the sole support for the diagnosis.

---

**Uncertain if a Code Should be Reported?**

**Procedure**

**Ask yourself ...**

Is there evidence of TAMPER™ for the diagnosis on this DOS?

If the answer is **Yes** ...

The diagnosis can be considered current and should be coded.

If the answer is **No** ...

Do **NOT** report the condition as current and consider the diagnosis as a PMH which is not reportable without TAMPER™.

---

**Locating Diagnoses within the Documentation**

Diagnoses can be reported from any portion of the medical record provided that they are accurately documented as current diagnoses or TAMPER™ can be found within the DOS. Do not code for conditions that have been previously treated and no longer exist. ALL diagnoses must pass the TAMPER™ test.

**Procedure**

Code all active/current diagnoses, conditions, problems, or other reasons for encounter/visit present in the medical record. Follow guidelines by coding any additional codes that describe coexisting conditions that require or affect patient care, treatment or management.
Chief Complaint & History of Present Illness (HPI)

Utilize TAMPER™ to determine if the diagnosis is supported and should be coded as active.

**Note:** The HPI often lists signs and symptoms that are not definitive or confirmed diagnoses. Inconclusive and unsure diagnoses should NOT be coded.

Past Medical History (PMH) and Other Lists

Do not code acute conditions from the PMH as active if only listed in PMH. There must be evidence of TAMPER™ elsewhere in the medical record to support the condition is still active at the time of the encounter.

**Note:** Be sure when reviewing medical records that the conditions have not been copied/pasted from a previous encounter and are no longer supported as active. This is especially true when coding from electronic medical records.

**Rationale:** This guidance was previously included in F14.

Examples of acute conditions that may get pulled over in the PMH or Problem List:

- Fractures
- CVA/Stroke
- Cancer
- DVT
- PE
- Common cold
- Gastroenteritis

If the diagnosis is being assessed, evaluated or treated during the encounter, the condition may be coded even if documented as ‘history of’ diagnoses.

Examples:

- History of HTN - member is on Lisinopril for management → Code as active
- History of Angina - managed with prn Nitroglycerin → Code as active

Chronic Diagnoses

Diagnoses listed as current, ongoing, active, controlled, uncontrolled, etc. should be coded. The term “chronic” is not viewed as support for the condition. It does not provide TAMPER. It is more of a description of how long the patient has had the disease (acute, chronic, long-term, etc.)

Status Codes

Status codes should be coded if they are current (BKA, ostomies, transplants, etc.)

Review of Systems (ROS)

Avoid coding any diagnoses that are only reported by the patient and not validated by the current provider.

**For Example:** Patient states that he or she has COPD, but provider does not examine for COPD and/or the patient is on no medication for the condition. Any confirmed diagnoses found in ROS must be clearly supported with TAMPER™.
Physical Exam (PE) Provider documents the objective findings from the physical exam. Code any diagnoses documented as active. Look closely for notations of ostomies/artificial openings, pressure ulcers, amputations addressed in the physical exam findings and code as applicable. Normal findings in the physical exam are not enough to support TAMPERTM of a listed diagnosis unless the provider documents a linkage of the negative findings to the diagnosis. There must be additional (assessment, medication, referral, etc.) to support an active diagnosis without this linkage.

**Rationale:** This guidance was previously included in F15, but provides different information. A negative/normal finding on a ‘typical’ exam does not support a documented diagnosis. The diagnosis may be from a previous visit and is no longer active.

Assessment & Plan Active diagnoses documented in the assessment and plan should only be coded if clearly supported with TAMPERTM unless they are one of the approved chronic conditions (see Appendix B).

**Rationale:** This information was previously included in F13, but does not provide the same direction. Due to EMR issues with cloning/carrying forward information, Altegra Health will not assume diagnosis listed in CC and assessment is an active diagnosis unless there is evidence of TAMPERTM. (Also includes F15.)

**For Example:** Asthma noted in final impression. No medications or other management plan. Lungs were assessed as part of a head to toe exam during the visit, but the lung assessment was not linked to an asthma evaluation by the provider. NO acceptable support for this diagnosis. Asthma CANNOT be assigned a code.

Uncertain Diagnoses Do not code uncertain diagnoses. Code the condition(s) to the highest degree of specificity for that encounter/visit, such as symptoms, signs, or other reason for the visit. Do NOT code if described as:

- Suggestive of/Symptoms of/Likely
- Probable/Suspect/Tendency/Possible
- Consistent with/Compatible with
- Presumed/Sign(s) of/Suspect
- Suspicious for/Pending
- Rule-Out/Perhaps/Questionable
If the diagnosis documented at the time of discharge on a hospital Discharge Summary is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established.

(INPATIENT DISCHARGE TO A SHORT-TERM, ACUTE, LONG-TERM CARE AND PSYCHIATRIC HOSPITALS ONLY)

**Code Selection**

It is very important to code to the highest degree of specificity. Do NOT code the diagnosis directly from the Index as you may miss important code assignment instructions. Follow all coding guidelines and conventions for accurate code assignment.

Use the following procedure when determining code selection:

1. **Define the main term of the documented diagnosis.** When trying to determine the main term, it is sometimes helpful to read the diagnosis right to left.

2. **For Example: COPD** is found by looking for Disease/pulmonary/chronic/obstructive.

3. **Look the diagnosis up in the Alphabetic Index.** For example, the Index to Diseases and Injuries, Neoplasm Table, Table of Drugs and Chemicals and Index to External Causes of Injuries.
   - Refer to any notes under main term
   - Read any terms enclosed in parentheses
   - Do not skip subterms indented under the main term
   - Follow any mandatory cross-reference instructions, such as “See also”.

4. **Verify the code in the Tabular List.**
   - Pay close attention to any category notes located under the three (3) character category.
   - Look for other code selection directions. For example, Code First, Excludes Notes, Use Additional Code If Applicable, etc.

5. **Review and apply any applicable chapter specific coding guidelines.**

**Additional Coding Guidelines**

**Acute & Chronic**

Certain conditions require specific documentation to support them as ACUTE in nature in order to capture the codes. As long as these conditions are supported as new or acute in the body of the note, you should code the acute codes.

These conditions include, but are not necessarily limited to:

- CVA/Stroke/TIA
- Acute Myocardial Infarction
- Pulmonary Embolism or Acute DVT
Fracture (Traumatic and Pathologic)

Procedure
If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both.

Borderline
If the provider documents a "borderline" diagnosis, the diagnosis is coded as confirmed, unless the classification provides a specific entry, such as borderline diabetes. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). If the documentation is unclear regarding a borderline condition, the condition cannot be coded.

Procedure
If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such.

Body Mass Index (BMI)
BMI should be coded when properly documented and there is clinical significance for the face to face visit. (Coding Clinic Appendix A #8)

Rationale: This guidance was previously included in F12.

Use the following criteria to code BMI:

- A BMI value can only be coded when documented during a face-to-face visit with an approved provider.
- BMI may be recorded by ancillary staff.
- Do not calculate BMI from documented height and weight. Only report when the BMI value itself is documented.

Pay attention to patient age to select the correct code:

- Adult BMI codes = 21 years of age or older
- Pediatric BMI codes = 2-20 years of age
- Children under the age of 2 = code selection is based on growth charts published by the Centers for Disease Control and Prevention using weight percentiles.

You CANNOT infer ‘obesity’, ‘morbid obesity’, etc. based on a BMI value. The provider must specifically state an ‘obesity’ diagnosis. If it is not documented, code for the BMI value only. (Coding Clinic Appendix A #9)

Note: Altegra Health considers the two words, obese and obesity, interchangeable and will index and code obese to obesity. However, this does not extend to ‘obese
abdomen’. An obese abdomen does NOT mean the patient is obese. It means the patient has an obese abdomen.

**Continue Medication as Treatment Plan**

**Can the diagnoses be coded if...?**

No medication list is present on the note. Only one diagnosis is documented in the Assessment/Plan with “continue meds” documented as the plan of care next to or below the diagnosis.

**YES**

Rationale: Given there is only one condition being addressed, if the provider indicates that the condition is being treated with medication, this is clear enough documentation to support the diagnosis as active.

No medication list is present on the note. Multiple diagnoses are documented in the Assessment/Plan with “continue meds” documented underneath the list of diagnoses.

**NO**

Rationale: Because there are multiple conditions, and there is no other documentation to indicate which of the conditions is being treated with medication, we cannot assume that the statement “continue meds” applies to all of the listed conditions.

A medication list is present in the body of the note. Multiple diagnoses are documented below in the Assessment/Plan with “continue meds” documented underneath the list of diagnoses.

**YES**

Rationale: If the medication list contains medication commonly prescribed specifically for a condition listed in the Assessment/Plan, you will report the diagnosis as stated.

**Evidence of**

When the provider documents “evidence of” a particular condition, it is not considered an uncertain diagnosis and should be appropriately coded. (See Coding Clinic Appendix A #2)

**ICD Code Documented In Place Of Written Diagnosis**

Do NOT code diagnoses documented as an ICD-9-CM and/or ICD-10-CM code only. The provider must provide a written diagnostic statement. (See Coding Clinic Appendix A #3)

**Multiple Diagnoses/Conditions for Same Disease**

Review documentation throughout the DOS to code to the greatest specificity. For example: If both Hyperlipidemia and Mixed Hyperlipidemia are found in the DOS and TAMPER™ has been used to make the assessment, choose only the most specific diagnosis, Mixed Hyperlipidemia.

**Linking Diagnoses/Manifestations**

Do not assume cause and effect relationships unless guidelines indicate to do so (ex: Hypertension & CKD). The provider must document a link between conditions within the document. Code all conditions separately unless the cause-and-effect is clear (e.g. ‘with’, ‘due to’, ‘secondary to’, ‘caused by’, etc.)
Stable & Controlled
These types of terms establish that the provider “assessed” the status of the condition (e.g. COPD - stable or hypercholesterolemia - controlled).

Note: The list here including stable and controlled is not all-inclusive. There are other terms which are commonly used to assess the status of a condition. Those may be considered TAMPER as well. The key point is that any term which describes the status (e.g. controlled, uncontrolled, poorly controlled, worsening, improving, etc.) or severity (mild, moderate, severe, etc.) is considered to be “assessed”, which is one of the elements of TAMPER.

Prophylactic/Preventative Medication
Conditions being managed through prophylactic measures should not be coded as active. If the medication/treatment is being administered prophylactically, the patient is attempting to prevent the condition and it would not be considered active.

For Example: A history of DVT or CVA with member on anticoagulation medication.

Up & Down Arrows
Do not code a diagnosis based on Up/Down arrows within the documentation. This should not be used as TAMPER (assessment) as the arrows can easily be misinterpreted. The provider must state the status of the condition.
(See Coding Clinic Appendix A #4)

For Example: ↑ cholesterol, ↓ blood pressure

Conditions “With”
The word “with” should be interpreted to mean “associated with” or “due to.” The documentation does not need to provide a link between conditions when there is a subterm “with” in the Index. If you cannot arrive at a combination code through the Alpha Index using the term “with”, code the conditions separately. (See Coding Clinic Appendix A #5)

Rationale: This guidance was previously included in F9.
## COMMON RISK ADJUSTMENT DIAGNOSES

### Artificial Openings

Artificial opening status affects patient care decisions. Before selecting a code, make sure the opening is still current because many artificial openings may be temporary (PMH). Usually, there are two code choices:

1. Status of – opening is current
2. Attention to/care for – encounter included care directed to the artificial opening.

There may be additional codes to report complications, adjustment or changes made to the opening.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.0</td>
<td>Z43.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.0</td>
<td>Z93.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ileostomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.2</td>
<td>Z43.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.2</td>
<td>Z93.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G-tube PEG Tube</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.1</td>
<td>Z43.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.1</td>
<td>Z93.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colostomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.3</td>
<td>Z43.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.3</td>
<td>Z93.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cystostomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.5</td>
<td>Z43.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.50</td>
<td>Z93.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Urinary Tract</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to</td>
<td>V55.6</td>
<td>Z43.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of</td>
<td>V44.6</td>
<td>Z93.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Asthma

Coding of acute exacerbation of asthma and status asthmaticus together, only the code with the highest specificity (status asthmaticus) should be assigned at the DOS level. (Coding Clinic Appendix A #6)

Code selection is first based on how the asthma is described: mild intermittent, mild persistent, moderate persistent, severe persistent, or unspecified. Within each of these choice are options for uncomplicated, exacerbated, or with status asthmaticus.

<table>
<thead>
<tr>
<th>Asthma Code Examples</th>
<th>ICD-10-CM</th>
<th>Use Additional</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Intermittent</td>
<td>J45.2--</td>
<td>Exposure to tobacco smoke</td>
<td>Z77.22</td>
</tr>
<tr>
<td>Mild Persistent</td>
<td>J45.3--</td>
<td>Exposure to tobacco smoke in perinatal period</td>
<td>P96.81</td>
</tr>
<tr>
<td>Moderate Persistent</td>
<td>J45.4--</td>
<td>History of tobacco use</td>
<td>Z87.891</td>
</tr>
<tr>
<td>Severe Persistent</td>
<td>J45.5--</td>
<td>Occupational exposure to tobacco smoke</td>
<td>Z57.31</td>
</tr>
<tr>
<td>Other &amp; Unspecified</td>
<td>J45.9--</td>
<td>Tobacco dependence</td>
<td>F17.--</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tobacco use</td>
<td>Z72.0</td>
</tr>
</tbody>
</table>
ICD-10-CM tabular List notes under J44:

- Includes asthma with chronic obstructive pulmonary disease
- Code also type of asthma if applicable (J45.-)
- COPD and Asthma NOS both documented assign one code J44.9
- COPD and Asthma specified type assign two codes J44.9 and J45.- based on documentation

Cerebrovascular Accident (CVA)

Only code as active when the CVA is occurring and up to discharge for the treatment of the stroke. Once the patient has been discharged, code as PMH. Code any remaining deficits (sequelae) as a result of the CVA. Documentation must state a cause and effect relationship to the residual condition. A relationship cannot be assumed.

Common late effects related to CVA, TIA and cerebrovascular disease include:

- Aphasia (inability to speak)
- Dysphasia (difficulty speaking)
- Dysphagia (difficulty swallowing)
- Ataxia (lack of muscle coordination)
- Hemiparesis/Hemiplegia (weakness on one side of the body)
  When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. (See Coding Clinic Appendix A #7)

Cancer (CA)

Active cancer codes should be coded or validated if there is documentation of active treatment/status.

Documentation containing evidence of the following validate the coding of cancer as active:

- Current anti-neoplastic drug therapy
- Current chemotherapy/radiation therapy
- Referral to a specialist/surgeon for treatment options/management
- Affirmation of current disease management ("patient’s chemotherapy being managed by oncologist")
- Existing metastasis of cancer
- Refusal of surgical/other treatment by patient
- Watchful Waiting (meaning they are not sure what course of treatment will be taken)
- Physician’s pathology or other acceptable study interpretations revealing cancer
- Documentation of status of terminal cancer (e.g. on hospice or palliative care)

In the case of hormone therapy for breast/prostate cancer, such as Tamoxifen and Lupron, the provider should always indicate the status of cancer (e.g.
active, “history of”, in remission, etc.). However, if the provider does not and simply states “Prostate CA – on Lupron” or “Breast cancer – on Tamoxifen”, code as active. The following examples show when NOT to code cancer for patients on Tamoxifen, Lupron or other hormonal therapies:

- Documentation states in the body of the note that the drug is being administered “prophylactically “or “preventatively”.
- “History of” prostate cancer, on Lupron is documented – with no other documentation in the body of the note to indicate the cancer is active.

**Depression**

Providers often document both Bipolar Disorder and Depression.

- When the documentation states:
  - **Bipolar Disorder** - code for unspecified bipolar disorder F31.9
  - **Depression** - code for unspecified depression F32.9
  (F31.9 has an EXCLUDES1 for F32, so code only F31.9 in this situation)

- When coding Anxiety and Depression:
  (AH Coding Refresh 2015)
  - **For a diagnostic statement of depression and anxiety** (when there is no association between the two conditions) - code 311/F32.9, Depressive disorder, NEC, and 300.00/F41.9, Anxiety state, unspecified. (Separate codes)
  - **For a diagnostic statement of depression with anxiety** - code 300.4/F41.8. (The combination code F41.8 is used for Other specified anxiety disorders further defined in the tabular as Anxiety depression or mixed anxiety and depression disorder.)
  - **For a diagnostic statement of depression with anxiety as persistent** - assign code F34.1 for Dysthymic Disorder. (Coding Clinic Appendix A #10)

**Coding Examples:**

- **Anxiety/depression**: Code F41.9 and F32.9
  A slash in a medical record does not confirm the relationship between the two conditions. The slash may have several meanings such as “and”, “or”.

- **Anxiety WITH depression**: Code F41.8
  Clear linkage per Coding Clinic and ICD-9 tabular Anxiety WITH depression, persistent: Code F34.1

- **Anxiety AND depression**: Code F41.9 and F32.9
  There is no clear linkage between diagnoses.

If provider notes **Mood Disorder** follow the Alphabetic Index to assign code F39. If both depression and mood disorder are noted, follow the Index to mood, disorder, and depressive and assign the single code F32.9.
Diabetes (DM)

Diabetes mellitus (DM) codes are combination codes that include the type of DM, the body system affected, and the complications affecting that body system.

- Assign as many codes from categories 249-250/E08- E13 as needed to identify all of the associated conditions.
- When determining whether or not a diagnosis is a manifestation of diabetes or another separate disease process, consider these ICD-9-CM/ICD-10-CM ICD conventions:
  - The word “and” should be interpreted to mean either “and” or “or” when it appears in a title and does not support a manifestation.
  - The word “with” should be interpreted to mean “associated with” or due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List and supports a manifestation.
  - If a disease is listed as “diabetic” such as diabetic retinopathy, it would be considered a manifestation of diabetes and coded as such.

In ICD-10, for the following index entries – code to Diabetes, by type, with hyperglycemia:
- Diabetes, inadequately controlled
- Diabetes, out of control
- Diabetes, poorly controlled

Note: ICD-10-CM does not recognize the status of “uncontrolled” diabetes so if documented as such we will code to Diabetes unspecified (E11.9). (Coding Clinic Appendix A #11)

Deep Vein Thrombosis (DVT)

No Acute or Chronic Status
If DVT is documented without mention of acute or chronic status, follow the Alphabetic Index to find Thrombosis, vein, deep I82.40- and note that acute is a non-essential modifier (DVT NOS is I82.40-)

Chronic Status
If chronic DVT is documented, you CANNOT code chronic deep vein thrombosis without first indicating the site of the DVT. If unspecified chronic DVT is noted, code I82.409. If the site is indicated, for example the calf, we can code the chronic DVT as “calf I82.5Z9”.

Rationale: This information was previously included in F17, but provides different guidance. Altegra Health will not flag that a provider did not include acute or chronic. A selection of DVT NOS (453.40/182.409) is an indicator that specificity was not provided. This is proper coding per ICD-10-CM coding guidelines.
HIV & AIDS

Confirmation does not require documentation of positive serology or culture for HIV. The provider’s statement that the patient is HIV positive or has a HIV-related (opportunistic) illness is sufficient. Code conditions as follows:

- When the member is noted to be “HIV positive,” “known HIV,” or similar terminology without any documentation of symptoms, code V08/Z21 Asymptomatic human immunodeficiency virus (HIV) infection status.
- When the member is noted with any known HIV-related illness, code 042/B20.

Use additional code(s) to identify all manifestations of HIV infection, if known, such as the following HIV-Related/Opportunistic Conditions (OIs):

- Candidiasis of bronchi, trachea, esophagus, or lungs
- Invasive cervical cancer
- Coccidioidomycosis
- Cryptococcosis
- Cryptosporidiosis, chronic intestinal (greater than 1 month’s duration)
- Cytomegalovirus disease (particularly CMV retinitis)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (greater than 1 month’s duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis
- Isosporiasis, chronic intestinal (greater than 1 month’s duration)
- Kaposi’s sarcoma
- Lymphoma, multiple forms
- Mycobacterium avium complex
- Tuberculosis
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

Pregnancy

Pregnancy Codes by Trimester/Weeks of Gestation

In ICD-10, most pregnancy codes have a final character indicating the trimester of the pregnancy. Trimesters are indicated as follows:

- 1st trimester – less than 14 weeks
- 2nd trimester – 14 weeks to less than 28 weeks
- 3rd trimester – 28 weeks until delivery

All pregnancy codes (category O00-O9A) also require an additional code from category Z3A to report the weeks of gestation.
Complicating Pregnancy
It is up to the physician to state that a pregnancy is NOT being affected by a specific condition. Therefore, any pre-existing or newly acquired condition during the course of the pregnancy is complicating the pregnancy. Associated Codes can be looked up in the Alphabetic Index by:

- Pregnancy > complicated by > [condition/disease]
- [condition/disease] > complicating pregnancy

V22.0 and V22.1/Z34 are coded when a patient presents for a prenatal check-up and there are NO documented complications. These codes are NEVER used with any pregnancy codes.

High-Risk Pregnancy
Supervision of a high-risk pregnancy (V23/O09), is NOT the same as a complicated pregnancy. These codes may be used in conjunction with other pregnancy codes.

Examples of high-risk pregnancy:
- Age of mother
- Gestational diabetes mellitus
- History of complications from previous pregnancies
- More than 1 fetus
- Pre-existing chronic condition
- Previous fetal loss
- Weight (e.g. overweight, excessive gain weight, malnutrition)

Outcome of Delivery
When a delivery occurs, an outcome of delivery code (ICD-9: V27, ICD-10: Z37) should be used as a secondary diagnosis to show the number of live born/stillborn.

Additional codes from other chapters may be used in conjunction with pregnancy codes.

Do not code newborn codes on the mother’s chart or pregnancy codes on a newborn’s chart.

Post-Partum Follow-Up Visit
V24.2/Z39.2 is coded for post-partum follow-up visits.
### APPENDIX A - FREQUENTLY ASKED QUESTIONS (CODING CLINIC REFERENCES)

<table>
<thead>
<tr>
<th>No.</th>
<th>Reference</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Volume 29, Number 1, Q1 2012</td>
<td><strong>Question</strong>&lt;br&gt;Coders are confused as to the correct coding of “borderline” diagnosis. The advice published in Coding Clinic, First Quarter 2011, pages 9-10 appears to be contradictory. The advice instructs coders to assign code 416.8, Other chronic pulmonary heart diseases, for borderline pulmonary hypertension as if it were confirmed; however, a diagnosis of borderline diabetes without further confirmation of the disease is assigned to code 790.20, Abnormal glucose. Should code 793.2, Nonspecific (Abnormal) findings on radiological and other examination of body structure, Other intrathoracic organ, be assigned for a diagnosis of “borderline pulmonary hypertension” or should all borderline diagnoses require clarification from the attending physician so that the appropriate code may be reported?</td>
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<td></td>
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<td><strong>Answer</strong>&lt;br&gt;“Borderline diagnoses” are coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-9-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification. Coding Clinic First Quarter 2012 17 Corrections Subacute Deep Vein Thrombosis Coding Clinic, First Quarter 2011, page 21, advised the assignment of code 453.9, Acute venous embolism and thrombosis of other specified veins, of unspecified site, for a subacute deep vein thrombosis (DVT). However, code 453.40, Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity, is the default when “Thrombosis, vein, deep” is referenced in the index. Clotted Peripherally Inserted Central Catheter (PICC) Coding Clinic, Second Quarter 2011, pages 4-5, contained an error. The answer should have read 996.74, Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft, Due to other vascular device, implant and graft, instead of code 996.1, for a clotted PICC line. Thrombus (clot) is an inclusion term under subcategory 996.7. 18 Coding Clinic First Quarter 2012 Notice</td>
</tr>
<tr>
<td>2</td>
<td>Volume 26, Issue 3, Q3 2009</td>
<td><strong>Question</strong>&lt;br&gt;Is it appropriate to report codes for diagnoses recorded as “evidence of cerebral atrophy” and “appears to be a nasal fracture,” when documented on outpatient radiology reports?</td>
</tr>
<tr>
<td></td>
<td>Coding Uncertain Diagnoses</td>
<td><strong>Answer</strong>&lt;br&gt;The phrase “appears to be,” listed in the diagnostic statement fit the definition of a probable or suspected condition and would not be coded in the outpatient setting. The Official Guidelines for Coding and Reporting, Section IV.I. state, ‘Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.’ In terms of coding and reporting for hospital inpatients, according to the Official Guidelines for</td>
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</table>
| 3   | Volume 2, Number 4, Q4 2015 | **Question**  
Since our facility has converted to an electronic health record, providers have the capability to list the ICD-10-CM diagnosis code instead of a descriptive diagnostic statement. We are seeking clarification for whether there is an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-10-CM code number?  

**Answer**  
Yes, there are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient’s diagnosis, condition and/or problem. It is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-10-CM is a statistical classification, per se, it is not a diagnosis. Some ICD-10-CM codes include multiple different clinical diagnoses and it can be of clinical importance to convey these diagnoses specifically in the record. Also some diagnoses require more than one ICD-10-CM code to fully convey the patient’s condition. It is the provider’s responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.  

While we’re aware that some payers may allow submission of code numbers on lab orders, Coding Clinic recommends that physician provide narrative diagnoses/signs/symptoms as the reason for ordering the test. |
| 4   | Volume 1, Number 1, Q1 2014 | **Question**  
Codings on the Basis of Up or Down Arrows  
It is not appropriate for the coder to report a diagnosis based on up and down arrows. Diagnosing a patient’s condition is solely the responsibility of the provider. Up and down arrows can have variable interpretations and do not necessarily mean “abnormal.” They could simply be indicating change (including improvement) over past results. Therefore, the provider should be queried regarding the meaning of the arrows and request that the appropriate documentation of a condition or diagnosis be provided. This information is consistent with the coding guideline on abnormal findings which states: “abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.” The same advice applies for both inpatient and outpatient admissions. |
| 5   | Volume 3, Number 1, Q1 2016 | **Question**  
The ICD-10-CM Alphabetic Index entry for ‘Diabetes with’ includes listings for conditions associated with diabetes, which was not the case in ICD-9-  

...
### Question

Are we to assume that ICD-9-CM guidelines not included in ICD-10-CM will not be valid beginning when ICD-10-CM is implemented? For example, ICD-9-CM guideline Section I.C8.a.4, “Acute exacerbation of asthma and status asthmaticus” does not have a counterpart in the ICD-10-CM guidelines.

### Answer

Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM. However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature (as in the example noted in the question) and therefore not appropriate for coding guidelines. With respect to the coding of acute exacerbation of asthma and status asthmaticus together, only the code for the more severe condition (i.e., status asthmaticus) should be assigned.
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| 7   | Volume 2, Number 1, Q1 2015 | **Residual Right-Sided Weakness Due to Previous Cerebral Infarction**

**Question**
The patient is a 72-year-old male admitted to the hospital, because of gastrointestinal bleeding. The provider documented that the patient had a history of acute cerebral infarction with residual right-sided weakness (dominant side), and ordered an evaluation by physical and occupational therapy. What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA without mention of hemiplegia/hemiparesis?

**Answer**
Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.

| 8   | Volume 25, Issue 4, 2008 | **Assigning Body Mass Index (BMI) Codes**

**Question**
We understand that while body mass index (BMI) code assignment may be based on documentation found in a dietitian’s note, the codes for overweight and obesity should be based on the provider’s documentation (the physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis).

Can the BMI codes (V85.x) be assigned on the basis of the dietitian’s note without a corresponding documented diagnosis of overweight, obesity or morbid obesity from the provider?

**Answer**
If the BMI has clinical significance for the patient encounter, the specific BMI value may be picked up from the dietitian’s documentation. The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet the criteria for a reportable secondary diagnosis, the BMI would need to have some bearing or relevance in terms of patient care. For reporting purpose, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring

Once the provider has provided documentation of the clinical condition, such as obesity, the coder can use the dietitian’s note to assign the appropriate BMI codes from category V85.

| 9   | Volume 28, Issue 3, Q3 2011 | **Clinical Significance of Obesity**

**Question**
If the provider documents obesity or morbid obesity in the history and physical and/or discharge summary only without any additional documentation to support clinical significance of this condition, can it be
<table>
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<tr>
<td>30</td>
<td></td>
<td>coded? There is no other documentation to support clinical significance such as evaluation, treatment, increased monitoring, or increased nursing care, etc., for this condition.</td>
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<tr>
<td><strong>Answer</strong></td>
<td></td>
<td>Individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the body mass index (BMI) code meets the requirement for clinical significance when obesity is documented. Refer to Coding Clinic, Third Quarter 2007, pages 13-14, for additional information on coding chronic conditions.</td>
</tr>
<tr>
<td>10</td>
<td>Volume 28, Issue 3, Q3 2011 Depression and Anxiety</td>
<td><strong>Question</strong> What is the code assignment for depression and anxiety? <strong>Answer</strong> Assign codes 311, Depressive disorder NEC, and 300.00, Anxiety state, unspecified, for a diagnostic statement of depression and anxiety. Code 300.4, Dysthymic disorder, is not appropriate since the provider has not established a linkage between the two conditions. When there is no association between the two conditions, assign separate codes. If, however, the provider documents depression with anxiety, assign code 300.4, Dysthymic disorder.</td>
</tr>
<tr>
<td>11</td>
<td>4/8/16 Response to Submitted Question</td>
<td>This letter is in response to your request for clarification in coding uncontrolled diabetes mellitus. ICD-10-CM does not classify uncontrolled diabetes mellitus. Please query the provider for clarification of whether &quot;diabetes uncontrolled&quot; is considered diabetes with hyperglycemia or hypoglycemia so that the appropriate codes may be reported. It would be inappropriate for coders to assume a diagnosis without clarification from the provider. When the documentation is vague or unclear, the provider should be queried. Currently, only &quot;out of control&quot; and &quot;poorly controlled&quot; diabetes mellitus are indexed to diabetes with hyperglycemia. There is no index entry for &quot;uncontrolled&quot; diabetes mellitus...</td>
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<tr>
<td>12</td>
<td>Volume 9, Issue 2, Q2 1992 Q &amp; A</td>
<td><strong>Question</strong> With the new fifth digits for leukemia which specify leukemia with and without mention of remission, when would it be appropriate to use a code from subcategory V10.6, Personal history of leukemia? <strong>Answer</strong> Assign a code from subcategory V10.6 only when the physician documents that the patient has been completely cured. A patient in remission still has leukemia.</td>
</tr>
<tr>
<td>13</td>
<td>Volume 27, Issue 3, Q3 2010</td>
<td><strong>Question</strong></td>
</tr>
</tbody>
</table>
Acute on Chronic Kidney Failure

What is the appropriate code assignment for a patient with documented acute kidney failure and end stage renal disease (ESRD) during the same admission? Is acute kidney failure an acute exacerbation of chronic kidney failure?

**Answer**
No, acute kidney failure is not an acute exacerbation of chronic kidney failure. Acute kidney failure and chronic kidney failure are two separate and distinct conditions. Acute renal failure has an abrupt onset and is potentially reversible. Chronic kidney failure progresses slowly over time and can lead to permanent kidney failure. The causes, symptoms, treatments, and outcomes of acute and chronic are different. End-stage renal disease is when the kidneys permanently fail to work. If both acute and chronic kidney failure are clearly documented, code both.
## APPENDIX B – FLAGGED EVENT CODES (F CODES)

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Description</th>
<th>Purpose</th>
<th>Current Instructions</th>
<th>KEEP / REMOVE</th>
<th>New Description</th>
<th>New Instructions</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>Unacceptable Signature</td>
<td>To confirm the provider authenticated the documented service.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types with or without provider signature deficiencies. The Flagged Event Code F1 indicates codes missed due to inability to confirm the provider authenticated the service with an appropriate signature.</td>
<td>KEEP</td>
<td>Signature Deficiency</td>
<td>Indicates an inability to confirm the provider authenticated the service with a valid signature (see above for signature requirements). The document is flagged to notify the Client they will need to attach an attestation statement for this DOS to validate the documentation prior to submitting the code(s) for risk adjustment calculations.</td>
<td>An acceptable signature is a Risk Adjustment Reporting requirement. Deficiencies with signature are can be corrected with an attestation statement.</td>
</tr>
<tr>
<td>F2</td>
<td>Incomplete Documentation</td>
<td>Indicates documentation that is missing a page(s) but all the documentation requirements are met with the pages received. AH will report the codeable diagnoses from the portions submitted.</td>
<td></td>
<td>NEW</td>
<td>Incomplete Documentation</td>
<td></td>
<td>Notification to the client that the chart was incomplete as there may be more codeable diagnoses in the missing pages.</td>
</tr>
<tr>
<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
<td>Current Instructions</td>
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<tr>
<td>F3</td>
<td>Missing DOS</td>
<td>To confirm the encounter occurred during the measurement period.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types with or without date of service deficiencies. NSD (no service date) will be used in these cases. The Flagged Event Code F3 indicates codes missed due to inability to confirm date of service (default DOS will be 1/1/2099).</td>
<td>KEEP</td>
<td>DOS Deficiency</td>
<td>Indicates a deficiency in the documented DOS. The system automatically assigns 01/01/2099 to any encounter that has F3 applied for an incomplete/missing DOS. Additionally, F3 will be added to provider consult/referral letters that do not have a clearly stated DOS. F3 indicates to the client that the document needs to be reviewed and an addendum added to update/correct the DOS to validate the documentation prior to submitting the code(s) for risk adjustment calculations.</td>
<td>DOS is a Risk Adjustment requirement to confirm the visit occurred during the measurement period. DOS can be corrected with an amendment to the documentation.</td>
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<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
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<tr>
<td>F3a</td>
<td>Partial/Incomplete Date Of Service</td>
<td>To confirm the encounter occurred during the measurement period.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types with or without date of service deficiencies. The Flagged Event Code F3a indicates codes missed due to inability to confirm complete date of service. In order to code, the year (XXXX) at minimum must be in the measurement time frame. • If month is missing default to January (January/1/XXXX) • If day is missing default to first day of the month (3/1/XXXX) • If month/day is missing default to January and first day of month 1/1/XXXX</td>
<td>REMOVE</td>
<td></td>
<td></td>
<td>A partial/incomplete DOS is a DOS deficiency which is covered with F3.</td>
</tr>
<tr>
<td>F4</td>
<td>No Patient Name</td>
<td>To confirm the medical condition identified is for the correct patient.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types with or without patient name deficiencies. The Flagged Event Code F4 indicates patient name is missing from medical record documentation.</td>
<td>KEEP</td>
<td>Patient Identifier Deficiency</td>
<td>F4 indicates to the client that the patient name is missing or incomplete within the document. The document is flagged to inform the Client that they need to review and add an addendum to update/correct the patient name prior to submitting the code(s) for risk adjustment calculations.</td>
<td>A patient identifier is a Risk Adjustment requirement to confirm the note is for the selected patient. Patient Name can be corrected with an amendment to the documentation.</td>
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<tr>
<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
<td>Current Instructions</td>
<td>KEEP / REMOVE</td>
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<td>New Instructions</td>
<td>RATIONALE</td>
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<tr>
<td>F4a</td>
<td>Partial/Incomplete Patient Name</td>
<td>To confirm the medical condition identified is for the correct patient when only a partial name is documented.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types with or without patient name deficiencies. The Flagged Event Code F4a indicates only partial or incomplete name is documented in medical record.</td>
<td>REMOVE</td>
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<td></td>
<td>A partial/incomplete Name is a Patient Identifier deficiency which is covered with F4.</td>
</tr>
<tr>
<td>F5</td>
<td>Unconfirmed Provider Type</td>
<td>To confirm acceptable provider type.</td>
<td>AH will code medical conditions from acceptable documentation with or without confirmation of an acceptable provider type. However, when an unacceptable provider type can be confirmed (e.g., RN), AH will not code the encounter. The Flagged Event Code F6 indicates codes missed due to inability to confirm acceptable provider type.</td>
<td>KEEP</td>
<td>Provider Type Deficiency</td>
<td></td>
<td>An acceptable provider type is a Risk Adjustment requirement. Missing, inaccurate or unclear documentation of the provider specialty can be corrected with an amendment to the documentation.</td>
</tr>
<tr>
<td>F6</td>
<td>Unconfirmed Provider Type</td>
<td>To confirm acceptable provider type.</td>
<td>AH will code medical conditions from acceptable documentation with or without confirmation of an acceptable provider type. However, when an unacceptable provider type can be confirmed (e.g., RN), AH will not code the encounter. The Flagged Event Code F6 indicates codes missed due to inability to confirm acceptable provider type.</td>
<td>KEEP</td>
<td>Provider Type Deficiency</td>
<td></td>
<td>An acceptable provider type is a Risk Adjustment requirement. Missing, inaccurate or unclear documentation of the provider specialty can be corrected with an amendment to the documentation.</td>
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</table>
## Coding Guidelines

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<tr>
<th>Code</th>
<th>Current Description</th>
<th>Purpose</th>
<th>Current Instructions</th>
<th>KEEP / REMOVE</th>
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<th>New Instructions</th>
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<tbody>
<tr>
<td>F7</td>
<td>Co-Existing Condition Set 1</td>
<td>To identify co-existing condition as defined by CMS. Note: Only use F7 on the eight (8) Chronic conditions when there is no support found in the record.</td>
<td>AH will code conditions as chronic conditions that would be reported when they are documented by acceptable provider types. The Flagged Event Code F7 flags these conditions as documented in the medical record. These conditions represent chronic, ongoing conditions that would be part of a general overview of the patient’s health when treating co-existing conditions for all but the most minor of medical encounters (CHF, Atrial Fibrillation, Diabetes, COPD, Multiple Sclerosis, Hemiplegia, Rheumatoid Arthritis, and Parkinson).</td>
<td>REMOVE</td>
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<td></td>
<td>Coding Guidelines indicate to code all co-existing conditions. This flag is not needed as it is covered in the AH Coding Guidelines.</td>
</tr>
<tr>
<td>F8</td>
<td>Chronic Conditions Set 2</td>
<td>To identify additional chronic conditions as defined in part by CMS, AH recommendation and client request. Note: Only use F8 on the Chronic Conditions Set 2 when there is no support found in the record.</td>
<td>AH will code conditions identified as chronic conditions that would be reported when they are documented by acceptable provider types. The Flagged Event Code F8 flags these conditions as documented in the medical record. These conditions represent chronic, ongoing conditions that would be part of a general overview of the patient’s health when</td>
<td>REMOVE</td>
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<td></td>
<td>All active (supported by TAMPER or on AH chronic list) chronic diagnoses will be coded by AH. These codes are supported by coding guidelines and do not require a flag.</td>
</tr>
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<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
<td>Current Instructions</td>
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<td>treating co-existing conditions for all but the most minor of medical encounters (CKD, HIV w/ related illness, Hepatitis B or Hepatitis C, Cystic Fibrosis, Aplastic Anemia, Schizophrenia, Bipolar, Heart Failure, Peripheral Vascular Disease (Peripheral Arterial Disease, Intermittent Claudication).</td>
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<tr>
<td>F9</td>
<td>Cause and Effect Relationship</td>
<td>To identify documentation of Diabetes With as cause and effect relationship for the following 3 manifestations: Neurological, Ophthalmic &amp; Renal</td>
<td>AH will code documentation of Diabetes With as diabetic manifestations when they are documented specifically with neurological, ICD9 250.6X/ICD10 E11.40) ophthalmic (ICD9 250.5X/ICD10 E11.39), and renal (ICD9 250.4X/ICD10 E11.29) conditions. The Flagged Event Code F9 flags these conditions as documented in the medical record. These conditions represent the 3 most commonly associated diabetic manifestations.</td>
<td>REMOVE</td>
<td></td>
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<td>Per Coding Guidelines and Coding Clinic 'With' can be interpreted as cause and effect. When 'with' is used and there is a subterm in the index AH will code as a manifestation code.</td>
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<tr>
<td>F10</td>
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<td></td>
<td>N/A</td>
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<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
<td>Current Instructions</td>
<td>KEEP / REMOVE</td>
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<td>New Instructions</td>
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<tr>
<td>F11</td>
<td>Coding of Medical Conditions w/Unlinked Medications</td>
<td>To identify documentation of diagnosis that is supported by unlinked medication.</td>
<td>AH will code medical conditions from an acceptable documentation by acceptable provider types where the condition is supported by a medication that is not directly linked to the condition but is commonly used for treatment of the condition. The Flagged Event Code F11 is used to identify a condition that is coded either from the problem list, past medical history or within the narrative note which contains no documented support except the documentation of an active medication that is commonly used to treat the condition. When a F11 is appended the provider has made no direct link between the active medication used for support and the documented diagnosis. Example: HTN and Heart Failure documented by the provider, no other medical record support and the patient’s medication list, on that date of service, has Lisinopril listed (with no...</td>
<td>REMOVE</td>
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<td></td>
<td>AH guidelines indicate to code a condition as active when a medication is not linked but is only used for one purpose. If the medication has multiple uses, the provider must provide linkage to support an active condition.</td>
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<tr>
<td>Code</td>
<td>Current Description</td>
<td>Purpose</td>
<td>Current Instructions</td>
<td>KEEP / REMOVE</td>
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<td>evidence of it being discontinued). AH would code HTN and Heart Failure and append an F11.</td>
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<th>New Instructions</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>F12</td>
<td>BMI Not Relevant To The Visit</td>
<td>To confirm the BMI is pertinent to the visit</td>
<td>AH will code all documented BMIs found in the medical record from acceptable documentation by acceptable provider types. The Flagged Event Code F12 indicates BMI was coded from the visit, but the BMI was not pertinent to the visit. Example: 52 year old is seen for headache and sinus congestion, and diagnosed with Sinusitis. Vital Signs taken at visit were Blood Pressure 125/70, P 86, Temp 99.5, Wt 160, Ht 5’7, and BMI 25.1. AH will code ICD9 V85.21/ICD10 Z68.25 and append F12 to indicate the BMI reading was not pertinent to the visit.</td>
<td>REMOVE</td>
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<td>Per AAPC CRC Training Course, BMI 'can be an important variable in analytics and is often collected universally whenever documented.' AH will code BMI whenever it is documented in the note to ensure clients have BMI information for other reporting measures.</td>
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<td>F13</td>
<td>Chief Complaint / Reason for the Visit</td>
<td>To provide diagnosis codes documented as the reason for the visit.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider Complaint/Reason documented as the reason types. The Flagged Event Code F13 indicates a diagnosis was documented in the reason for the visit AND in the assessment/plan, but no support found in the medical record for that diagnosis (monitoring, evaluation, assessment or treatment). Example: Chief Complaint of HTN, DM, and hyperlipidemia. Same diagnoses listed in final assessment/plan; however, unlike DM and HTN, there is no MEAT(monitoring, evaluation, assessment, or treatment) for the hyperlipidemia in the note. AH will code ICD9 272.4/ICD10 E78.5 and append F13 to indicate the hyperlipidemia is without support but listed in both chief Complaint/reason for visit AND assessment/plan.</td>
<td>REMOVE</td>
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<td>AH will only code conditions that are supported as active (TAMPER) or are on the AH chronic list.</td>
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<td>F14</td>
<td>Past Medical History</td>
<td>To provide diagnosis codes from past medical history.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F14 indicates a condition was documented in past medical history and AH used TAMPER (treatment, assessment, monitor/medicate, plan, evaluate or referral) to code as an active diagnosis. Example: PMH of HTN. B/P reading taken and normal, no medication prescribed. AH will code HTN as active due to B/P reading being documented and append F14 to indicate the use of TAMPER.</td>
<td>REMOVE</td>
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<td>In order to code from the PMH/Problem List, the condition must have TAMPER within the note more than a vital reading that is typically collected at every visit unless the provider links the vital to the condition.</td>
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<td>F15</td>
<td>Diagnosis Found – Physical Exam and/or Review of Systems are Normal</td>
<td>To document conditions where PE and/or ROS are normal.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F15 indicates the diagnosis was documented in the medical record and all indicators for this diagnosis under physical exam and/or review of symptoms are documented as normal. There is no additional support in the medical record for this diagnosis. Example: Asthma listed in assessment/plan. Physical exam of lungs clear, no wheezing. No other MEAT (monitoring, evaluation, assessment, or treatment) listed. AH will code asthma and append F15 to indicate the use of a negative finding in physical exam to support diagnosis.</td>
<td>REMOVE</td>
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<td>This situation is covered in the guidelines. AH will not use negative findings alone to support a condition unless the provider linkage to the condition. There must be additional TAMPER to code the condition as active.</td>
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<td>F16</td>
<td>N/A</td>
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<td>F17</td>
<td>DVT</td>
<td>To flag diagnosis of DVT when not documented as chronic or acute.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F17 indicates DVT was documented in the medical record, but provider did not indicate acute or chronic. AH will code as ICD 9 453.40/ICD10 I82.409 when this occurs and append the flagged event code. Example: DVT listed in assessment/plan. Patient on Coumadin, and plan to have Doppler in 2 months. AH will code DVT NOS (ICD9 453.40/ICD10 I82.409) and append F17 to indicate provider did not document as acute or chronic.</td>
<td>REMOVE</td>
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<td>AH follows coding guidelines for code selection. If acute or chronic are not documented, DVT NOS will be selected. A reporting of NOS indicates to the Client that there was not more specificity in the note.</td>
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<td>F18</td>
<td>Interpreted Diagnostic Report</td>
<td>To flag diagnosis codes taken from interpreted diagnostic reports.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F18 indicates diagnosis was documented on interpreted diagnostic report found in the medical record (a non face to face visit). Diagnostic testing with acceptable provider interpretation, examples include: Cardiology and Vascular Surgeons, Interventional Radiology, Neurology, and Pulmonology. Example: Interpreted Echo found in medical record within acceptable timeframe, with pulmonary HTN documented. Coder will code ICD9 416.8/ICD10 I27.2 and append F18.</td>
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<td>AH will not code from non-face-to-face visits with the exception of pathology reports.</td>
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<td>F19</td>
<td>No Date of Service on Provider Consult/Referral Letter</td>
<td>To flag diagnosis codes taken from provider consult/referral letters that are missing the date of service.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F19 indicates diagnosis was coded from provider consult/referral letters that are missing the date of service. AH will assume the date of letter is the date of service, and flag with F19. Example: Provider letter dated 3/5/2015. No mention in letter when date of service took place. AH will code date of service as 3/5/2015 and flag with F19.</td>
<td>REMOVE</td>
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<td>This is included in F3.</td>
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<td>F20</td>
<td>Diabetes and Manifestation, same number/bullet</td>
<td>To flag diagnosis codes taken from lists on face to face visit where diabetes and the manifestation are listed in same number/bullet.</td>
<td>AH will code medical conditions from acceptable documentation by acceptable provider types. The Flagged Event Code F20 indicates diabetes and manifestation diagnoses were listed under the same number or separated by comma or bulleted, and the conditions were assumed to be linked. Do not link diabetes and other condition if not typically a known manifestation of diabetes. Example: We will assume the</td>
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<td>ICD Guidelines indicate that the provider must provide clear causation unless otherwise directed within the guidelines. A comma on the same line does not provide clear linkage and the codes will be coded separately.</td>
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<td>DM and retinopathy are linked and code as ICD9 250.50, 362.01/ICD10 E11.319, and append flag F20 to both codes (also taking into consideration we have support). Assessment/Plan: 1. Hypertension 2. DM, Retinopathy</td>
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<tr>
<td>NCE</td>
<td>Noncodable Event</td>
<td>To confirm the documentation for this face-to-face encounter contained no medical conditions that could be coded using ICD-9-CM.</td>
<td>AH will code medical conditions with ICD-9 codes, including V codes and E codes, from acceptable documentation with confirmation of an acceptable provider type. NCE indicates a face-to-face encounter occurs but noncodable diagnosis was documented.</td>
<td>KEEP</td>
<td>Non-Codeable Event</td>
<td>No Risk Adjustment codes found and/or note will be considered invalid due to documentation deficiencies which cannot be corrected.</td>
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