Risk Adjustment Documentation Tips & Coding for Common Diagnoses

Major Depressive Disorder (MDD)

Documentation should include:
Current clinical status, episode, severity

DESCRIPTION	ICD-10-CM
Single episode, mild	F32.0
Single episode, moderate	F32.1
Single episode, severe without psychotic episodes	F32.2
Single episode, severe with psychotic episodes	F32.3
Single episode, partial remission	F32.4
Single episode, full remission	F32.5
Recurrent, mild	F33.0
Recurrent, moderate	F33.1
Recurrent, severe without psychotic episodes	F33.2
Recurrent, severe with psychotic episodes	F33.3
Recurrent, partial remission	F33.41
Recurrent, full remission	F33.42

Documentation Best Practices

Each encounter should be considered stand-alone, showing the nature and severity of each relevant condition as well as an assessment and plan for the management of care. Not every condition will risk-adjust, but with supporting documentation reflecting the objective findings, all areas of the record may be used to identify these diagnoses for coding purposes. Reducing documentation deficiencies with specificity is key to risk adjustment. Audits ensure clinical documentation meets regulatory, billing, and quality standards. This helps verify accuracy and compliance.

Diabetes Mellitus (DM)

Documentation should include:
Level of control, linked complications, type

DESCRIPTION	TYPE 1	TYPE 2
With kidney complications	E10.2-	E11.2-
With ophthalmic complications	E10.3-	E11.3-
With neurological complications	E10.4-	E11.4-
With circulatory complications	E10.5-	E11.5-
With skin complications**	E10.62-	E11.62-
With oral complications	E10.63-	E11.63-
With hyperglycemia	E10.65	E11.65
Without complications	E10.9	E11.9
Type 2 DM in remission*		E11.A

*** Remission is >3 months sustained normal glucose levels**
****Also, code ulcer if applicable**

Chronic Kidney Disease (CKD)

Documentation should include:
Acuity, cause, dialysis status if applicable, stage, status

DESCRIPTION	ICD-10-CM
CKD stage 1 (normal)	N18.1
CKD stage 2 (mild)	N18.2
CKD stage 3a (moderate)	N18.31
CKD stage 3b (moderate)	N18.32
CKD stage 4 (severe)	N18.4
CKD stage 5 (kidney failure)	N18.5
End-stage renal disease (ESRD)	N18.6

Documentation Tips

- Address chronic conditions annually
- Avoid ambiguity
- Cause and effect linkage
- Clinical decision-making process
- Highest known level of specificity
- Industry standard acronyms
- No "history" when current
- Support all relevant diagnoses
- Support all relevant manifestations
- Update problem lists

Chronic Obstructive Pulmonary Disease (COPD)

Documentation should include:
Causes, comorbidities, severity, tobacco status, type

DESCRIPTION	ICD-10-CM
Chronic bronchitis, unspecified	J42
Emphysema	J43.-
COPD with acute lower respiratory infection	J44.0
COPD with acute exacerbation	J44.1
Asthma	J45.-
Bronchiectasis	J47
Chronic respiratory failure	J96.10

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Congestive Heart Failure (CHF)

Documentation should include:
Acuity, cause and effect, risk factors, stage, status, type

DESCRIPTION	CD-10-CM
Acute systolic CHF Chronic	I50.21
systolic CHF	I50.22
Acute on chronic systolic CHF	I50.23
Acute diastolic CHF	I50.31
Chronic diastolic CHF	I50.32
Acute on chronic diastolic CHF	I50.33
Acute combined CHF* Chronic	I50.41
combined CHF*	I50.42
Acute on chronic combined CHF*	I50.43

Stage ranges 1 through 4
***Combined refers to systolic and diastolic linkage**

TAMPER

- **Treat**
  Clinical services or interventions
- **Assess**
  Current status of condition, risks
- **Monitor**
  Ongoing tracking of symptoms
- **Plan**
  Next steps for care
- **Evaluate**
  Patient's response to treatment
- **Refer**
  Coordination of care

Actionable, clear, specific, timely Avoid copy and paste

Status Codes

Update annually

DESCRIPTION	ICD-10-CM
Amputee status	Z89.4-Z89.5
Artificial opening (ostomy) Body	Z93.-
mass index (adult)	Z68.2-Z68.-
History of CVA (post-acute episode discharge)*	Z86.73 I25.2
History of MI (>4 weeks, no treatment)	Z21
HIV status	Z79.4
Insulin long-term use	Z94.0
Kidney transplant status	Z99.81
Oxygen dependence	Z99.11
Respirator dependence	Z72.0
Tobacco use	Z94.-
Transplant status	

***Document current residuals of CVA**

Cancer

Documentation should include:
Current treatment, metastases, relapse/remission, status, type

DESCRIPTION	ICD-10-CM
Malignant neoplasm	C01-C96.9
Melanoma in situ	D03.0-D03.9
Benign neoplasm	D32.0-D35.4
Neoplasm of uncertain behavior	D42.0-D44.7

Active - current chemo, radiation, adjuvant therapy
Document complications of current treatment

MVP Contact Information

For questions or more information, please email MVP's Provider Educators

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Heart Disease

Documentation should include:
Angina if applicable, associated pain, complications

DESCRIPTION	ICD-10-CM
Stable angina	I20.9
Unstable angina	I20.0
Atherosclerotic heart disease, unstable angina	I12.110
Hypertensive heart, heart failure	I11.0
Hypertensive heart, CKD 1-4, heart failure	I13.0, N18.-
Hypertensive heart, CKD 5 or ESRD	I13.11, N18.-
Hypertensive heart, CKD 5 or ESRD, heart failure	I13.2, N18.-