Medicare Risk Adjustment

Purpose of Risk Adjustment

Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee. Risk scores measure individual beneficiaries' relative risk and risk scores are used to adjust payments for each beneficiary's expected expenditures. By risk adjusting plan bids, CMS is able to use standardized bids as base payments to plans.

Statutory and Regulatory Authority for Risk Adjustment

The Medicare Advantage (MA) program provides Parts A and B services under Part C of Title XVIII of the Social Security Act ("the Act"). CMS administers risk adjustment payments to MA organizations in accordance with Subpart G of 42 CFR §422.304. This regulatory provision is based on sections 1853, 1854, and 1858 of the Act. CMS risk adjusts Part C payments made to MA plans under Section 1853(a) (3) of the Act; these rules are codified at 42 CFR 422.310. CMS risk adjusts payments to PACE organizations under 1894(d) (2).

MA plans include MA-only plans, MA-PD plans, regional plans, employer group health plans, and Special Needs Plans (SNPs). CMS risk adjusts certain demonstration plan payments, such as the Part C payments made to the dual demonstration plans (Wisconsin Partnership Program, MassHealth Senior Care Options, and Minnesota Senior Health Options and Minnesota Disability Health Options), and Social Health Maintenance Organizations(SHMOs).

CMS risk adjusts Part D payments to Medicare Advantage Prescription Drugs plans (MA-PDs), standalone Prescription Drug Plans (PDPs), and PACE organizations under 1860(d); these rules are codified at 42 CFR 423.

Key Payment dates are:

Mid-February: 45 days prior to the release of the Rate Announcement, CMS releases the *Advance Notice of Methodological Change* for the following payment year.

First Monday in April: CMS releases the *Rate Announcement* for the following payment year.

First Monday in June: Plan bids are due.

The History of Medicare Risk Adjustment

- The Balanced Budget Act (BBA) of 1997:
  - Created Medicare + Choice (M+C) Part C Program
  - Mandated CMS to implement risk adjustment payment methodology to M+C (now MA) organizations beginning in 2000 (PIP DCG)
  - Payment based on the health status and demographic characteristics of an enrollee
  - Mandated frailty adjustment for enrollees in the Program for All-Inclusive Care for the Elderly (PACE)
- Beneficiary Improvement Act of 2000 (BIPA)
  - Mandated CMS to implement risk adjustment payment methodology to M+C (now MA) organizations based on inpatient and ambulatory data beginning in 2004 (CMS HCC)
  - Established the implementation schedule to achieve 100% risk adjustment payments by 2007
  - Mandated introduction of risk adjustment to ESRD enrollee payments
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
  - Created Medicare Part D - new prescription drug benefit program which was implemented in 2006
  - Created new program called Medicare Advantage (MA) that replaced M+C program
  - Introduced bidding into the MA program and amended the MA payment methodology. Also retained most M+C provisions.
  - Included risk adjustment as a key component of the bidding and payment processes for both the MA program and the prescription drug benefit.

CMS-HCC Risk Adjustment Model

The CMS-HCC risk adjustment models are used to calculate risk scores, which predict individual beneficiaries' health care expenditures, relative to the average beneficiary. Risk scores are used to adjust payments and bids based on the health status (diagnostic data) and demographic characteristics (such as age and gender) of an enrollee. Both the Medicare Advantage and Prescription Drug programs include risk adjustment as a component of the bidding and payment processes.

CMS uses risk adjustment to:

- Standardize bids so that each plan has a bid for the average Medicare beneficiary
- Compare bids based on populations with different health statuses and other characteristics
- Adjust plan payment based on the characteristics of the enrolled population

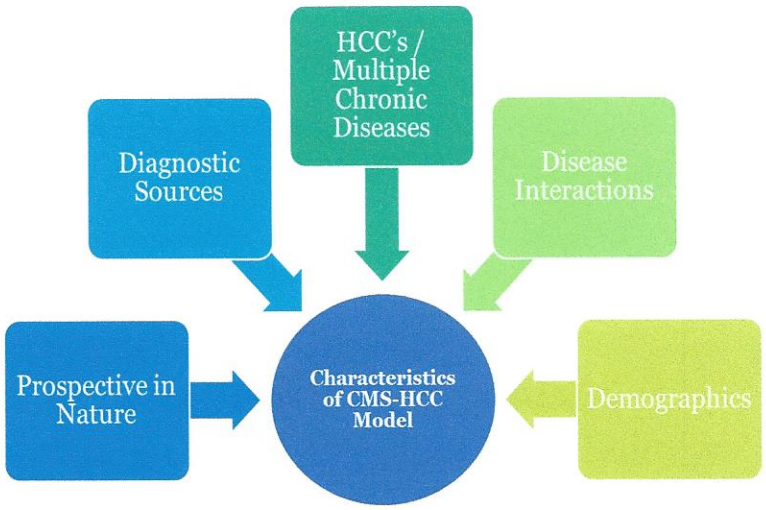
Role and Responsibilities of Plan Sponsors

Risk Adjustment Data Submission Requirements – Plan Sponsors (Medicare Advantage Organizations (MAOs), PACE organizations, and 1876 Cost HMO/CMPs) must:

- Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting.
- Implement procedures to ensure that diagnoses are from acceptable data source. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians. Plan Sponsors are responsible for determining provider type based on the source of the data.
    - Submit the required data elements from acceptable data sources according to the coding guidelines.
- Submit all required ICD-9-CM diagnosis codes for each beneficiary and submit unique diagnoses once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clusters.
- For Part B-only beneficiaries enrolled in a plan, the plan sponsor must submit ICD-9-CM diagnosis codes under the same rules as for a beneficiary with both Parts A and B. The plan should also submit ICD-9-CM codes for Part A services provided under a non-Medicare contract.

- If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any ICD-9-CM diagnosis codes have been erroneously submitted, the plan sponsor is responsible for deleting the submitted ICD-9-CM diagnosis codes as soon as possible.
- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of ICD-9-CM diagnosis codes on an ongoing basis.

Characteristics of CMS-HCC Model



10 Principles Guided the Creation of the CMS-HCC Diagnostic Classification System:

- Principle 1—Diagnostic categories should be clinically meaningful.
- Principle 2—Diagnostic categories should predict medical expenditures.
- Principle 3—Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
- Principle 4—In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate. Because each new medical problem adds to an individual's total disease burden, unrelated disease processes should increase predicted costs of care. However, the most severe manifestation of a given disease process principally defines its impact on costs. Therefore, related conditions should be treated hierarchically, with more severe manifestations of a condition dominating (and zeroing out the effect of) less serious ones.
- Principle 5—The diagnostic classification should encourage specific coding.
- Principle 6—The diagnostic classification should not reward coding proliferation. The classification should not measure greater disease burden simply because more ICD-9-CM codes are present.
- Principle 7—Providers should not be penalized for recording additional diagnoses (monotonicity). This principle has two consequences for modeling: (1) no condition category (CC) should carry a negative payment weight, and (2) a condition that is higher ranked in a disease hierarchy (causing lower-rank diagnoses to be ignored) should have at least as large a payment weight as lower-ranked conditions in the same hierarchy.
- Principle 8—The classification system should be internally consistent (transitive).
- Principle 9—The diagnostic classification should assign all ICD-9-CM codes (exhaustive classification).
- Principle 10—Discretionary diagnostic categories should be excluded from payment models.

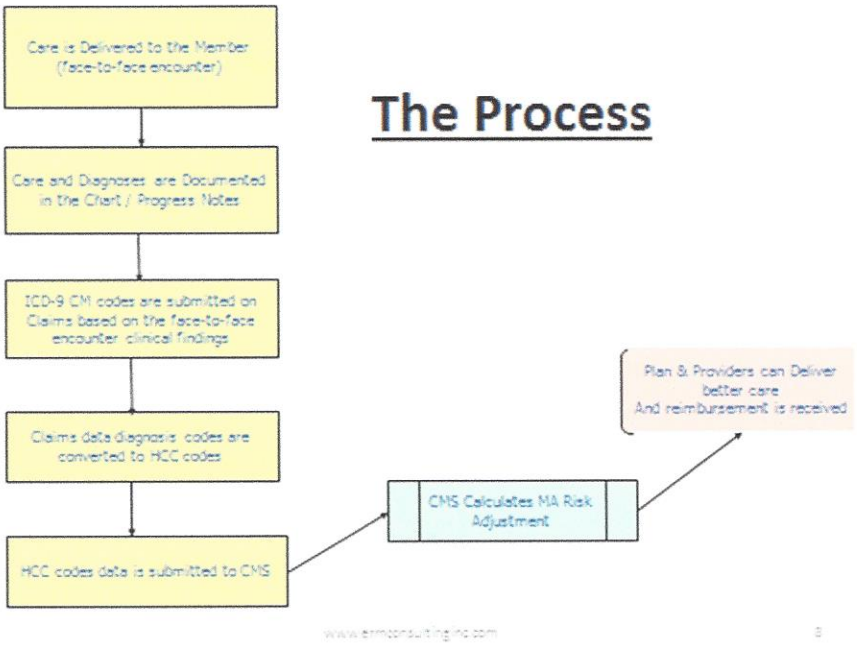
What is a Hierarchical Condition Category (HCC) ?

- Hierarchies are imposed among related CCs, so that a person is coded for only the most severe manifestation among related diseases.
- For example , ICD-9-CM Ischemic Heart Disease codes are organized in the Coronary Artery Disease hierarchy, consisting of four CCs arranged in descending order of clinical severity and cost, from CC 81 Acute Myocardial Infarction to CC 84 Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease. A person with an ICD-9-CM code in CC 81 is excluded from being coded in CCs 82, 83, or 84 even if codes that group into those categories were also present.
- Similarly, a person with ICD-9-CM codes that group into both CC 82 Unstable Angina and Other Acute Ischemic Heart Disease andCC 83 Angina Pectoris/Old Myocardial Infarction is coded for CC 82, but not CC 83.
- After imposing hierarchies, CCs become Hierarchical Condition Categories, or HCCs.

CMS-HCC Model

- What is a Hierarchical Condition Category?
  - Category of medical conditions that map to a corresponding group of ICD-9 diagnosis codes
- 2,913 ICD-9 Codes Map to 1 of 70 HCC's

*Per the ICD-9-CM Official Guidelines for Coding and Reporting: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."



In addition to the CMS-HCC Model, there are 2 other risk adjustment model of payments.

Two of the models include sub-models or categories.

CMS-HCC model for Medicare Part A and B (aka Part C)

- New Enrollee Sub-Model
- Community Sub-Model
- Long Term Institutional Sub-Model

ESRD model for ESRD Beneficiaries

- New Enrollee Sub-Model
- Dialysis Sub-Model
- Transplant Sub-Model
- Post Transplant Sub-Model

Part D drug model

Calibration of the CMS-HCC Risk Adjustment Models

The CMS-HCC risk adjustment model is used to adjust payments for Part C benefits offered by MA plans and PACE organizations to aged/disabled beneficiaries. The CMS-HCC model includes both diseases and demographic factors. There are separate sets of coefficients for beneficiaries in the community, beneficiaries in long term care institutions, and new enrollees.

When CMS recalibrates the CMS-HCC risk adjustment model, it uses data from fee-for-service (FFS) claims, using one year's diagnoses to predict the following year's expenditures. When developing the model, CMS consulted with a panel of outside clinicians to review the ICD-9 codes in order to group them with other clinically similar ICD-9 codes. These diagnosis groupings were then mapped to condition categories based on similar clinical characteristics and severity, and cost implications. Both the panel of clinicians and analyses of cost data informed the creation of condition categories.

Coefficients for condition categories were estimated by regressing the total expenditure for A/B benefits for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (e.g., age/sex group, Medicaid status, disability status).

While all ICD-9 codes are mapped to a condition category; however, not all condition categories are included in the model used in payment. The decision to include a condition category in the model is based on each category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that don't predict costs well – because the coefficient is small, the t-value is low, the number of beneficiaries with a certain condition is small so the coefficient is unstable, or the condition does not have well specified diagnostic coding – are not included in the model. In a final step, hierarchies were imposed on the condition categories, assuring that more advanced and costly forms of a condition are reflected in a higher coefficient.

In order to use the risk adjustment model to calculate risk scores for payment, CMS creates a relative factor for each demographic factor and HCC in the model. CMS does this by dividing all the dollar coefficients by the average per capita predicted expenditure for a specific year (i.e., the "denominator year"). See Table 3 below for a list of data years and denominator years in each version of the risk adjustment model. The relative factors are used to calculate risk scores for individual beneficiaries, which will average 1.0 in the denominator year for the FFS population.

Each time the risk adjustment model is recalibrated, the coefficients will change for several reasons. Changes in the marginal cost attributable to an HCC, relative to changes in the average cost, can alter the relative factor associated with that HCC. Similarly, changes in the marginal cost attributable to an HCC, relative to changes in the marginal costs attributable to all other HCCs, can also result in changes in the relative factor associated with that HCC.

TOP 10 Most Common HCC's

COPD $3112

- 496 COPD
- 493.20 Asthma w/chronic COPD (Chronic Obstructive Asthma)
- 491.9 Chronic Bronchitis
- 492.8 Emphysema

CHF $3198

- 428.0 CHF
- 425.4 Primary Cardiomyopathy (Ischemic is not an HCC)
- 402.91 Hypertensive Heart Disease w/heart failure

Vascular Disease $2465

- 443.9 Peripheral Vascular Disease
- 443.81 PVD in other diseases (diabetes)
- 453.40 Acute DVT
- 440.0 Atherosclerosis of Aorta
- 441.4 Abdominal Aortic Aneurysm

Cancer $1622-$8213

- All malignant neoplasm's including Melanoma but not skin cancer
- All secondary malignant neoplasm's -
- Highest HCC if site is documented $17,753

Ischemic Heart Disease $2215

- 411.1 Unstable Angina

Specified Heart Arrhythmia $2285

- 426.0 Complete AV block
- 427.31 Atrial Fibrillation
- 427.81 Sick Sinus Syndrome

Diabetes $1264 - $3962

- all diabetes (250.XX) and most of the manifestations

Ischemic or Unspecified Stroke $2067

- 436 CVA
- 434.91 Unspecified cerebral artery occlusion, with infarction
- Angina/Old MI $1903
- 413.9 Angina
- 412 Old MI

Rheumatoid Arthritis & Inflammatory Connective Tissue Disease $2699

- 714.0 Rheumatoid Arthritis
- 710.0 SLE

Compliant Coding Begins With Compliant Documentation

When Documenting think MEAT

You must follow the rules of ICD-9 coding when coding chronic conditions. You must also have "MEAT" to code these chronic conditions...

- **M=Monitor, E=Evaluated, A=Addressed/Assess, T=Treated**
- If no "MEAT" is found for conditions stated, you cannot code.
- Providers must also follow CMS signature guidelines.
- **REMEMBER: If it is not documented, it didn't happen!!!**

Sample Language	
Assessment	**Plan**
Stable	Monitor
Improved	D/C Meds
Tolerating Meds	Continue Current Meds
Deteriorating	Refer

Example Language
Hypertensive CKD 3, stable well controlled, continue Atenolol.
COPD, stable on Advair

Most Common Errors Found in Documentation

Don't document "H/O" of any disease that currently exists.

– The statement "history of" in ICD-9 terms means that the patient no longer has this condition. However, "H/O" is ok when documenting some status conditions such as an Amputation, Old MI or Cancer

- **Rule of thumb in coding is**

– If a patient is on a medication for a condition and if the medication were to be stopped, would the condition resume, and the answer is mostly likely or yes, then you still code the condition.

Examples

– H/O CHF – pt is on lasix 428.0

– H/O Angina – pt has nitroquick 413.9

– H/O COPD – pt is on Advair 496

- **This also applies to a pacemaker for SSS or Complete or 3rd degree heart block...if the SSS or Heart Block is documented you can still code it 427.81 or 426.0**

ALCOHOL AND DRUG DEPENDENCE

- Alcohol dependence, Chronic alcoholism or Alcoholism in remission 303.90 & 303.93
- Drug dependence or Drug dependence in remission
- (opiate, anxiolytic, sedative, hypnotic, hallucinogen or amphetamine) 304.90 & 304.93
- Patient has arrived at a stage of physical dependency and would experience physical signs of withdrawal with sudden cessation

**Alcohol abuse and drug abuse are not HCC's 305.XX

Major Depression 296.XX

– PHQ9 score >10

– 5 of 9 DSMIV criteria

– Medication

– Following with a mental health provider

– **if only "Depression" 311 is documented...it is not an HCC code!

Neoplasms

Must have current treatment to the site

Treatment to the site is considered:

- Chemotherapy, Radiation or Adjunct therapy
- Or if patient elects not to have any treatment

Breast Ca (174.9) – on Tamoxifan, Arimidex, Femara etc. would be considered adjunct therapy

- Documentation needs to say "Breast Ca onTamoxifan"
- If not then H/O Breast cancer V10.3

Prostate Ca (185) – *on Lupron, Casodex or Zoladex would be considered adjunct therapy*

- Documentation needs to say "Prostate Ca on Lupron"
- If not then H/O Prostate Ca. V10.46

METASTATIC CANCER

- Mets is the highest HCC $17,753 – **only if the site it has metastasized to is documented**

– H/O Breast Ca with Mets to lung V10.3 & 197.0

– Prostate Ca on Lupron with bone Mets 185 & 198.82

– H/O Colon Ca with Mets to the liver V10.05 & 197.7

If you document like this the highest HCC opportunity will be missed

– Metastatic Breast Ca $1622 (if Breast ca is under treatment) 174.9 & 199.1

– Metastatic Colon Ca $1622 (if Colon ca is under treatment) 154.0 & 199.1

– Lung Ca with Mets $8213 (if Lung ca is under treatment) 162.9 & 199.1

– H/O Lung Ca with Mets V10.11 & 199.1

CVA

Acute condition that can only be documented and coded during **the initial episode of care** – 434.9X

– Once the patient is discharged from hospital documentation should reflect:

"h/o CVA, s/p CVA or Old CVA V12.54"

UNLESS THEY HAVE A LATE EFFECT!

- **Late effects of CVA should be documented and coded as such**

– CVA with hemiplegia/hemiparesis 438.20

– CVA with dysphagia 438.82

DVT

Acute DVT (initial episode of care)

– 453.40

• **Chronic DVT** (on an anti-coagulant)

– 453.50

• **H/O DVT** (not on an anti-coagulant)

– V12.51

Need to document "chronic DVT" if patient is on an anti-coagulant

*** Same guidelines for Pulmonary Embolism

COMMON OMISSIONS YEAR OVER YEAR

• Artificial openings

– Gastrostomy V44.1

– Colostomy V44.3

– Tracheostomy V44.0

– Ileostomy V44.2

• Amputations

– BKA V49.75

– AKA V49.76

– Foot V49.73

– Toe V49.71 or V49.72

• AAA – Abdominal aortic aneurysm – 441.1 (w/o repair)

• Aortic Atherosclerosis – 440.0

Diabetes Coding

- What if I have a patient who has multiple manifestations or complications???
- Code the 250.xx with the highest RAF
- Then code the buddy code – the corresponding complication or manifestation
- Then code all other complications
    - They are additive!

*2013 Changes for Coefficients

HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation$_{1,4}$	0.371
HCC16	Diabetes with Neurologic or Other Specified Manifestation$_{1,4}$	0.371
HCC17	Diabetes with Acute Complications$_{1,4}$	0.371
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation$_{1,4}$	0.371
HCC19	Diabetes without Complication$_{1}$	0.127

Diabetes Coding *CMS Medicare Database

ICD-9 CODE	ICD-9 CODE DESCRIPTION
250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.10	DIABETES WITH KETOACIDOSIS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.20	DIABETES WITH HYPEROSMOLARITY, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.30	DIABETES WITH OTHER COMA, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.40	DIABETES WITH RENAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.50	DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.60	DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.70	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.80	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.90	DIABETES WITH UNSPECIFIED COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED

Buddy Codes - Required when 4th digit is 1-8

Peripheral Neuropathy due to Diabetes

250.60 Diabetes with neurological manifestations

357.2 Polyneuropathy in Diabetes

Diabetic Peripheral Vascular Disease

250.70 Diabetes with peripheral circulatory disorders

443.81 PVD in Diabetes

Diabetic Calf Ulcer

250.80 Diabetes with other specified complications

707.12 Ulcer

Linking Words

Linking words create a relationship between diseases and manifestations

*Assures coders of a cause and effect between disease and manifestation, as we cannot assume.

- Appropriate terms:
- Due to
- Secondary to

Must use of associative suffix 'ic' or 'ive' (diabetic ulcer or hypertensive heart disease)

The terms "probable" and "more than likely" do not provide linkage

Top 10 Coding Errors for Risk Adjustment – According to AAPC

http://news.aapc.com/index.php/2013/03/top-10-medicare-risk-adjustment-coding-errors/

1. The record does not contain a legible signature with credential.
2. The electronic health record (EHR) was unauthenticated (not electronically signed).
3. The highest degree of specificity was not assigned the most precise ICD-9-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
4. A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. If the record indicates depression, NOS (311 *Depressive disorder, not elsewhere classified*), but the diagnosis code written on the encounter document is major depression (296.20 *Major depressive affective disorder, single episode, unspecified*), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.
5. Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).
6. Status of cancer is unclear. Treatment is not documented.
7. Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
8. Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
9. Chronic conditions or status codes aren't documented in the medical record at least once per year.
10. A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

What is A Risk Score and How it is Determined?

Demographic and diagnostic information is used to calculate each beneficiary's risk score—a relative measure of expected health care costs where 1.0 represents average risk.

Risk Score Calculation for a Community-Based 86-Year-Old Medicare Beneficiary Risk Marker	**Relative Risk Factor**
Male, Age 85-89	0.692
Diabetes without Complication (HCC 19)	0.162
Hip Fracture/Dislocation (HCC 158)	0.429
TOTAL	**1.283**

Risk scores for beneficiaries with the same health conditions, age, and other characteristics should be identical, regardless of whether the beneficiaries are in an MA plan or Medicare fee-for-service (FFS).

- However, differences in incentives may affect the intensity with which MA plans and FFS providers code medical diagnoses.
- Deficit Reduction Act of 2005 required CMS to adjust MA risk scores to account for any diagnostic coding differences. CMS began adjusting MA risk scores in 2010.
- Health Care and Education Reconciliation Act of 2010 required an annual minimum reduction in MA risk scores to account for diagnostic coding differences.

GAO Studies on Diagnostic Coding Differences

- In January 2012, we reported on (1) the extent to which diagnostic coding differences affected risk scores and payments to MA plans in 2010; and (2) our evaluation of CMS's methodology for determining a diagnostic coding adjustment for 2010, 2011, and 2012.

- In January 2013, using an enhanced methodology, we reported on (1) the extent to which diagnostic coding differences affected risk scores and payments to MA plans in 2010, 2011, and 2012; and (2) CMS's methodology for determining diagnostic coding adjustments for 2013 and future years.

Concerns about CMS's Methodology for Calculating Risk Score Adjustments

- For 2010, CMS based its adjustment on the results of its data analysis.

- CMS's methodology had several shortcomings, including not using the most recently available data.

- For 2011 through 2013, CMS based its adjustment on the results of its data analysis and its consideration of other factors, such as payment changes made to the MA program under PPACA.

- CMS used the same adjustment in 2011 through 2013 that it used for 2010.

- We could not identify the legal basis for CMS to consider factors other than its data analysis results in determining an adjustment.

Recommendations for CMS

In our 2013 report, we reaffirmed our original recommendations:

To help ensure appropriate payments to MA plans, the Administrator of CMS should take steps to improve the accuracy of the adjustment made for differences in diagnostic coding practices between MA and Medicare FFS.

Such steps could include, for example:

- accounting for additional beneficiary characteristics,

- including the most current data available,

- identifying and accounting for all years of coding differences that could affect the payment year for which an adjustment is made, and

- incorporating the trend of the impact of coding differences on risk scores.

Risk Adjustment Changes for 2014

CMS has announced a new CMS-HCC Model for payment year 2014 in their combined **Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter**, published April 1, 2013.

Important provisions of the announcement, related to Risk Adjustment:

- *Clinically Revised CMS-HCC Model. CMS will implement the new risk adjustment model, but will phase-in changes over a two year period. In 2014, CMS will blend 75 percent of the 2014 model risk score with 25 percent of the 2013 model risk score. The new model will be fully phased-in by January 1, 2015.*

- *Medicare Enrollee Health Risk Assessment. As noted in the Advance Notice, CMS is considering excluding from risk adjusted payment any diagnosis data collected from MA enrollee Health Risk Assessments which are not confirmed by a subsequent clinical encounter. CMS planned to collect flags in 2013 of these risk assessments. Based on comments received, CMS is delaying the collection of flags until calendar year 2014. Further determination about exclusion of these data will be published in the 2015 Advance Notice*

- *Coding Intensity Adjustment. The Coding Intensity Adjustment for 2014 is 4.91 percent.*

- *Normalization Factor. Because 2014 payment will be based on a blend of the old and new CMS-HCC Models, there will be two normalization factors:*

  - ***2013 CMS-HCC model: 1.041.***

  - **2014 CMS-HCC model: 1.026.**

2013 Disease Coefficients

Disease Coefficients	Description Label	Community Factors	InstitutionalFactors
HCC1	HIV/AIDS	0.458	1.732
HCC2	Septicemia/Shock	0.766	0.796
HCC5	Opportunistic Infections	0.465	0.471
HCC7	Metastatic Cancer and Acute Leukemia	2.175	0.910
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	0.919	0.576
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.706	0.413
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.187	0.240
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation1,4	0.371	0.413
HCC16	Diabetes with Neurologic or Other Specified Manifestation1,4	0.371	0.413
HCC17	Diabetes with Acute Complications1,4	0.371	0.413
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation1,4	0.371	0.413
HCC19	Diabetes without Complication1	0.127	0.173
HCC21	Protein-Calorie Malnutrition	0.745	0.358
HCC25	End-Stage Liver Disease	1.006	0.937
HCC26	Cirrhosis of Liver	0.413	0.350
HCC27	Chronic Hepatitis	0.262	0.350
HCC31	Intestinal Obstruction/Perforation	0.310	0.352
HCC32	Pancreatic Disease	0.362	0.374
HCC33	Inflammatory Bowel Disease	0.302	0.283
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.585	0.670
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.361	0.304
HCC44	Severe Hematological Disorders	1.129	0.600
HCC45	Disorders of Immunity	0.945	0.533
HCC51	Drug/Alcohol Psychosis3	0.373	-
HCC52	Drug/Alcohol Dependence3	0.373	-
HCC54	Schizophrenia	0.517	0.407
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.360	0.301
HCC67	Quadriplegia, Other Extensive Paralysis	1.147	0.518
HCC68	Paraplegia	1.061	0.480
HCC69	Spinal Cord Disorders/Injuries	0.491	0.238
HCC70	Muscular Dystrophy3	0.464	-

HCC71	Polyneuropathy	0.321	0.277
HCC72	Multiple Sclerosis	0.516	0.157
HCC73	Parkinson's and Huntington's Diseases	0.643	0.138
HCC74	Seizure Disorders and Convulsions	0.278	0.192
HCC75	Coma, Brain Compression/Anoxic Damage	0.580	0.060
HCC77	Respirator Dependence/Tracheostomy Status	1.767	2.129
HCC78	Respiratory Arrest	1.117	1.121
HCC79	Cardio-Respiratory Failure and Shock	0.531	0.485
HCC80	Congestive Heart Failure	0.346	0.228
HCC81	Acute Myocardial Infarction	0.294	0.439
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.274	0.439
HCC83	Angina Pectoris/Old Myocardial Infarction	0.170	0.331
HCC92	Specified Heart Arrhythmias	0.289	0.245
HCC95	Cerebral Hemorrhage	0.359	0.151
HCC96	Ischemic or Unspecified Stroke	0.265	0.151
HCC100	Hemiplegia/Hemiparesis	0.534	0.069
HCC101	Cerebral Palsy and Other Paralytic Syndromes3	0.131	-
HCC104	Vascular Disease with Complications	0.594	0.470
HCC105	Vascular Disease	0.302	0.138
HCC107	Cystic Fibrosis	0.385	0.378
HCC108	Chronic Obstructive Pulmonary Disease	0.340	0.378
HCC111	Aspiration and Specified Bacterial Pneumonias	0.734	0.605
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.206	0.197
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.236	0.440
HCC130	Dialysis Status	1.348	2.228
HCC131	Renal Failure	0.297	0.353
HCC132	Nephritis	0.116	0.353
HCC148	Decubitus Ulcer of Skin	1.165	0.517
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.476	0.291
HCC150	Extensive Third-Degree Burns3	1.246	-
HCC154	Severe Head Injury	0.580	0.060
HCC155	Major Head Injury3	0.171	-
HCC157	Vertebral Fractures without Spinal Cord Injury	0.467	0.154
HCC158	Hip Fracture/Dislocation3	0.435	-
HCC161	Traumatic Amputation	0.793	0.266
HCC164	Major Complications of Medical Care and Trauma	0.311	0.325
HCC174	Major Organ Transplant Status	1.084	0.925
HCC176	Artificial Openingsfor Feeding or Elimination	0.659	0.861
HCC177	Amputation Status, Lower Limb / Amputation Complications	0.793	0.266

2014 Medicare Advantage Final Call Letter

After receiving many comments on its Draft Call Letter, CMS published its Contract Year 2014 Final Call Letter on April 1, 2013. The Final Call Letter addresses a wide variety of issues that will affect all parties involved in Medicare Advantage ("MA") and Medicare Part D arrangements, including plans, beneficiaries, providers, and administrative services entities, such as pharmacy benefit managers ("PBMs"). In addition to announcing and explaining changes that parties must adapt to for CY 2014, CMS also provides insight into program modifications it is considering for CY 2015. Below we discuss some of the important changes that will affect plans, providers, and beneficiaries, and we highlight areas where CMS scrutiny is increasing.

Changes to Plan Reimbursement and Administration

Payment Increase – CMS Assumes Physician Fee Schedule Fix

CMS heeded the call from many commenters who took issue with CMS's proposed methodology that would have led to MA rate reductions in 2014. The Social Security Act mandates that the MA growth percentage reflect HHS's estimate of the per capita rate of growth in expenditures. The Draft Call Letter assumed a 25% reduction to the physician fee schedule based on no fix to the sustainable growth rate. In the Final Call Letter, CMS shifted its position to instead assume Congressional action to fix rate reductions and a 0% change for the 2014 physician fee schedule. The result of this change is monumental – instead of a 2.2% decrease, MA rates are expected to increase by 3.3%. Members of Congress and industry groups have praised CMS's revised position. Annual rate setting is always a critical issue for Medicare Advantage Organizations ("MAOs") and they will collectively breathe a sigh of relief, for now, given how close CMS came to finalizing the significant rate reductions.

Updated CMS-HCC Risk Adjustment Model/Recalibration

CMS responded to commenters requesting that CMS delay implementation of the updated CMS-HCC risk adjustment model proposed in the Draft Call Letter. The updated CMS-HCC model applies more current data in updates and includes clinical revisions of diagnoses in each HCC. Stakeholders identified a wide range of concerns with the new CMS-HCC model, including that it could decrease risk scores and payments, and negatively impact MA plans with a significant number of chronic conditions. As a result, CMS elected to finalize the proposed model, but limited the impact of the change by blending the risk scores to take into account both the 2013 and the 2014 CMS-HCC models. For 2014, CMS will weigh the normalized risk scores from the 2013 model by 25%, and the normalized risk scores from the clinically revised model by 75%. Although CMS may have mitigated some of stakeholders' concerns by blending the risk scores to take into account the 2013 and 2014 models, MA plans should be aware of the specific clinical changes made to the CMS-HCC model that may impact risk scores and plan payments. CMS also adopted an MA Coding Adjuster of 4.91%. Some commenters were concerned that the Coding Adjuster and CMS-HCC risk adjustment model changes were duplicative but CMS believes that it has accounted for the changes to the risk adjustment model when it calculated the Coding Adjuster and therefore there is no duplication.

CMS Questions Value of MA Health Risk Assessments

CMS received many comments about its proposal to require MA plans to "flag" diagnosis codes reported as a result of a Health Risk Assessment ("HRA") and to potentially exclude diagnoses reported through an HRA and for which the beneficiary did not receive follow-up care. CMS has delayed the "flag" requirement until 2014 dates of service and intends to propose and finalize a policy regarding the extent to which diagnoses from HRAs, without follow-up care, may be used to calculate risk scores for payment year 2015.

In its Draft Call Letter, CMS announced that it was considering whether or not the MA HRAs provide valuable information for risk adjustment purposes. CMS recognized that HRAs can identify gaps in care, contribute to improved care, and promote prevention, but was concerned that these evaluations were used to collect diagnoses codes and do not result in follow-up care or treatment for the beneficiary. Multiple commenters were concerned that the proposal conflicted with the current CMS-HCC risk adjustment methodology, how risk adjusted payments were calculated, and how the methodology was calibrated. Commenters were also concerned that the proposal would result in fewer HRAs being conducted and that the requirement would be administratively burdensome.

HRAs and the documentation they produce are important tools for both MA plans and their beneficiaries. When conducted properly, an HRA should result in a complete and accurate record of a beneficiary's diagnoses and a well-developed personal plan of care. Many types of providers contract with MA plans to provide HRAs, such as traditional primary care providers and medical clinics. Moving forward, MA plans will need to review their arrangements with all entities providing HRAs to ensure that follow-up care and beneficiary outreach is being appropriately provided.

Star Ratings

The Final Call Letter references changes to the 2014 Star Ratings that are designed to "further align" with CMS policy goals. In November 2012, CMS solicited and subsequently received approximately 80 comments relating to proposed enhancements to Medicare Parts C and D Star Ratings. After reviewing the comments, CMS decided to make changes to certain measures (including those relating to call centers, quality improvement, high-risk medication use, medication adherence for diabetes medications, and others), but will not introduce new measures for 2014. The Final Call Letter also highlights, and Plan Sponsors should continue to monitor, CMS's proposal to change the calculation of the overall rating and the Part C and D summary ratings that may be implemented in 2015 with the goal of more accurately classifying a contract's "true performance."

For more information about Star Ratings, please see BNA's Medicare Star Ratings–What Plan Sponsors Need to Know, written by Theresa Carnegie and Roy Albert.

Employer Group Waiver Plan ("EGWP") Guidance

All EGWP specific guidance in the Final Call Letter relates to CMS's creation of "other health insurance" ("OHI"). In April 2012, CMS finalized a regulatory change to the definition of "Part D supplemental benefits" through which it excluded supplemental benefits offered by EGWPs. In the same notice, CMS established OHI as a

defined term to encompass those supplemental benefits offered by EGWPs and benefits traditionally offered by EGWPs through commercial wrap products. The effective date of the changes announced in the April 2012 notice relating to the treatment of OHI was scheduled to be January 1, 2013, but CMS ultimately delayed the effective date to January 1, 2014 for EGWPs that were struggling to implement the changes in compliance with ERISA.

The Final Call Letter provides technical guidance to Plan Sponsors and their PBMs on how to properly adjudicate and map a claim that involves OHI. The Letter includes helpful examples and addresses what amounts count towards TrOOP, how to calculate patient liability reduction due to other payer ("PLRO"), and how to apply OHI to beneficiaries who are eligible for the low income cost subsidy ("LICS"). Depending upon the benefit design an EGWP selects, beneficiaries may have higher cost-sharing requirements as the result of OHI at certain coverage points. If OHI results in cost-sharing above the defined standard benefit, PLRO is reported as a negative amount. If the beneficiary is LICS eligible, negative PLRO offsets the LICS amount that the EGWP would otherwise receive. The full beneficiary cost sharing continues to count towards TrOOP regardless of whether PLRO is negative.

CMS also reminds Plan Sponsors that the OHI definition and the consequences of it will be effective January 1, 2014, and that while OHI is a non-Medicare benefit, most prescription claims will remain subject to Part D requirements because EGWPs will be using OHI in almost every instance to reduce cost sharing on a prescription claim already covered under the Part D benefit.

Changes for Beneficiaries

Beneficiary Costs

In contract year 2014, beneficiaries will enjoy some reduced deductibles and out-of-pocket maximums, will have increased coverage in the Part D coverage gap, and will be protected from their MA plans significantly increasing the effective cost of coverage.

The Final Call Letter sets the deductible and out-of-pocket maximums for the Part D Defined Standard Plan below all of the CY 2013 levels. This will result in beneficiaries receiving coverage faster but may also result in beneficiaries reaching the coverage gap sooner. Once in the coverage gap, beneficiaries will receive additional benefits as a result of the Part D program covering 2.5% (on top of the 50% discount provided by pharmaceutical manufacturers) of covered brand drugs and 28% of covered generic drugs.

MA beneficiaries who remain in the same MA plan in which they were enrolled in 2013 will generally experience a total beneficiary cost ("TBC") change of no greater than $34 per member per month, down from $36 in 2013. CMS may deny an MAO's bid if it would increase beneficiary cost sharing or decrease benefits too significantly year to year in a given MA plan, a concept referred to as the TBC change. In the Draft Call Letter, CMS proposed a TBC limit of $30 per member per month, but adopted a $34 limit for contract year 2014 after many commenters expressed the need for more flexibility due to the many payment-related changes MAOs face in 2014.

Capitated Financial Alignment Demonstration

CMS reiterated guidance from the Draft Call Letter addressing the Capitated Financial Alignment Demonstration (the "Demonstration"). Under the Demonstration, health plans enter into a three-party contract with CMS and States to manage care for individuals dually eligible for Medicare and Medicaid. The Final Call Letter cites additional CMS guidance it anticipates issuing in the near future.

For more detail about the Demonstration, please refer to CMS's Financial Alignment Demonstration website and materials from last month's Roundtable conducted by Susan Berson and Roy Albert sponsored by the Medicare Advantage and Part D Affinity Group of the Payors, Plans, and Managed Care Practice Group of the American Health Lawyers Association titled Financial Alignment Demonstration for Medicare/Medicaid Dual Eligibles: The Next Frontier? (subscription required).

Practices Drawing Increased Scrutiny

Inappropriate use of Prior Authorization Forms

CMS is concerned that some Part D Plan Sponsors and/or their PBMs are inappropriately using their prior authorization process to limit beneficiaries' choice of pharmacies. These Plan Sponsors and PBMs have developed prior authorization forms that require so much information that once a form is complete, it can serve as a valid prescription. Upon approval of the claim, these Plan Sponsors and PBMs are filling the prescription through their own mail-order pharmacies, therefore ignoring the beneficiary's right to choose a pharmacy. CMS has received many complaints about this practice and believes that using prior authorization forms in this manner violates CMS requirements. CMS instructs Plans Sponsors and PBMs to discontinue this practice. Plan Sponsors and PBMs should review their prior authorization practices and ensure that they comply with CMS requirements.

Auto-Ship Refill Programs through Mail Order Pharmacies

CMS believes that many Part D beneficiaries receive unwanted refill prescriptions as the result of mail order pharmacy auto-refill programs. According to CMS, if a beneficiary receives a prescription via mail that he or she does not want, generally the pharmacy is unable to restock the medication and does not reverse the claim, ultimately resulting in significant waste. To reduce the incidence of this, starting in 2014, Part D Plan Sponsors must require their network pharmacies, retail and mail, to obtain beneficiary consent to deliver a prescription prior to each delivery, regardless of whether the prescription to be filled is new or a refill. Additionally, CMS strongly recommends that Plan Sponsors require network pharmacies to implement this consent requirement for the remainder of 2013.

This new requirement will affect Plan Sponsors, their PBMs, and network pharmacies. All parties involved should consider the documentation and processes necessary in order to comply with the new consent requirement. Additionally, Plan Sponsors and PBMs will need to update their pharmacy audit plans to ensure each pharmacy is complying with the consent requirement.

CMS also states that it is reconsidering its approval of mail-service benefit designs that include 30-day mail-service supplies. Plan Sponsors should expect CMS to deny benefit designs that include very attractive mail-

service cost sharing incentives for 30-day supplies unless the same cost sharing is available at retail pharmacies. CMS is concerned that some plans are using incentives to entice beneficiaries to use mail-order service even when mail-service may not be the best option for the beneficiary and believes that mail-service is more appropriate for longer term prescription supplies. Plan Sponsors and PBMs will need to closely examine the cost implications of transferring 30-day mail supplies to retail pharmacies and mail-order pharmacies that fill many 30-day supply prescriptions will need to prepare for the possible loss of these prescriptions.

Incremental Fills of Schedule II Controlled Substances Prescriptions

CMS cites a September 2012 OIG Report finding that the majority of Part D sponsors were inappropriately paid a total of $25 million in 2009 for Schedule II controlled substances billed as refills. CMS uses the Report to mandate that Plan Sponsors establish internal controls, such as retrospective auditing and adjusting or deleting PDEs that were erroneously submitted for illegal or improper refills, to prevent Part D payment for illegal refills of Schedule II controlled substances. Commenters to the Draft Call Letter emphasized that the industry, through the National Council for Prescription Drug Programs, has been actively addressing the limitation of the current HIPAA prescription drug billing standard with respect to distinguishing partial or incremental fills of an original prescription from refills. While CMS recognized the efforts of the National Council for Prescription Drug Programs, Plan Sponsors must still develop internal controls to prevent improper payment for Schedule II controlled substances, which have the highest potential for abuse of any prescription drugs that are legally available in the United States.

Post Point-of-Sale Claim Adjustments and Administrative Fees

The Final Call Letter provides significant guidance instructing Plan Sponsors and PBMs on how to properly report PDEs when a claim is adjusted after the point-of-sale. CMS does not believe the guidance sets forth new policy, but rather that it summarizes current guidance and provides more clarity. Whether or not the guidance establishes new policies, Plan Sponsors and PBMs should carefully review their claims processing and PDE reporting practices to ensure they are complying with CMS's interpretation of its current guidance.

It has come to CMS's attention that many Plan Sponsors and PBMs completely recoup the amount originally paid for a claim under inappropriate circumstances, and even when such recoupment is appropriate, they do not properly report the recoupment to CMS. CMS divides the types of claim errors into three categories; financial, administrative, and coverage. Financial errors occur when a Plan Sponsor or PBM inaccurately calculates and pays a valid claim. Administrative errors occur when a pharmacy includes inaccurate or incomplete data in fields that do not affect the financial calculation and coverage determination of the claim. Coverage errors occur when a claim is paid that should not have been covered under Part D, such as a fraudulent claim or a claim for an excluded drug. CMS clarifies that only claims that suffer from coverage errors should result in full recoupment; the other types of errors should result in adjustments when appropriate.

Further, Plan Sponsors and PBMs have been using the DIR reporting process to report certain claims adjustment to CMS when they should have been updating PDE submissions instead. CMS explains that PDE adjustment or deletion (in the case of full recoupment) is the only reporting methodology that is consistent with payment

accuracy. PDEs are required to represent the amounts actually paid to the pharmacies and failing to submit an adjusted PDE when the original PDE record contains inaccurate information is a misrepresentation and results in the submission of erroneous data. According to CMS, reporting the adjustments to claims paid through DIR negatively affects the accuracy of the Part D payment and the reliability and usefulness of the PDE data. CMS recognizes that confusion exists regarding the field "pharmacy payment adjustments" in the DIR reporting tool and it will be providing further clarification on this field in the 2012 DIR reporting instructions.

Some Plan Sponsor and PBM commenters were concerned with CMS's clarifications, believing that they would result in them bearing the cost of pharmacy errors when a pharmacy does not submit correct information that is required in order for CMS to accept the PDE. CMS believes that this will not be a problem because pharmacies should be able to provide the correct information if given a reasonable amount of time. CMS also reminded Plan Sponsors that it is their responsibility, not the pharmacy's responsibility, to verify NPIs and to investigate apparently erroneous NPIs.

Pharmacy commenters were supportive of the guidance and also requested CMS to set PBM audit standards. While CMS declined to set such standards, as PBMs are well aware, many states have been adopting PBM regulations limiting PBMs' rights to audit pharmacies and creating strict rules regarding how audits may be conducted.

Finally, CMS is considering revising its definition of "negotiated price" as a result of Plan Sponsors and PBMs charging pharmacies post point-of-sale claim administrative fees. According to some commenters, these fees are often associated with preferred pharmacy networks, but other commenters reported that these fees are standard in the industry. CMS believes that these fees, for example, $1.00 per claim, result in an overstatement of negotiated price and that this practice is inconsistent with the Part D rules. CMS acknowledges that its definition of negotiated price can be interpreted to permit these types of arrangements, but states that these arrangements are contrary to CMS's intent that negotiated price transparently reflect *all* pharmacy price concessions on a per-drug-claim basis. While CMS considers how to revise the definition of negotiated price, Plan Sponsors will not be considered to be non-compliant so long as the fees are reported through DIR reporting.

Preferred Pharmacy Networks

Although regulations permit lower cost sharing at certain network pharmacies, CMS points out that cost sharing reductions cannot increase CMS payments to plans. CMS notes that its initial data suggests that aggregate unit costs weighted by utilization for the top 25 brand and top 25 generic drugs may be higher in preferred networks than non-preferred networks for certain plans. When this cost differential is combined with lower cost-sharing amounts, CMS is concerned that higher unit costs may make Part D payments greater for preferred networks when compared to non-preferred networks. Plan Sponsors should be cognizant of this area of concern for CMS, and ensure that cost sharing reductions do not increase CMS payments to certain plans. Further, Plan Sponsors should understand that communications to beneficiaries addressing preferred networks must be clear and unambiguous and that the designation of preferred and non-preferred networks in plan benefit packages and Medicare Plan Finder pricing submissions must be accurate.

* * *

While the change in Medicare Advantage rates may capture the most immediate attention, the policies set forth in the Final Call Letter span the Medicare Advantage and Prescription Drug Benefit Programs. In addition to carefully reviewing the Final Call Letter, Plan Sponsors should continue to monitor future guidance, as CMS indicates that relevant policy statements are likely to be issued in the near future.

ICD-10 & MRA

Atherosclerotic Coronary Artery Disease and Angina

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

Primary Malignancy Previously Excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

Diabetes mellitus and the Use of Insulin

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned. CodeZ79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Dominant/Non-dominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14: Chronic kidney disease. If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.