

# Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS

Issue 23 Spring 2022

## *i* In this Issue

- COVID-19 Update
- Liberty Dental is the new dental network in Florida!
- Colorectal Cancer Screening
- Smoking cessation
- SDOH
- Quality
- Be a 10 Today

## COVID-19 Update

SARS-Cov-2, the virus that causes Covid-19 was first observed in December 2019. Since then we have been living through the first pandemic in an era of effective vaccinations and new therapies. While the speed of developing safe and effective vaccines has been miraculous, the virus continues to demonstrate that, if enough people become infected, natural selection will allow the virus to escape from our efforts to contain it.

Each of the waves of Covid-19 has been caused by a virus that is either more efficiently transmitted than prior variants or can partially escape immunity from prior infections or vaccinations.

The most recent variant, Omicron, is less sensitive to immunity from prior infection or vaccination. However, vaccination with three doses of vaccine still retains the ability to prevent severe disease and death in most people. We also have therapies that can be given to people in the early stages of disease that make it less likely that people will become severely ill or die. So, despite a worldwide epidemic, tools remain available to protect ourselves and our patients.

Because the virus has continued to evolve, becoming less susceptible to the vaccines developed from the initial virus, and we have learned more about how to best vaccinate people, vaccine recommendations have changed from two vaccinations given close together, which was done to get as many people vaccinated as soon as possible, to adding a third dose to increase and prolong the effectiveness of the vaccines. The recommendations are likely to and should be expected to, change with the viral changes.

When medications to treat HIV became available the surgeon general stated that medicines don't work if you don't take them.

*continued on page 2*



Visit us 24/7 on the web:  
PHP FL: [www.php-fl.org](http://www.php-fl.org)

700 SE 3rd Ave, 4th floor,  
Ft. Lauderdale, FL 33316

*continued from page 1*

The same is true for vaccines.

They will not be helpful unless everybody (or almost everybody) is vaccinated. The only disease eradicated by man is smallpox, and that was done by vaccination. To help end the pandemic and protect our patients we need to facilitate vaccination in all our patients and employees, as well as assuring they can be diagnosed and treated early in their infections.

Emerging data suggest some people with moderately to severely compromised immune systems do not always build the same level of immunity compared to people who are not immunocompromised. The CDC's recommendations ensure everyone, including people who are the most vulnerable to COVID-19, gets as much protection as possible through vaccination.

**The Centers for Disease Control and Prevention recently updated its recommendations for COVID-19 vaccination for people who are moderately or severely immunocompromised.**

| COVID-19 Vaccination Schedule for People Who Are Moderately or Severely Immunocompromised |          |  |  |  |   |  |         |   |         |  |  |  |
|---|----------|--|--|--|---|--|---------|---|---------|--|--|--|
| Vaccine   | 0 month  |  | 1 month  |  | 2 month                                       |  | 3 month |   | 4 month |  | 5 month  |  |
| <b>Pfizer-BioNTech</b><br>(ages 5-11 years)   | 1st Dose |  | 2nd dose<br>(3 weeks after 1st dose)   |  | 3rd dose<br>(at least 4 weeks after 2nd dose) |  |         |   |         |  |  |  |
| <b>Pfizer-BioNTech</b><br>(ages 12 years and older)                                       | 1st Dose |  | 2nd dose<br>(3 weeks after 1st dose)   |  | 3rd dose<br>(at least 4 weeks after 2nd dose) |  |         |   |         |  | Booster dose<br>(at least 3 months after 3rd dose) |  |
| <b>Moderna</b><br>(ages 18 years and older)   | 1st Dose |  | 2nd dose<br>(4 weeks after 1st dose)   |  | 3rd dose<br>(at least 4 weeks after 2nd dose) |  |         |   |         |  | Booster dose<br>(at least 3 months after 3rd dose) |  |
| <b>Janssen</b><br>(ages 18 years and older)   | 1st Dose |  | 2nd dose<br>(additional dose using an mRNA COVID-19 vaccine [at least 4 weeks after first dose]) |  |   |  |         | Booster dose<br>(at least 2 months after additional dose) |         |  |  |  |

## Liberty Dental is the new dental network in Florida!

AHF MCO of Florida, Inc., operator of PHP, has contracted with Liberty Dental to be the plan's dental provider through its network of dentists. There are now even more dentists available to our members. Please check the PHP Provider Directory for a complete list of Liberty Dental providers online at: [www.php-fl.org/provider-find](http://www.php-fl.org/provider-find)





## Colorectal Cancer Screening

### March is Colorectal Cancer Awareness Month

National Colorectal Cancer Awareness Month, held in March each year, offers healthcare providers a valuable opportunity to educate their community about these diseases and promote awareness of the importance of colorectal cancer screening, prevention, and treatment.

According to the American Cancer Society, colorectal cancer is the third most common cancer diagnosed in both men and women in the U.S. While the risk is slightly higher for men (4.3% chance of developing the disease), the risk remains high for women (4%). Every year, colorectal cancer claims the lives of nearly as many women as ovarian, cervical, and uterine cancers combined.

Thanks to several factors — including advances in prevention, screening, and treatment — colorectal cancer death rates have declined 53% among men and 57% among women from 1969 to 2017. Unfortunately, this comes alongside a rise in diagnoses for patients under 50 years of age and continued high rates of diagnosis and death for patients of African or Alaska Native descent. In addition, while screening rates tend to be higher for patients 45 years of age or older, rates are lower for younger patients. Since colorectal cancer has a 90.2% five-year relative survival rate if found at the localized stage, screening remains an imperative defense against the disease.

Healthy People 2030, a 10-year national health care initiative overseen by the Office of Disease Prevention and Health Promotion, has many objectives related to colorectal cancer, including reducing the death rate, increasing the proportion of adults who receive screening based on the most recent guidelines and increasing the proportion of people with colorectal cancer who get tested for Lynch syndrome.

This Colorectal Cancer Awareness Month, providers should counsel all patients aged 45 years and older about the benefits of colorectal cancer screening and the options that PHP has available to members.

## Smoking Cessation

Tobacco use is the leading cause of preventable illness and death in the United States. People living with HIV are 2-3 times more likely to be smokers than their age-matched HIV-uninfected counterparts.

According to the CDC, a smoker who has HIV are more likely to get HIV-related infections, including:

- Thrush (a mouth infection, also called oral candidiasis)
- Hairy leukoplakia (white mouth sores)
- Bacterial pneumonia
- Pneumocystis pneumonia, a dangerous lung infection

Smokers who have HIV are also more likely to get other serious illnesses than nonsmokers with HIV. They include:

- COPD (chronic obstructive pulmonary disease, a serious lung disease that causes severe breathing problems and includes emphysema and chronic bronchitis)
- Heart disease and stroke
- Lung cancer, head and neck cancer, cervical cancer, and anal cancer

Further, HIV-infected smokers may be at increased risk of poorer immunologic and virologic responses to ART.

Therefore, providers should ask patients about smoking as part of primary care management and current users should be asked about smoking at every visit. According to most surveys, patients are interested in smoking cessation. Brief (<3 min) tobacco dependence interventions are effective, and every tobacco user should be offered treatment.

Counseling and medication are effective when used by themselves for treating tobacco dependence. However, a combination of counseling and medication is more effective than either alone. Nicotine replacement therapies (NRTs) such as nicotine patches, gum, and lozenges, do not interact with ARVs and have low toxicity at recommended dosages, even in patients with cardiovascular disease. In moderate to heavy smokers, the “patch plus”, a combination NRT regimens, have achieved better 6-month abstinence rates in several trials than the use of a single product. The nicotine patch is used to deliver a consistent level of nicotine, and the gum or lozenge is used to minimize symptom flares as needed during the day. Bupropion with the nicotine patch or bupropion with as-needed nicotine lozenges also achieved better 6-month abstinence rates in several trials than the use of the patch alone. Varenicline has been associated in rare instances with violent thoughts, intent, or actions toward oneself or others. It is a second-line medication for patients who have failed an appropriate trial of NRT, bupropion, or combination therapy in the past year. Patients being considered for or who are on varenicline should be screened, warned of, and monitored for suicidality and violence risk.



PHP is pleased to offer its members a valuable and effective program to help members stop smoking...for good. Quit for Life is a comprehensive smoking cessation program that can help them stop using tobacco. There is no cost to members for this program.

### The Quit for Life program includes many tools.

- Eight weeks of free patches or gum
- One-on-one calls with a trained Quit Coach
- A packet of written materials including a Quit Guide with resources
- Texts on the members' cell phone
- Website with e-learning tools, forums and access to a Web Coach®
- Access to a toll-free number to call for help seven days a week

Please refer your patients to sign up for Quit for Life:

Call: 1-855-252-4871

Join online: [www.quitnow.net/ahf](http://www.quitnow.net/ahf)

# SDOH

## Social Determinants of Health- Health Care Access and Quality

The Healthy People 2030 Health Care Access and Quality Goal:  
Increase access to comprehensive, high-quality health care services.

Many people in the United States don't get the health care services they need. Healthy People 2030 focuses on improving health by helping people get timely, high-quality health care services.

About 1 in 10 people in the United States don't have health insurance.<sup>1</sup> People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

PHP health plans provide people living with HIV/AIDS quality healthcare since 1995 when it started the nation's first Medi-Cal health plan for HIV-positive people living in Los Angeles. The Medicare and Medi-Cal health plans provide comprehensive benefits for members including routine doctors and specialist office visits, emergency and urgent care, hospitalization, pharmacy, transportation, and other wellness assistances.

As a PHP provider, you are supporting the needs of the members and improving their health outcomes with quality healthcare. Having a primary care provider (PCP) is important for maintaining health and preventing and managing serious diseases. PCPs can develop long-term relationships with patients and coordinate care across health care providers. Strategies like team-based care and innovative payment methods are promising approaches for improving access to primary care.





## Quality

The Quality Improvement (QI) program is an evolving program that works to provide for the ever-changing needs of our plan members and providers. Every year, the QI program evaluates work accomplished, opportunities for improvement, and interventions to best assist you in improving your patients' health. QI also manages the Centers for Medicare & Medicaid (CMS) Five-Star Quality Rating System to evaluate the health plans' quality and performance. These ratings are updated annually and are presented in the form of stars. The program is a key component in financing health care benefits for PHP Plan Members. Five stars is the highest possible score and fewer stars indicate lower quality. QI partners with all departments and the medical staff to provide optimum care for our members and increase our plan's star rating. Currently, PHP Florida is a 4.5 STAR rating and PHP California is a 4 STAR rating. Some of the ways this is achieved is with HEDIS, the CAHPS Survey, and the HOS Survey:

### HEDIS

The Quality Improvement Department is currently in the middle of our annual HEDIS Audit. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry. The measurements are developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumer organizations and consumers to compare health plan performance to other plans and to national or regional benchmarks. To understand the terminology, whenever the HEDIS "Report" year is mentioned, it means that the data from the previous year was used. For example, for HEDIS reporting year 2022, the data will come from records from 2021. AHF Plan members are in the HEDIS data measurement set for the Medi-Cal/ Medicaid or Special Needs Plan (SNP) Medicare as required by regulatory requirements by the Center for Medicare and Medicaid Services (CMS). This article will focus on the measures that are being reported by AHF. To maximize the scores, we have written the following information and tips. Please note: data can be retrieved electronically from claims coding to determine the score for a measure. This is known as administrative data and is run first. If there is no useable administrative data for a qualifying member for a specific measure – the medical record is requested and the data is retrieved via medical record abstraction. This is called hybrid data. A measurement score is determined by adding the administrative data "hits" and the medical record data abstracted. Administrative data is preferred to hybrid data since it is less labor and resource-intensive to obtain.



## HOS

Medicare Health Outcomes Survey (HOS) is a patient-reported health perception survey used for our managed care members.

### The goal of the HOS:

- To gather valid and reliable clinically meaningful data from our members that have many uses
- Target quality improvement activities and resources
- Monitor health plan performance and reward top-performing health plans
- Help beneficiaries make informed health care choices
- Advance the science of functional health outcomes measurement

Each spring a random sample of members is drawn and surveyed from each PHP (Medicare plan). The survey contains 6 Activity of Daily Living (ADL) items as the core items used to calculate the frailty adjustment factor. The survey also includes 12 physical and mental health status questions, one question about memory loss interfering with daily activities, and one question about urinary incontinence. The survey includes questions that address mental and physical health, physical and social functioning, pain, energy, and quality of life. Members are surveyed one year to collect a baseline and then surveyed again two years later to measure the change in health over time. You CAN help improve HOS measures. Use a patient's annual wellness visit to discuss the following: Balance problems, falls, difficulty walking, and other risk factors for falls.

- Suggest the use of a cane or a walker.
- Check blood pressure with the patient standing, sitting, and reclining.
- Suggest an exercise or physical therapy program.
- Suggest a vision or hearing test.
- Perform bone density screening, especially for high-risk members. The need for physical activity and ways to increase physical activity.
- Talk to the patient about the importance of exercise and physical activity.
- Discuss with the patient how to start, increase or maintain activity. Bladder control and potential treatments for bladder-control issues that may arise as the patient ages.
- Ask the patient if bladder control is a problem.
- If so, ask if it interferes with sleep or daily activities.
- Talk to the patient about treatment options. Physical and mental health.
- Ask the patient about physical and mental health compared to two years ago.
- Discuss ways to improve the status of both mental and physical health.
- Suggest the patient begins exercise programs or physical therapy if warranted.

These topics can be discussed by the office or nursing staff while patients are waiting to be seen, and can be addressed by the provider during the visit. PHP acts as your partner to facilitate the coordination of care and services.



# BE A TEN TODAY!

## CAHPS

Each year the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is sent out to all our plan members. CAHPS reports are solely based on the members' (consumers) perception of their experiences with the health plan. These surveys ask your patients (our members) to rate and evaluate their experiences with the best possible answer being Always, Excellent, or 10!

### The significance of CAHPS:

- It factors into our Medicare STAR ratings.
- CAHPS makes up about 30% of a health Plan's STARS composite score. A high STARS score affords the plan a higher reimbursement rate from CMS, providing the plan with the capability of improving our resources and staff support. Conversely, a low score (3 STARS or below), may result in the plan having their CMS contract terminated.
- It helps improve the quality of your practice and the patient experience of care with effective communication. The partnership is strengthened when the Health Plan, RNCMs, primary and specialty providers maintain open lines of communication about patient care, referrals and authorization timelines.

The scores must reflect the good care you are providing! For this category the questions asked of your patients are:

### In the last 6 months:

- when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- when your personal doctor ordered a blood test, x-ray, or other tests for you, how often did you get those results as soon as you needed them?
- how often did you and your personal doctor talk about all the prescription medicines you were taking?
- did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

### Please help us increase the score for California and sustain the good Florida results. Some improvement tips are:

- When you refer a patient to a specialist, ask the patient to bring you a copy of the specialist report.
- Regularly talk to your patients about any specialists or other providers they have seen or need to see.
- Consider implementing a reminder in the medical record to request test results or follow-up reports. This will ensure appropriate follow-up for the patient.
- Set an expectation for the patient so they know when they will receive a follow-up call or test results.

### Questions to ask your patients:

- How did your appointment go with the specialist?
- Did he/she explain the treatment plan to you?
- Were you comfortable with the information and how it was explained?
- Did you receive your results on any testing that was done?
- Do you need another appointment or do you have a follow-up appointment already scheduled?
- Do you have any concerns with the treatment you received or will need going forward?

### Improve Provider Care Coordination by ALWAYS being an EXCELLENT 10!







# 2021/2022 AHF PCP ICD-10 Coding Summary

Prepared by AHF Risk Adjustment Team

**USE THE EMR/CPS DROP DOWN LIST FOR GREATEST SPECIFICITY**

**Additional ICD-10 resources can be found at:**

CMS.gov (ICD-10 list <https://www.cms.gov/medicare/icd-10/2021-icd-10-cm>)

**CMS-HCC Model:**

[https://www.cms.gov/medicare/health-plans/medicareadvantage/medicareadvantage/risk-adjustors.html](https://www.cms.gov/medicare/health-plans/medicareadvantage/medicareadvantage/medicareadvantage/risk-adjustors.html)

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS

Issue 23 Spring 2022

| CONDITION/<br>CONDITION CATEGORY                         | ADDITIONAL<br>DESCRIPTION  | ICD-10 CODES & SECTION RANGE ( ADDT'L SPECIFIC<br>CODE DESCRIPTORS ** REQUIRED)   | UNSPECIFIED/LESS<br>SPECIFIC CODES  |
|--|--|---|---|
| <b>IMMUNE AND HEMATOLOGIC DISORDERS</b>                  |  |   |   |
| <b>AIDS, HIV disease</b>                                 |  | B20 Human Immunodeficiency Virus Disease  |   |
| <b>Asymptomatic HIV with no history of AIDS dx</b>       | No Hx of AIDS Indicator Conditions or CD4 < 200                                  | Z21 Asymptomatic HIV infection status   |   |
| <b>Coagulation Defects, Hematologic D/O</b>              | Coagulation Deficiency<br><br>Hemolytic Anemia                                   | D68.4 Acquired coagulation factor deficiency<br>D68.2 Hereditary deficiency of clotting factors<br>D59.8 Other acquired hemolytic anemias<br>D59.2 Drug-induced hemolytic anemia  | D68.9 Coagulation defect<br><br>D59.9 Acquired hemolytic anemia, unspecified          |
| <b>Neutropenia<br/>Thrombocytopenia<br/>Pancytopenia</b> |  | D70.9 Neutropenia, unspecified<br>D69.6 Thrombocytopenia<br>D61.811 Drug-induced pancytopenia   | D70.3 Neutropenia due to infection<br>D61.818 Othr Pancytopenia                       |
| <b>CARDIOVASCULAR AND RENAL DISORDERS</b>                |  |   |   |
| <b>Angina Pectoris</b>                                   | Typical CP, cardiac RF   | I20.1 Angina Pectoris with documented spasm   | I20.9 Angina, unspecified   |
| <b>Heart Failure</b>                                     | CHF  | I50.20 Unspecified systolic (congestive) heart failure<br>I50.30 Unspecified diastolic (congestive) HF  | I50.9 Heart failure, unspecified  |
| <b>Heart Disease w/HF<br/>Cardiomyopathy</b>             |  | I11.0 Hypertensive heart disease w/ heart failure<br>I42.0 Dilated cardiomyopathy   | I42.9 Cardiomyopathy, uns   |
| <b>Atherosclerosis</b>                                   |  | I70.0 Atherosclerosis of aortic artery<br>I70.2__ Atherosclerosis of the extremities (Choose most specific DX)  |   |
| <b>Peripheral vascular disease</b>                       | Claudication   | I73.9__ Peripheral vascular disease (PVD)   |   |
| <b>Chronic DVT</b>                                       | Chronic embolism and thrombosis of deep veins of lower extremity                 | I82.5__ (Choose Proximal/Distal and Right/Left Extremity)   | I82.509 Chronic embolism and thrombosis of unspecified deep veins of lower extremity  |
| <b>Acute Renal Failure</b>                               | Acute kidney injury (AKI)  | N17.0 Acute kidney failure (Choose most specific)   | N17.9 Acute kidney fail, un   |
| <b>CKD stage 3a or stage 3b</b>                          | GFR 30-59 ml/min   | N18.31 CKD stage 3a, N18.32 CKD stage 3b  | N18.30 CKD stage 3, unsp  |
| <b>CKD stage 4</b>                                       | GFR 15-29 ml/min   | N18.4 CKD stage 4   |   |
| <b>CKD stage 5</b>                                       | GFR < 15 ml/min  | N18.5 CKD stage 5   |   |
| <b>End Stage Renal Disease</b>                           | CKD requiring chronic dialysis<br>Dependence on renal dialysis                   | N18.6 End Stage Renal Disease (ESRD)<br>Z99.2 Dependence on renal dialysis  |   |
| <b>METABOLIC AND NUTRITIONAL DISORDERS</b>               |  |   |   |
| <b>Diabetes Mellitus</b>                                 | Diabetes Mellitus poorly controlled  | E11.9 Type 2, E10.9 Type 1, E08.9 d/t underlying dx   | E11.9 Unspecified Diabetes  |
| <b>DM, Renal Complications</b>                           | Diabetes Mellitus w/ Renal Manifestations  | E11.65 DM type 2 w/ hyperglycemia<br>Z79.4 Long-term use of insulin   |   |
| <b>DM, Ophthalmic Comp</b>                               | Diabetes w/ Ophthalmic Manifestations  | E11.2 DM type 2 w/ kidney complications<br>E11.21 DM type 2 w/ nephropathy  | Use additional code to identify CKD stage (N18.0-3)                                   |
| <b>DM, Neurological Comp</b>                             | Diabetes w/ Neurological Manifestations  | E11.22 DM type 2 w/ chronic kidney disease  |   |
| <b>DM, Circulatory Comp</b>                              | Diabetes w/ Peripheral Circulatory Manifestations                                | E11.3 DM type 2 w/ ophthalmic complications<br>E11.319 DM type 2 w/ retinopathy   |   |
| <b>DM, Skin complications</b>                            | Diabetes w/associated Skin Manifestations  | E11.36 DM type 2 w/ cataract<br>E11.4 DM type 2 w/ neurological complications<br>E11.42 DM type 2 w/ polyneuropathy<br>E11.5 DM type 2 w/ circulatory complications<br>E11.51 DM type 2 w/ peripheral angiopathy<br>E11.62 DM type 2 w/ skin complications<br>E11.621 DM type 2 w/ foot ulcer (L97.4*)<br>E11.622 DM type 2 w/ other skin ulcer | Use additional code to identify site & severity of ulcer (L97.1-L97.9, L98.41-L98.49) |
| <b>Protein-Calorie Malnutrition</b>                      | Malnutrition<br>Cachexia/Wasting syndrome  | E44.1 Mild, E44.0 Moderate, E43 Severe<br>R64 Cachexia  | E46 Malnutrition, unsp  |
| <b>Morbid Obesity</b>                                    | BMI > 40 or BMI ffl 35 with comorbid condition (e.g. DM, CAD, sleep apnea, etc.) | E66.01 Morbid (severe) obesity (BMI) 40.0-44.9,adult<br>Z68.41 (BMI) 40.0-44.9,adult<br>Z68.42 (BMI) 45.0-49.9,adult<br>Z68.43 (BMI) 50.0-59.9,adult<br>Z68.44 (BMI) 60.0-69.9,adult  |   |

| CONDITION/<br>CONDITION CATEGORY   | ADDITIONAL<br>DESCRIPTION  | ICD-10 CODES & SECTION RANGE ( ADDT'L SPECIFIC<br>CODE DESCRIPTORS ** REQUIRED)   | UNSPECIFIED/LESS<br>SPECIFIC CODES  |
|--|--|---|---|
| <b>NERVOUS SYSTEM DISORDERS</b>  |  |   |   |
| <b>Inflammatory &amp; Toxic<br/>Neuropathies</b>   | Polyneuropathy in other diseases classified elsewhere<br>Alcoholic polyneuropathy<br>Neuropathy due to drugs (including ARVs)  | G63 Polyneuropathy in diseases classified elsewhere*<br>G62.1 Alcoholic polyneuropathy<br>G62.0 Drug-induced polyneuropathy<br>G61.9 Inflammatory polyneuropathy  | *Please specify disease (e.g. HIV, cancer, etc.)  |
| <b>LIVER AND DIGESTIVE SYSTEM DISORDERS</b>  |  |   |   |
| <b>Cirrhosis</b>   | Cirrhosis of liver without alcohol   | K74.60 Cirrhosis of liver<br>K70.30 Alcoholic cirrhosis of liver w/o ascites<br>K70.31 Alcoholic cirrhosis of liver w/ ascites<br>K70.9 Alcoholic liver disease   | K74.60 Cirrhosis, unspec (code also Alcohol Dependence F10.20 or Hx of Alcohol Depend F10.21)                                   |
| <b>Alcoholic, cirrhosis</b>  |  |   |   |
| <b>Hepatitis</b>   | Chronic Hepatitis C<br><br>Chronic Hepatitis B   | B18.2 Chronic viral Hepatitis C (includes Hepatitis C Carrier)<br>B18.1 Chronic viral Hepatitis B without delta-agent (includes Hepatitis B Carrier)<br>B18.0 Chronic viral Hepatitis B with delta-agent  |   |
| <b>Esophageal Varices</b>  | Primary Esophageal Varices   | I85.00 Esophageal varices w/o bleeding<br>I85.01 Esophageal varices w/ bleeding   |   |
| <b>Portal Hypertension</b>   | Esophageal Varices due to cirrhosis, alcoholic liver dz, portal htn, etc.  | I85.10 Secondary esophageal varices w/o bleeding<br>I85.11 Secondary esophageal varices w/ bleeding<br>K76.6 Portal hypertension  |   |
| <b>MENTAL HEALTH AND SUBSTANCE DEPENDENCE &amp; ABUSE DISORDERS</b>                                  |  |   |   |
| <b>Substance Use Disorder,<br/><br/>Moderate/Severe, or<br/>Substance Use with<br/>Complications</b> | Alcohol Dependence<br><br>Amphetamine and Other Stimulant Dependence<br>Cocaine Dependence<br><br>Opioid Dependence<br><br>Cannabis Dependence<br><br>Other or Unspecified Drug Dependence | F10.20 Alcohol dependence, uncomplicated<br>F10.21 Alcohol dependence, in remission (or Hx of)<br>F15.20 Stimulant dependence, uncomplicated<br>F15.21 Stimulant dependence, in remission (or Hx)<br>F14.20 Cocaine dependence, uncomplicated<br>F14.21 Cocaine dependence, in remission (or Hx of)<br>F11.20 Opioid dependence, uncomplicated<br>F11.21 Opioid dependence, in remission (or Hx of)<br>F12.20 Cannabis dependence, uncomplicated<br>F12.21 Cannabis dependence, in remission (or Hx)<br>F19.20 Other psychoactive substance dependence<br>F19.21 Other psychoactive substance dependence, in remission (or Hx of) |   |
| <b>Substance Use Disorder,<br/>Mild, Except Alcohol and<br/>Cannabis</b>                             | Amphetamine and Other Stimulant Abuse<br>Cocaine Abuse<br><br>Opioid Abuse<br><br>Other or Unspecified Drug Abuse  | F15.10 Stimulant abuse, uncomplicated<br>F15.11 Stimulant abuse, in remission<br>F14.10 Cocaine abuse, uncomplicated<br>F14.11 Cocaine abuse, in remission<br>F11.10 Opioid abuse, uncomplicated<br>F11.11 Opioid abuse, in remission<br>F19.10 Other psychoactive substance abuse<br>F19.11 Other substance abuse, in remission  |   |
| <b>Schizophrenia</b>   |  | F20.0 Paranoid, F20.1 Disorganized<br>F25.9 Schizoaffective disorder  | F20.9 Schizophrenia, unsp   |
| <b>Reactive and Unspecified<br/>Psychosis</b>  |  | F23 Brief psychotic disorder<br>F28 Other psychotic disorder, not due to substance  | F29 Unspecified psychosis, not due to substance   |
|  | Major Depressive Disorder  | F33. MDD, recurrent *specify severity current ep<br>F33.40 MDD, recurrent, in remission   | F33.9 MDD, recurrent, uns   |
|  | Bipolar Disorder   | F32. MDD, single episode, *specify severity of ep<br>F32.5 MDD, single episode, in remission<br>F31. Bipolar D/O – specify type & severity  | *mild 0, mod 1, severe 2, etc<br><br>F31.9 Bipolar D/O, unspec  |
| <b>Personality Disorders</b>   | Personality Disorders<br>Dissociative Disorders  | F60. Personality D/O *specify type (e.g. paranoid)<br>F44. Dissociative D/O *specify type   | F60.9 Personality D/O, uns  |
| <b>PULMONARY D/O</b>   |  |   |   |
| <b>Obstructive/Chronic<br/>Pulmonary Disorders</b>   | COPD<br>COPD, w/Acute exacerbation<br><br><br>Emphysema<br>Chronic Bronchitis  | J44.9 Chronic obstructive pulmonary disease<br>J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation<br>J44.0 Obstr chr bronchitis w/acute bronchitis and/or acute lower respiratory infection<br>J43.9 Emphysema (includes emphysema w/ COPD)<br>J41.0 Simple chronic bronchitis<br>J44.9 Asthmatic or Emphysematous chronic bronch  | J44.9 COPD AND Chronic Obstructive Asthma, Unspecified<br><br><br>J43.9 Emphysema, unspec<br>J42 Unspecified chronic bronchitis |