Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 23 Spring 2022

In this Issue

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.

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PHP HMO SNP

PHC CALIFORNIA

Visit us 24/7 on the web:
PHP: www.php-ca.org
PHC California: www.phc-ca.org

P.O. Box 46160,
Los Angeles, CA 90046

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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
Pfizer-BioNTech (ages 5-11 years)	**1st Dose**	**2nd dose** (3 weeks after 1st dose)	**3rd dose** (at least 4 weeks after 2nd dose)			
Pfizer-BioNTech (ages 12 years and older)	**1st Dose**	**2nd dose** (3 weeks after 1st dose)	**3rd dose** (at least 4 weeks after 2nd dose)		**Booster dose** (at least 3 months after 3rd dose)	
Moderna (ages 18 years and older)	**1st Dose**	**2nd dose** (4 weeks after 1st dose)	**3rd dose** (at least 4 weeks after 2nd dose)			**Booster dose** (at least 3 months after 3rd dose)
Janssen (ages 18 years and older)	**1st Dose**	**2nd dose** (additional dose using an mRNA COVID-19 vaccine [at least 4 weeks after first dose])		**Booster dose** (at least 2 months after additional dose)		

Significant Updates to Medi-Cal Eligibility

American Rescue Act Plan (ARPA) Postpartum Care Coverage (PCE)

Under provisions of ARPA, DHCS is opting to extend the postpartum care period for currently eligible and newly eligible pregnant individuals, and broaden the scope of coverage to full-scope benefits during both the pregnancy and postpartum periods, effective April 1, 2022. The postpartum coverage period for individuals receiving pregnancy-related and postpartum care services as of April 1, 2022, will expand to include an additional ten months of coverage following the current 60-day postpartum period for a total of 12 months, without requiring a mental health diagnosis.

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 45years and older about the benefits of colorectal cancer screening and the options that PHP/PHC has available to members.

Medi-Cal Redetermination

During the COVID-19 public health emergency (PHE), Medi-Cal beneficiaries have not need to go through the annual redetermination process. Once the PHE is over, the annual redetermination process resumes. Please remind your Medi-Cal patients that If their contact information or household circumstances have changed, to please update their information as soon as possible by contacting their local county Dept. of Public Social Services (DPSS) office via phone at 1-866-613-3777 or online at https://www.yourbenefits.laclrs.org/ybn/SignInPage.html. This will help your patients keep their Medi-Cal coverage after the end of the COVID-19 PHE. Members may call Member Services for assistance with their redetermination paperwork if needed.

Medi-Cal Eligibility Expansion for Older Adults

Changes to Medi-Cal rules are coming! Medi-Cal will be available to all people who are 50 years of age or older who meet all Medi-Cal eligibility criteria, and immigration status will not matter. These changes will also let people keep more property and qualify for Medi-Cal. Please refer your patients to their local Dept. of Public Social Services (DPSS) office.

New PHC California Benefits

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year commitment by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing broad delivery system, program and payment. CalAIM seeks to transform Medi-Cal via:

Population Health Management	**Enhanced Care Management**	**Community Supports**
New Dental Benefits	**Behavioral Health Delivery System Transformation**	**Services and Supports for Justice-Involved Adults and Youth**
Transition to Statewide Dual Eligible Special Needs Plan and Managed Long-Term Services and Supports	**Standard Enrollment with Consistent Managed Care Benefits**	**Delivery System Transformation**

Today we are focusing on two key features: Enhanced Care Management (ECM) and Community Supports.

Enhanced Care Management (ECM)

- Addresses clinical and non-clinical needs of the highest -need individuals through the intensive coordination of services and care management

Community Supports

- Services that provide as a substitute for covered services such as hospital or skilled nursing facility admissions or emergency department use

Enhanced Care Management

The plan's Care Management staff are contacting PHC California members who meet one or more of the eligibility criteria listed below.

- Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need.
- Individuals who are considered high utilizers of care, including those who have had 5+ emergency department visits or 3+ unplanned hospital or short-term skilled nursing facility stays in the last 6 months, or those who have been identified by their health plan as having a pattern of high utilization that could have been avoided.
- Adults with serious mental illness (SMI) or substance use disorder (SUD) who are experiencing at least one complex social factor and meet additional criteria.
- Individuals transitioning from incarceration, or who have transitioned from incarceration within the past 12 months, who also have certain medical conditions.
- Individuals at risk for institutionalization and eligible for Long-Term Care services.
- Nursing facility residents who want to transition to the community and are strong candidates for a successful transition.

Members may also call PHC California to find out if and when they qualify to receive ECM services to enroll. Your patients may enquire about this program with you and may want to talk to you about ECM as a result of our outreach efforts. If you feel your PHC California patient may benefit from ECM services and meets the eligibility criteria based on the information we have provided you, please contact PHC California at 1-800-263-0067 or ECM-CA@ahf.org.

PHC California members who qualify for and consents to enroll into ECM will have their own care team, including an ECM care manager. This person will talk to them and their doctors, specialists, pharmacists, case managers, social services providers, and others. They will make sure everyone works together to get the member the care they need. An ECM care manager can also help members find and apply for other services in their community, including:

- Outreach and engagement
- Comprehensive assessment
- Care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Community Supports

The Community Supports program component will be integrated with care management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health.
Community Supports must be:

- medically-appropriate and cost-effective substitutes or settings for the State Plan service
- both optional for managed care plans to provide and for beneficiaries to use.
- authorized and identified in the managed care plan contracts.

PHC California's Current List of Community Supports

Housing Transition Navigation Services	**Housing Tenancy and Sustaining Services**
Personal Care and Homemaker Cervices	**Medically Tailored Meals/Medically Supportive Food**

For more information, please check out DHCS' CalAIM page at https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx.
For Plan specific questions regarding ECM and/or Community Supports, please contact Provider Relations at CAPR@ahf.org

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.1 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/PHC California 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/PHC California 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/medicareadvtgspecratestats/risk-adjustors.html

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

CONDITION/ CONDITION CATEGORY	ADDITIONAL DESCRIPTION	ICD-10 CODES & SECTION RANGE (ADDT'L SPECIFIC CODE DESCRIPTORS ** REQUIRED)	UNSPECIFIED/LESS SPECIFIC CODES
NERVOUS SYSTEM DISORDERS			
Inflammatory & Toxic Neuropathies	Polyneuropathy in other diseases classified elsewhere Alcoholic polyneuropathy Neuropathy due to drugs (including ARVs)	G63 Polyneuropathy in diseases classified elsewhere* G62.1 Alcoholic polyneuropathy G62.0 Drug-induced polyneuropathy G61.9 Inflammatory polyneuropathy	*Please specify disease (e.g. HIV, cancer, etc.)
LIVER AND DIGESTIVE SYSTEM DISORDERS			
Cirrhosis **Alcoholic, cirrhosis**	Cirrhosis of liver without alcohol	K74.60 Cirrhosis of liver K70.30 Alcoholic cirrhosis of liver w/o ascites K70.31 Alcoholic cirrhosis of liver w/ ascites K70.9 Alcoholic liver disease	K74.60 Cirrhosis, unspec (code also Alcohol Dependence F10.20 or Hx of Alcohol Depend F10.21)
Hepatitis	Chronic Hepatitis C Chronic Hepatitis B	B18.2 Chronic viral Hepatitis C (includes Hepatitis C Carrier) B18.1 Chronic viral Hepatitis B without delta-agent (includes Hepatitis B Carrier) B18.0 Chronic viral Hepatitis B with delta-agent	
Esophageal Varices **Portal Hypertension**	Primary Esophageal Varices Esophageal Varices due to cirrhosis, alcoholic liver dz, portal htn, etc.	I85.00 Esophageal varices w/o bleeding I85.01 Esophageal varices w/ bleeding I85.10 Secondary esophageal varices w/o bleeding I8511 Secondary esophageal varices w/ bleeding K76.6 Portal hypertension	
MENTAL HEALTH AND SUBSTANCE DEPENDENCE & ABUSE DISORDERS			
Substance Use Disorder, **Moderate/Severe, or Substance Use with Complications**	Alcohol Dependence Amphetamine and Other Stimulant Dependence Cocaine Dependence Opioid Dependence Cannabis Dependence Other or Unspecified Drug Dependence	F10.20 Alcohol dependence, uncomplicated F10.21 Alcohol dependence, in remission (or Hx of) F15.20 Stimulant dependence, uncomplicated F15.21 Stimulant dependence, in remission (or Hx) F14.20 Cocaine dependence, uncomplicated F14.21 Cocaine dependence, in remission (or Hx of) F11.20 Opioid dependence, uncomplicated F11.21 Opioid dependence, in remission (or Hx of) F12.20 Cannabis dependence, uncomplicated F12.21 Cannabis dependence, in remission (or Hx) F19.20 Other psychoactive substance dependence F19.21 Other psychoactive substance dependence, in remission (or Hx of)	
Substance Use Disorder, Mild, Except Alcohol and Cannabis	Amphetamine and Other Stimulant Abuse Cocaine Abuse Opioid Abuse Other or Unspecified Drug Abuse	F15.10 Stimulant abuse, uncomplicated F15.11 Stimulant abuse, in remission F14.10 Cocaine abuse, uncomplicated F14.11 Cocaine abuse, in remission F11.10 Opioid abuse, uncomplicated F11.11 Opioid abuse, in remission F19.10 Other psychoactive substance abuse F19.11 Other substance abuse, in remission	
Schizophrenia		F20.0 Paranoid, F20.1 Disorganized F25.9 Schizoaffective disorder	F20.9 Schizophrenia, unsp
Reactive and Unspecified Psychosis		F23 Brief psychotic disorder F28 Other psychotic disorder, not due to substance	F29 Unspecified psychosis, not due to substance
	Major Depressive Disorder Bipolar Disorder	F33._ MDD, recurrent *specify severity current ep F33.40 MDD, recurrent, in remission F32._ MDD, single episode, *specify severity of ep F32.5 MDD, single episode, in remission F31._ Bipolar D/O – specify type & severity	F33.9 MDD, recurrent, uns *mild 0, mod 1, severe 2, etc F31.9 Bipolar D/O, unspec
Personality Disorders	Personality Disorders Dissociative Disorders	F60._ P ersonality D/O *specify type (e.g. paranoid) F44._ Dissociative D/O *specify type	F60.9 Personality D/O, uns
PULMONARY D/O			
Obstructive/Chronic Pulmonary Disorders	COPD COPD, w/Acute exacerbation Emphysema Chronic Bronchitis	J44.9 Chronic obstructive pulmonary disease J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation J44.0 Obstr chr bronchitis w/acute bronchitis and/or acute lower respiratory infection J43.9 Emphysema (includes emphysema w/ COPD) J41.0 Simple chronic bronchitis J44.9 Asthmatic or Emphysematous chronic bronch	J44.9 COPD AND Chronic Obstructive Asthma, Unspecified J43.9 Emphysema, unspec J42 Unspecified chronic bronchitis