Total Care Advantage (HMO D-SNP)

Introduction to the Annual Wellness Visit and Quality Coding Provider Training

Part 1 of 2

2026

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE

Gold Coast Health Plan Presenters and Resources

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GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE

Course Objectives

1. Learn about Total Care Advantage, the new Medicare Advantage plan offered by Gold Coast Health Plan (GCHP)
2. Understand GCHP's approach to Quality Coding
3. Understand Medicare Advantage Payment Model and the Basics of Risk Adjustment
4. Learn the Components of Annual Wellness Visits and Local Workflows

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Introducing….

GOLD COAST HEALTH PLAN

TOTAL Care

ADVANTAGE

A **local** health plan.

Created in **our community**.

Created for **our community**.

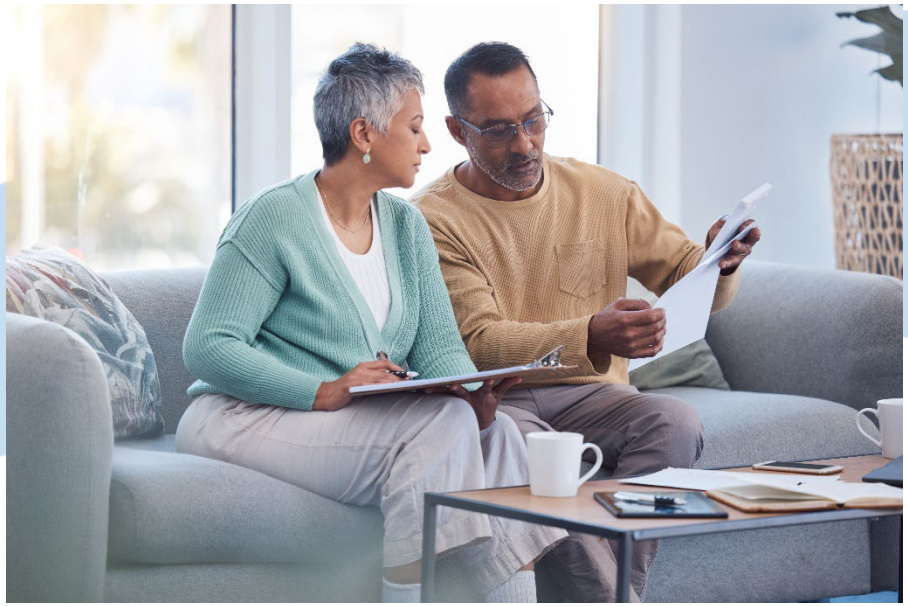
GCHP'S Total Care Advantage

As a **Medicare Advantage and Part D Plan** (MAPD or MA Plan), Total Care Advantage is a way for members to get Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are Medicare-approved plans. We must follow rules set by Medicare. Like, most Medicare Advantage Plans, Total Care Advantage includes drug coverage (Part D).

Dual Eligible Special Needs Plans (D-SNPs) are a type of MA Plan that enrolls people who have both Medicare and Medicaid (Medi-Cal in California). D-SNPs are required to have a Model of Care (MOC) that meets the needs of the members they serve.

In addition to Medicare benefits, Total Care Advantage provides all **Medi-Cal benefits,** including wrap-around services, such as:

- Medicare cost-sharing
- Long-term services and supports (LTSS)
- Transportation
- Community Supports



Enrollment is **voluntary**. Members can join if they:

- Have both Medicare Part A and B
- Have full-scope Medi-Cal
- Are 21 years or older
- Live in Ventura County

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Total Care Advantage Member Needs

Over 60% of our members have three or more chronic conditions and 15% have more than 10 chronic conditions.

The most common chronic conditions are hypertension, diabetes, depression, anxiety, kidney disease, arthritis and heart disease.

Many members, especially our younger members, have frailty (21%) and need the help from others for activities of daily living, like bathing, dressing and eating (6%).

Total Care Advantage members are more likely to be hospitalized and need support after the hospitalization than members who are not in D-SNPs.

More than 50% of our members are concerned that they will run out of food because they don't have money to buy more food.
More than 20% don't have transportation to get to the doctor or to go other places they need to go.

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Quality Coding

Understanding GCHP's approach

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Total Care Advantage Quality Coding Program

GCHP's Quality Coding Program is designed to ensure D-SNP quality performance and efficient delivery of integrated, high-quality care that addresses the complex medical, behavioral, and social needs of our members.

In the context of D-SNP, quality is evaluated by the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System and the accurate, timely identification and treatment of chronic conditions. Through the Quality Coding Program, GCHP aims to support providers to ensure quality improvement, regulatory compliance, and appropriate payment.

The program focuses on:

1. Ensuring access to comprehensive preventive care including the Initial Preventive Physical Exam (IPPE) and the Annual Wellness Visit (AWV).
2. High-quality care as measured by CMS Five-Star Quality Program.
3. Compliant, complete, and timely capture of diagnoses that accurately reflect patient complexity and quality treatment of those diagnoses.
4. Mitigation of risk of overpayments/underpayments by ensuring clinical documentation supports clinical conditions.

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Medicare Advantage Payment Model

Understanding the Basics of CMS Risk Adjustment

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CMS Risk Adjustment Overview

- CMS introduced Hierarchical Condition Categories (HCC) in 2004 to better predict future healthcare costs based on patient severity and chronic illness.
- Each HCC is linked to a specific diagnosis or a cluster of diagnoses based on clinical similarities and anticipated healthcare costs.
- The HCCs are combined with demographic factors to create a member-specific risk adjustment factor (RAF).
  - RAF is a numerical value (score) used by Medicare to predict a beneficiary's expected healthcare costs based on their health condition(s)
- **CMS is now on Version 28 (V28) of its Risk Adjustment model:**
  - V28 is more restrictive than the previous version (v24) and **focuses on clinical severity rather than the diagnosis volume.**
  - V28 maps thousands of ICD codes int**o 115 HCCs** to determine RAF.
- CMS has proposed a 2027 Model that:
  - Will use more recent data to calibrate the model.
  - Has new modifier codes used to exclude audio-only services.
  - Removes data from chart reviews that are not linked to an encounter.

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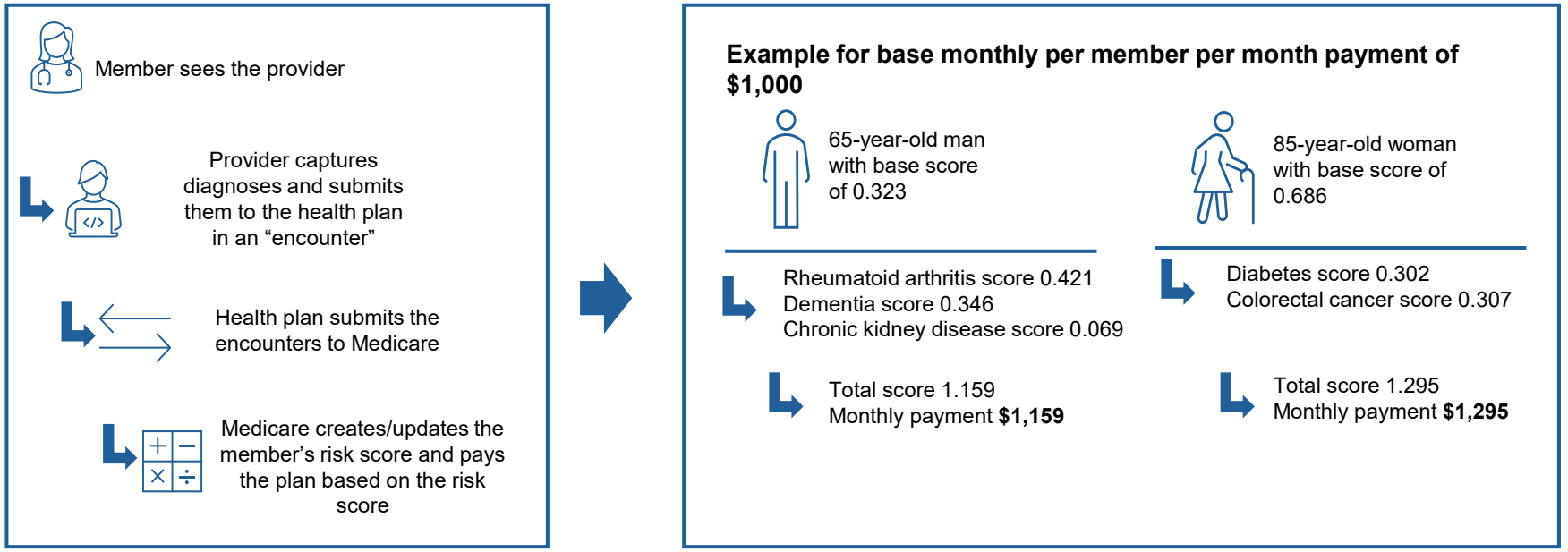
The Process to Develop a Member-Specific Risk Adjustment Score

Revenue to Plan: CMS pays the plan a capitated premium amount each month to cover the total cost of care for each member; the premium amount is based on each member's acuity.

Member Acuity: Acuity is measured through the capture of Hierarchical Condition Categories (HCC), which are combined to assign an individual Risk Adjustment Factor (RAF) score.

Risk Adjustment Factor (RAF) Score: A numerical value used to estimate a member's expected healthcare costs based on demographics (age, sex) and health status. The more acute a member, the higher their RAF score. **The RAF is reset every year.**



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Why Quality Coding Matters

Quality coding is the translation of clinical care into a standardized language used for reimbursement, research, and population health.

- **Plan Reimbursement:** Accurate documentation and coding leads to an accurate RAF score.
  - Accurate RAF score ensures the plan receives adequate funding from Medicare to provide high-quality care.
- **Provider Reimbursement:** Accurate documentation and coding supports accurate billing, ensuring providers are paid for the care they deliver.
- **Patient Care:** Accurate documentation and coding provides a clear clinical picture of the patient for other providers, ensuring quality care and patient safety.
- **Performance Metrics:** Quality Star Rating scores (HEDIS, Health Outcome Survey (HOS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) are derived directly from the codes submitted and care that happens in the provider's office.

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Common HCCs Providers Will See

- Diabetes (with and without complications)
- Congestive heart failure and cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic kidney disease (3 - 5)
- Atrial fibrillation
- Depression / bipolar
- Dementia
- Cancer
- Ulcers
- Vascular disease
- RA / connective tissue disorders
- Severe GI disease (Crohn's, UC)
- Substance use disorders

These 13 conditions drive 80% of risk score impacts.

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Diabetes

- Specify the type
- Note the cause and state any causal relationships
- Document all complications and disease interactions
- Record any treatment
- Include supporting evidence

Diabetes with ANY complication, including hyperglycemia,

Risk score: 0.186

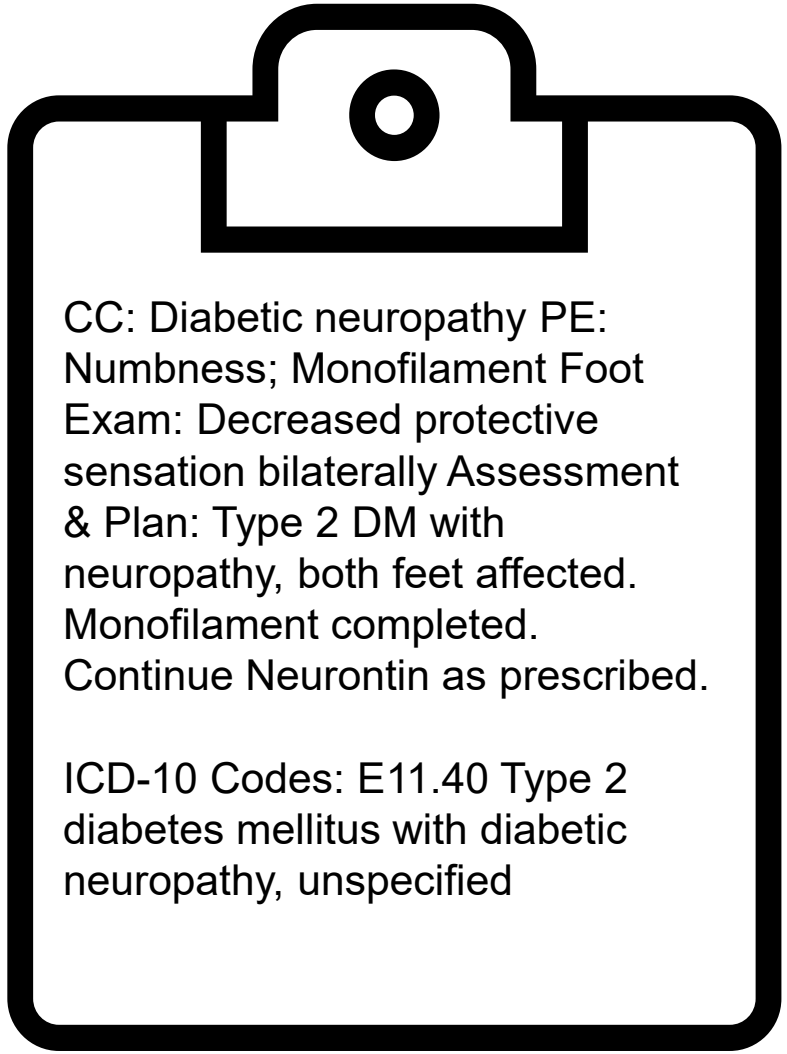
VS

Diabetes and Heart Failure combined result in an interaction score boost

Risk score: +0.183

31% of GCHP Total Duals 65+ have type 2 diabetes.

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



The assessment and plan thoroughly address the patient's diabetic neuropathy. An in office physical exam and monofilament test provide additional support for the diagnosis, and prescribed medications have been linked to the condition.

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Heart Failure (HF) and Cardiomyopathy

Cardiomyopathy has a lower HCC than heart failure. Do not use cardiomyopathy as a diagnosis when heart failure is more accurate.

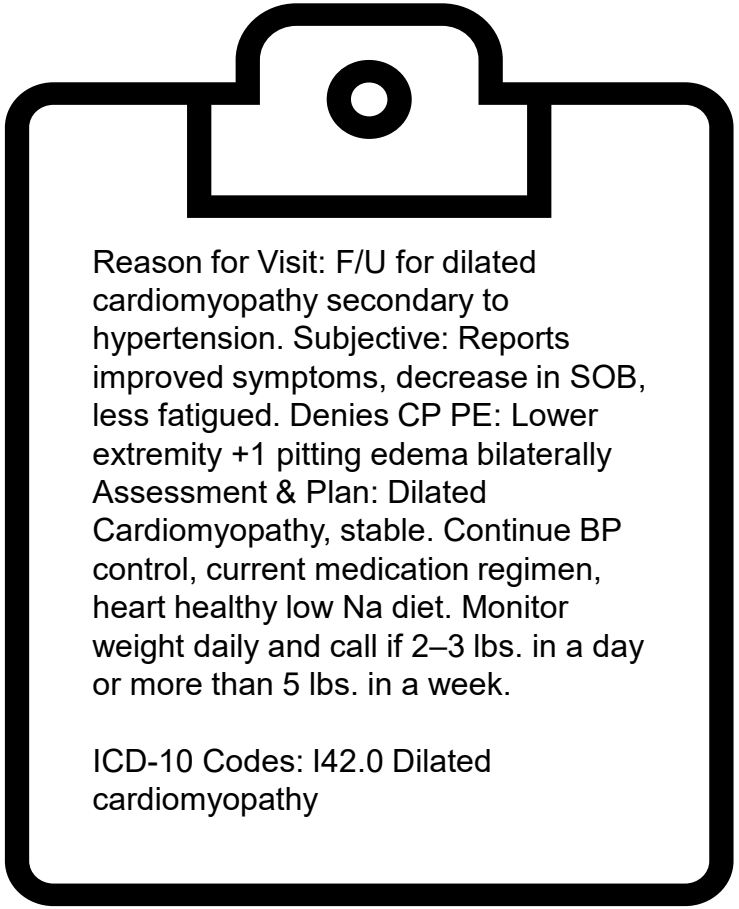
- Specify the precise type using all available descriptive details (e.g., dilated cardiomyopathy or acute on chronic heart failure with preserved ejection fraction)
- Specify the cause using terminology that clearly establishes causality, such as “associated with,” “due to,” or “secondary to”
- Describe the status as “stable,” “worsening,” “improved,” “compensated,” or “decompensated,” avoiding the term “history of” as it implies a past, resolved condition
- Record all present and absent signs and symptoms related to the patient’s condition during the visit (e.g., has shortness of breath or no swelling of lower legs)
- Understand and document co-morbidities

Acute on Chronic Heart Failure, Acute Heart Failure (Excludes Acute on Chronic), and Heart Failure, Except End Stage and Acute
Risk score: 0.406

VS

Cardiomyopathy/Myocarditis
Risk score: 0.173

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



Reason for Visit: F/U for dilated cardiomyopathy secondary to hypertension. Subjective: Reports improved symptoms, decrease in SOB, less fatigued. Denies CP PE: Lower extremity +1 pitting edema bilaterally Assessment & Plan: Dilated Cardiomyopathy, stable. Continue BP control, current medication regimen, heart healthy low Na diet. Monitor weight daily and call if 2–3 lbs. in a day or more than 5 lbs. in a week.

ICD-10 Codes: I42.0 Dilated cardiomyopathy

The provider specifically addressed the type of cardiomyopathy, documented a cause and current symptoms, and reported a stable status in the assessment.

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Cancer

- CMS is intentional in its HCC assignment with cancers
- It is vital to specify the diagnosis and assign the correct ICD-10 code
- Correct ICD-10 impacts HCC assignment of the cancer, which can affect the payment for care
- “History of” cancer diagnoses starting with a “Z” should only be used for resolved or past diagnoses.

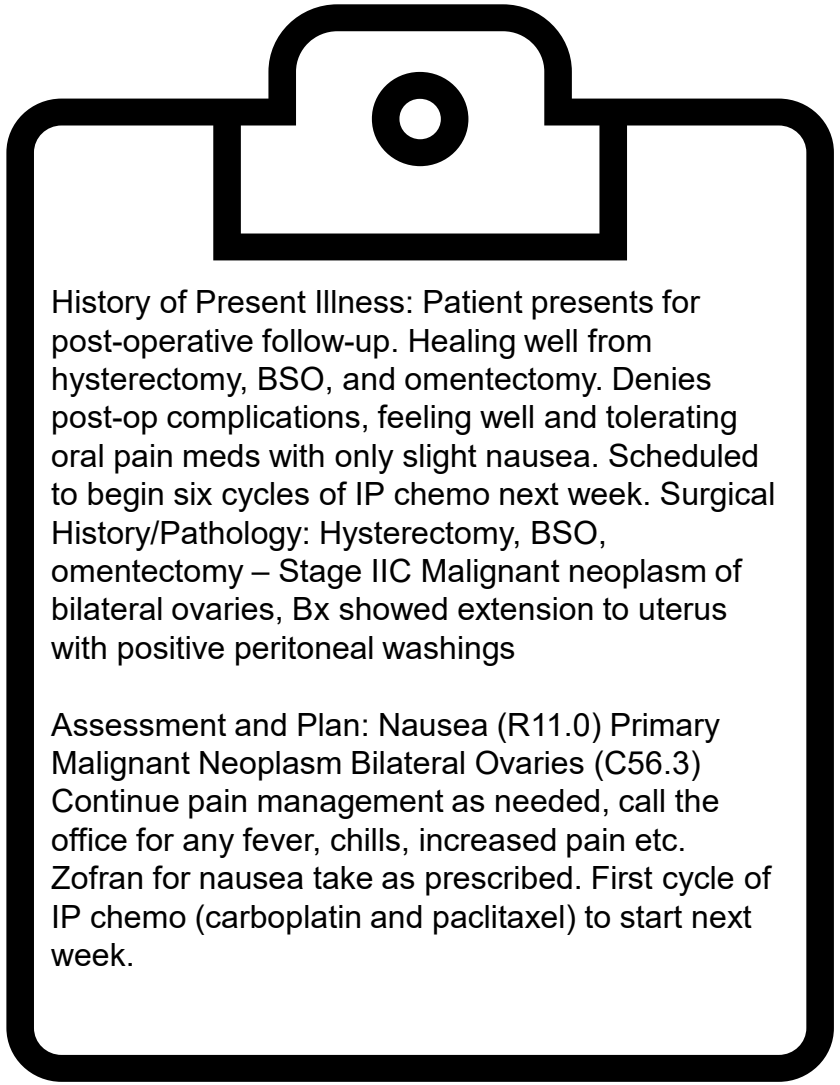
Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic

Risk score: 3.896

VS

Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
Risk score: 2.277

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



History of Present Illness: Patient presents for post-operative follow-up. Healing well from hysterectomy, BSO, and omentectomy. Denies post-op complications, feeling well and tolerating oral pain meds with only slight nausea. Scheduled to begin six cycles of IP chemo next week. Surgical History/Pathology: Hysterectomy, BSO, omentectomy – Stage IIC Malignant neoplasm of bilateral ovaries, Bx showed extension to uterus with positive peritoneal washings

Assessment and Plan: Nausea (R11.0) Primary Malignant Neoplasm Bilateral Ovaries (C56.3) Continue pain management as needed, call the office for any fever, chills, increased pain etc. Zofran for nausea take as prescribed. First cycle of IP chemo (carboplatin and paclitaxel) to start next week.

The clinician has appropriately documented the ovarian cancer as an active and current condition, documenting the current chemotherapy plan and addressing laterality for specificity.

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Chronic Kidney Disease (CKD)

- State the CKD stage based on the eGFR and identify the underlying condition (e.g., diabetes and hypertension) causing the CKD. CKD stages 2 or lower and unspecified do not contribute to RAF.
- Note patient symptoms (e.g., fatigue, weakness, changes in urine output) and physical exam findings (e.g., elevated blood pressure, edema – signs of fluid overload).
- Clearly document any significant changes in kidney function or clinical status and their potential causes.
- Document followup plans and repeat testing schedules to track progression.
- Include the following in the treatment plan: medications (including dosage), dietary modifications, blood pressure management, or referral to nephrologist.
- Interpret and include any lab results (e.g., serum creatinine, eGFR calculation, etc.).
- Specify the type of dialysis, frequency, and access site.

Chronic Kidney Disease, Moderate (Stage 3B) Risk score: 0.116

VS

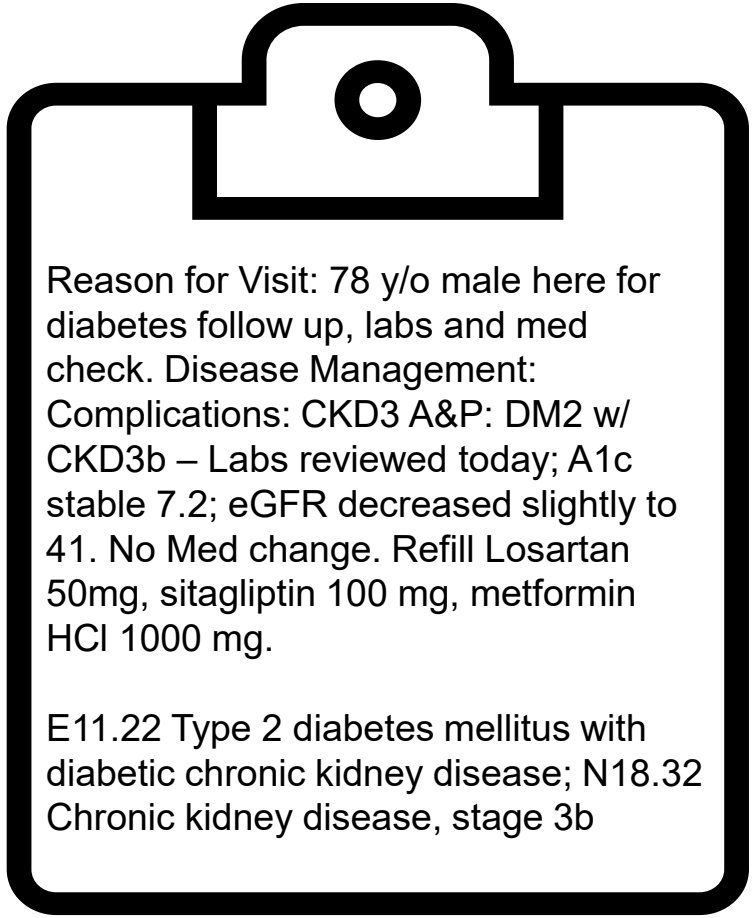
Chronic Kidney Disease, Severe (Stage 4) Risk score: 0.565

VS

Chronic Kidney Disease (Stage 5) Risk score: 0.985

13% of GCHP duals 65+ have a diagnosis of chronic renal failure.

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



Reason for Visit: 78 y/o male here for diabetes follow up, labs and med check. Disease Management: Complications: CKD3 A&P: DM2 w/ CKD3b – Labs reviewed today; A1c stable 7.2; eGFR decreased slightly to 41. No Med change. Refill Losartan 50mg, sitagliptin 100 mg, metformin HCl 1000 mg.

E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease; N18.32 Chronic kidney disease, stage 3b

The documentation reflects diabetes complicated by CKD. The provider reviewed the patient's labs to determine the specific CKD stage and formulated a treatment plan that included medication review.

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Behavioral and Personality Disorders

- Distinguish developmental versus intellectual disorders and classify the severity: Mild, Moderate, Severe
- Document any cognitive, language/speech, or physical impairments
- Link medications to the associated condition
- Document and code any associated comorbidities
- Document and code any underlying genetic disorders
- Distinguish from other underlying brain disease (chemical-related, epilepsy, etc.
- Mild depression or anxiety does not contribute to the RAF

Major Depression, Moderate or Severe, without Psychosis
Risk score: 0.316

VS

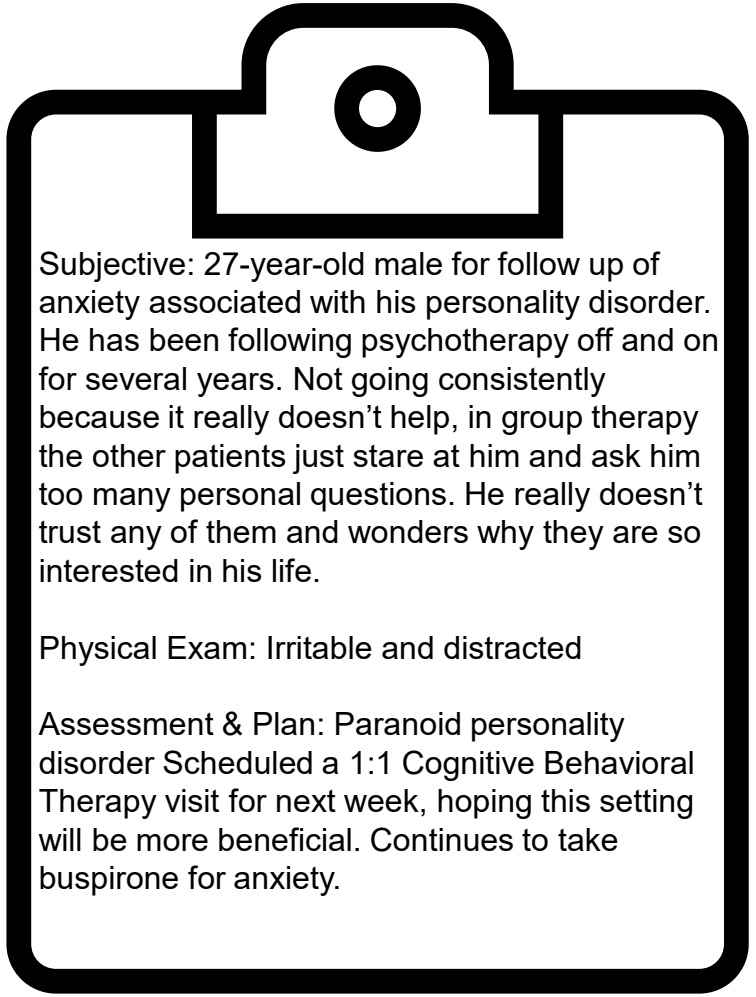
Personality Disorders; Anorexia/Bulimia Nervosa
Risk score: 0.420

VS

Schizophrenia
Risk score: 0.591

14% of GCHP younger duals (those 21 to 64) have a diagnosis of schizophrenia and affective psychosis.

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



Subjective: 27-year-old male for follow up of anxiety associated with his personality disorder. He has been following psychotherapy off and on for several years. Not going consistently because it really doesn't help, in group therapy the other patients just stare at him and ask him too many personal questions. He really doesn't trust any of them and wonders why they are so interested in his life.

Physical Exam: Irritable and distracted

Assessment & Plan: Paranoid personality disorder Scheduled a 1:1 Cognitive Behavioral Therapy visit for next week, hoping this setting will be more beneficial. Continues to take buspirone for anxiety.

The provider has documented behavioral signs and symptoms. In the A&P the provider specifically addressed the personality disorder, documented the type and indicated current treatment and management. Based on the documentation in the note, it is appropriate to code Paranoid Personality Disorder (F60.0).

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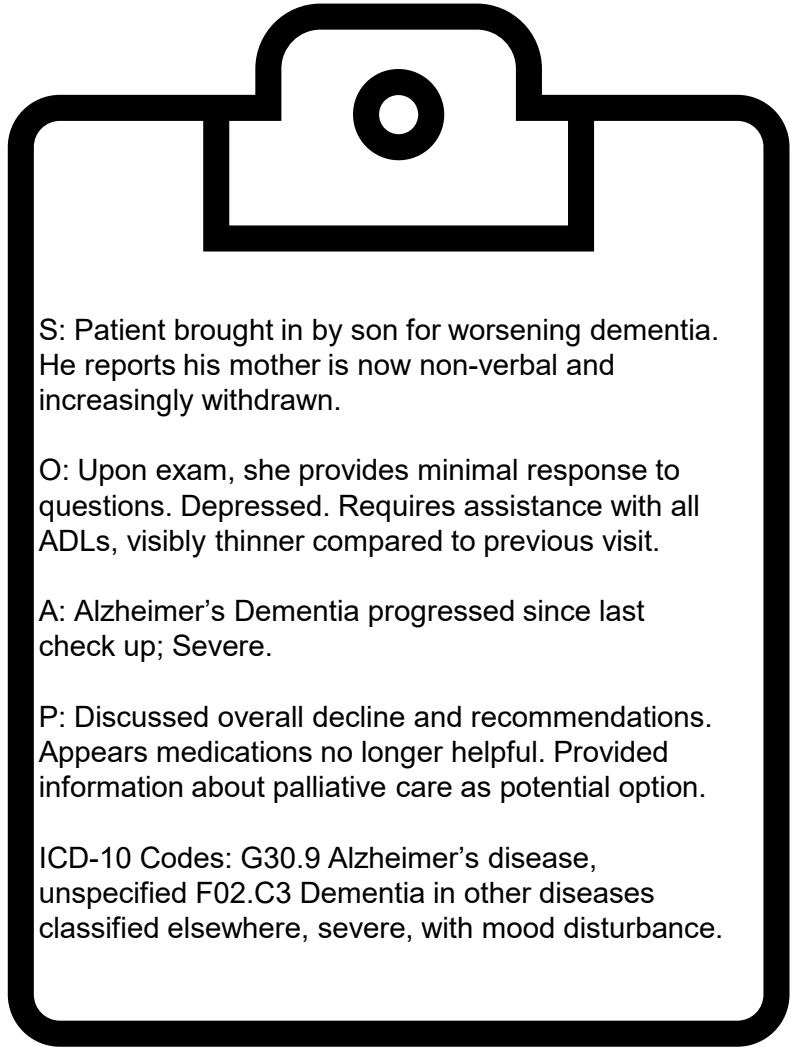
Dementia

- Document the Severity:
  - Mild: Clearly evident functional impact on daily life, affecting mainly instrumental activities. No longer fully independent/requires occasional assistance with daily life activities.
  - Moderate: Extensive functional impact on daily life with impairment in basic activities. No longer independent and requires frequent assistance with daily life activities.
  - Severe: Clinical interview may not be possible. Complete dependency due to severe functional impact on daily life with impairment in basic activities, including basic self care.
- Document Clear Description of Behaviors
- Document the Type: Document the specific type (e.g., Alzheimer's, Vascular, Frontotemporal, Lewy body) rather than just "dementia."
- Document the Underlying Cause ("due to") whenever possible
  - Vascular due to disease (Include ICD-10 code for underlying condition), or unspecified.

Dementia, Mild or Unspecified, Moderate or Severe, with or without behavioral disturbance
Risk score: 0.438

Note: Scenarios are for illustration purposes only. Actual scores vary based on multiple factors.



S: Patient brought in by son for worsening dementia. He reports his mother is now non-verbal and increasingly withdrawn.

O: Upon exam, she provides minimal response to questions. Depressed. Requires assistance with all ADLs, visibly thinner compared to previous visit.

A: Alzheimer's Dementia progressed since last check up; Severe.

P: Discussed overall decline and recommendations. Appears medications no longer helpful. Provided information about palliative care as potential option.

ICD-10 Codes: G30.9 Alzheimer's disease, unspecified F02.C3 Dementia in other diseases classified elsewhere, severe, with mood disturbance.

The provider documented severe Alzheimer's Dementia (severity and type), noting depression as a current behavioral disturbance observed during the exam. Recommendations were provided based on the clinical picture.

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Substance Use Disorder

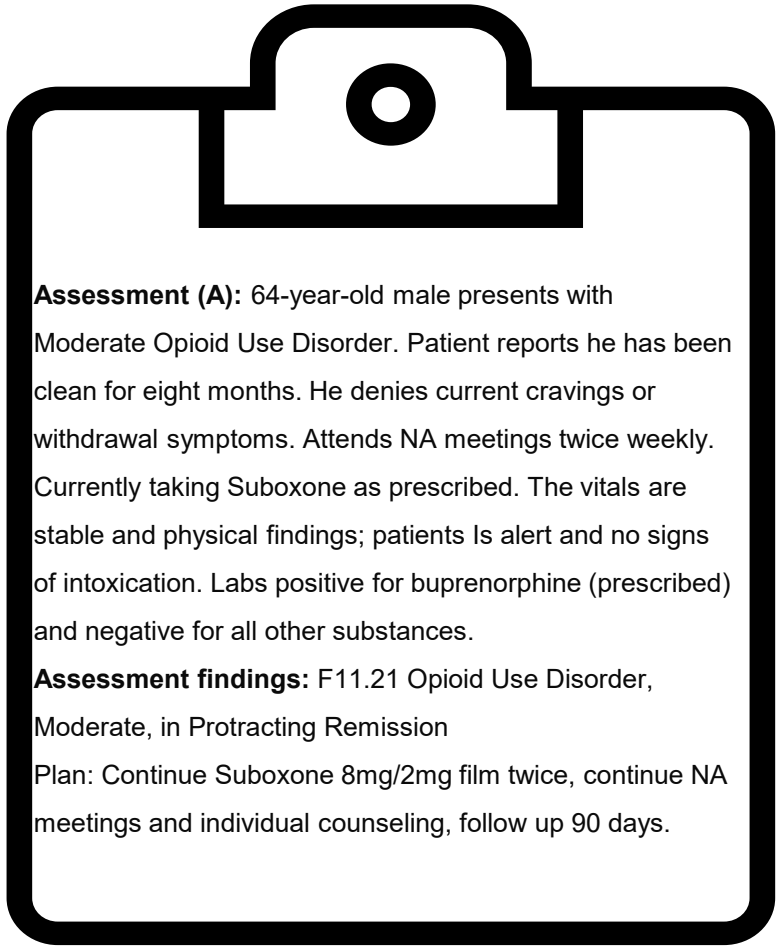
- To accurately document substance use disorder (SUD) for clinical care and RAF scoring, you must capture the specific substance (e.g., alcohol, opioid, cocaine), the severity (Mild, Moderate, or Severe), and the status (In Remission vs. Active)
- Under V28 CMS-HCC model, coding remission still carries a RAF weight, making precise status documentation vital.
- Document physical (withdrawal, tremors, intoxication) or psychological (cravings) findings
- Document usage frequency
- Determine the severity based on DSM-5 criteria
- Document referrals to therapy, prescriptions or 12-step program attendance

Treatment Plan:

Pharmacotherapy	Behavioral Health	Support System

Note: Coding Status: Active vs. Remission

- Active: Use when the patient is currently using or has use within last 30 days.
- In Remission: Use only if the patients has met zero DSM-5 criteria (except cravings) for at least three months (early remission) or 12 months (sustained remission)



Assessment (A): 64-year-old male presents with Moderate Opioid Use Disorder. Patient reports he has been clean for eight months. He denies current cravings or withdrawal symptoms. Attends NA meetings twice weekly. Currently taking Suboxone as prescribed. The vitals are stable and physical findings; patients Is alert and no signs of intoxication. Labs positive for buprenorphine (prescribed) and negative for all other substances.

Assessment findings: F11.21 Opioid Use Disorder, Moderate, in Protracting Remission

Plan: Continue Suboxone 8mg/2mg film twice, continue NA meetings and individual counseling, follow up 90 days.

Under V28, both Active and In Remission status still map to an HCC and generate a RAF score, but the values vary based on the specific substance and the severity.
Drug Use disorder (Moderate/Severe or In Remission) Maps to HCC 135, RAF Value-0.435
Alcohol use disorder (Moderate/Severe or In Remission) Maps to HCC138, RAF Value-0.170

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Pressure Ulcers

- Documentation MUST specify “pressure” and include: Site, Severity, Laterality, and Stage
- Stage 1: Skin changes, nonblanchable erythema
- Stage 2: An abrasion, blister and Partial thickness skin loss involving dermis and epidermis
- Stage 3: Full thickness skin loss involving damage and necrosis to subcutaneous tissue
- Stage 4: Full-thickness tissue loss, necrosis of soft tissues through underlying muscle, tendon, bone
- Deep Tissue Damage: Etiology is pressure and/or ischemia and may resolve without tissue loss
- Unstageable: Based on clinical documentation stage undetermined

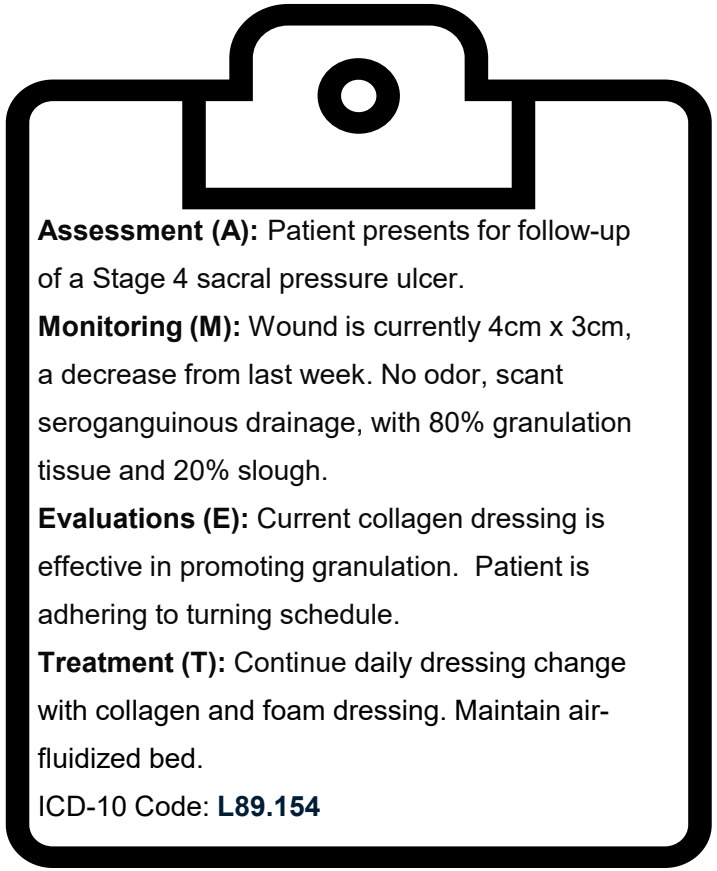
Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
Risk score: 2.580

VS

Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle Risk score: 1.422

VS

Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle
Risk score: 0.890



The provider has documented stage and site, and specifics related to the change/improvement since last visit. Evaluation of treatment efficacy and continued treatment ensure that the documentation is complete.

Note: Scenarios are for illustration purposes only.

Actual scores vary based on multiple factors.

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HCC Quick Reference

Why Exact Scores aren't listed on a chart:

- It is a common misconception among clinical staff that an HCC code translate to a flat number (e.g., diabetes equals to 0.166 points). The final Risk Adjustment Factor (RAF) score is entirely unique to the patient.
- The score is a math equation based on three moving parts.
  - Demographic Base Score
  - The HCC Disease Weight
  - Disease Interactions: If a patient has two specific conditions that compound each other, CMS adds a bonus "interaction" multiplier to the score because managing both together is highly complex.

Because the demographic base score changes the math for every single patient, coders and billers rely on software to calculate the exact financial weigh, rather than paper chart.

When building reference materials, it is important to emphasize that V28 changed how conditions are scored. The biggest change is a concept called "Constraining." To prevent over-coding, CMS now groups many related conditions together and gives them the exact same risk weight, complications or not.

Complete list of scores begin on page 183:
https://www.cms.gov/files/document/2024-announcement-pdf.pdf

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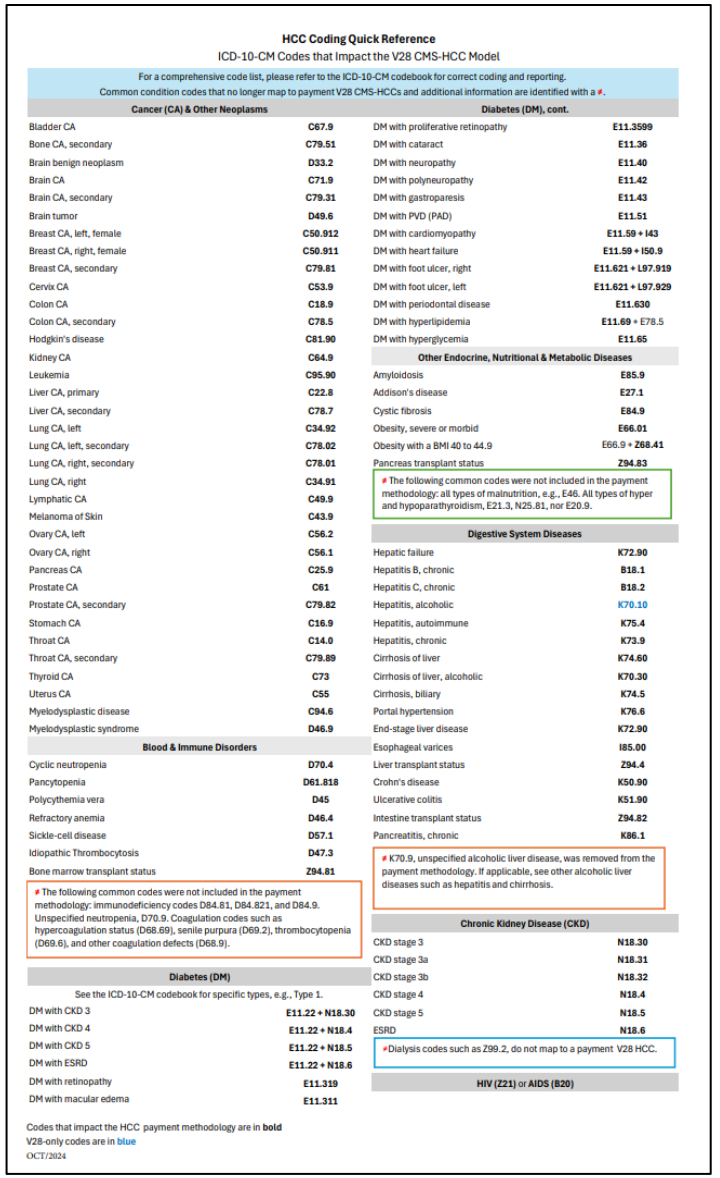

HCC Coding Quick Reference

ICD-10-CM Codes that Impact the V28 CMS-HCC Model

For a comprehensive code list, please refer to the ICD-10-CM codebook for correct coding and reporting.
Common condition codes that no longer map to payment V28 CMS-HCCs and additional information are identified with a #.

Cancer (CA) & Other Neoplasms	
Bladder CA	C67.9
Bone CA, secondary	C79.51
Brain benign neoplasm	D33.2
Brain CA	C71.9
Brain CA, secondary	C79.31
Brain tumor	D49.6
Breast CA, left, female	C50.912
Breast CA, right, female	C50.911
Breast CA, secondary	C79.81
Cervix CA	C53.9
Colon CA	C18.9
Colon CA, secondary	C78.5
Hodgkin's disease	C81.90
Kidney CA	C64.9
Leukemia	C95.90
Liver CA, primary	C22.8
Liver CA, secondary	C78.7
Lung CA, left	C34.92
Lung CA, left, secondary	C78.02
Lung CA, right, secondary	C78.01
Lung CA, right	C34.91
Lymphatic CA	C49.9
Melanoma of Skin	C43.9
Ovary CA, left	C56.2
Ovary CA, right	C56.1
Pancreas CA	C25.9
Prostate CA	C61
Prostate CA, secondary	C79.82
Stomach CA	C16.9
Throat CA	C14.0
Throat CA, secondary	C79.89
Thyroid CA	C73
Uterus CA	C55
Myelodysplastic disease	C94.6
Myelodysplastic syndrome	D46.9
Blood & Immune Disorders	
Cyclic neutropenia	D70.4
Pancytopenia	D61.818
Polycythemia vera	D45
Refractory anemia	D46.4
Sickle-cell disease	D57.1
Idiopathic Thrombocytosis	D47.3
Bone marrow transplant status	Z94.81

The following common codes were not included in the payment methodology: immunodeficiency codes D84.81, D84.821, and D84.9. Unspecified neutropenia, D70.9. Coagulation codes such as hypercoagulation status (D68.69), senile purpura (D69.2), thrombocytopenia (D69.6), and other coagulation defects (D68.9).

Diabetes (DM)	
See the ICD-10-CM codebook for specific types, e.g., Type 1.	
DM with CKD 3	E11.22 + N18.30
DM with CKD 4	E11.22 + N18.4
DM with CKD 5	E11.22 + N18.5
DM with ESRD	E11.22 + N18.6
DM with retinopathy	E11.319
DM with macular edema	E11.311
DM with proliferative retinopathy	E11.3599
DM with cataract	E11.36
DM with neuropathy	E11.40
DM with polyneuropathy	E11.42
DM with gastroparesis	E11.43
DM with PVD (PAD)	E11.51
DM with cardiomyopathy	E11.59 + I43
DM with heart failure	E11.59 + I50.9
DM with foot ulcer, right	E11.621 + L97.919
DM with foot ulcer, left	E11.621 + L97.929
DM with periodontal disease	E11.630
DM with hyperlipidemia	E11.69 + E78.5
DM with hyperglycemia	E11.65
Other Endocrine, Nutritional & Metabolic Diseases	
Amyloidosis	E85.9
Addison's disease	E27.1
Cystic fibrosis	E84.9
Obesity, severe or morbid	E66.01
Obesity with a BMI 40 to 44.9	E66.9 + Z68.41
Pancreas transplant status	Z94.83

The following common codes were not included in the payment methodology: all types of malnutrition, e.g., E46. All types of hyper and hypoparathyroidism, E21.3, N25.81, nor E20.9.

Digestive System Diseases	
Hepatic failure	K72.90
Hepatitis B, chronic	B18.1
Hepatitis C, chronic	B18.2
Hepatitis, alcoholic	K70.10
Hepatitis, autoimmune	K75.4
Hepatitis, chronic	K73.9
Cirrhosis of liver	K74.60
Cirrhosis of liver, alcoholic	K70.30
Cirrhosis, biliary	K74.5
Portal hypertension	K76.6
End-stage liver disease	K72.90
Esophageal varices	I85.00
Liver transplant status	Z94.4
Crohn's disease	K50.90
Ulcerative colitis	K51.90
Intestine transplant status	Z94.82
Pancreatitis, chronic	K86.1

K70.9, unspecified alcoholic liver disease, was removed from the payment methodology. If applicable, see other alcoholic liver diseases such as hepatitis and chirrhosis.

Chronic Kidney Disease (CKD)	
CKD stage 3	N18.30
CKD stage 3a	N18.31
CKD stage 3b	N18.32
CKD stage 4	N18.4
CKD stage 5	N18.5
ESRD	N18.6

Dialysis codes such as Z99.2, do not map to a payment V28 HCC.

HIV (Z21) or AIDS (B20)

Codes that impact the HCC payment methodology are in **bold**
V28-only codes are in blue
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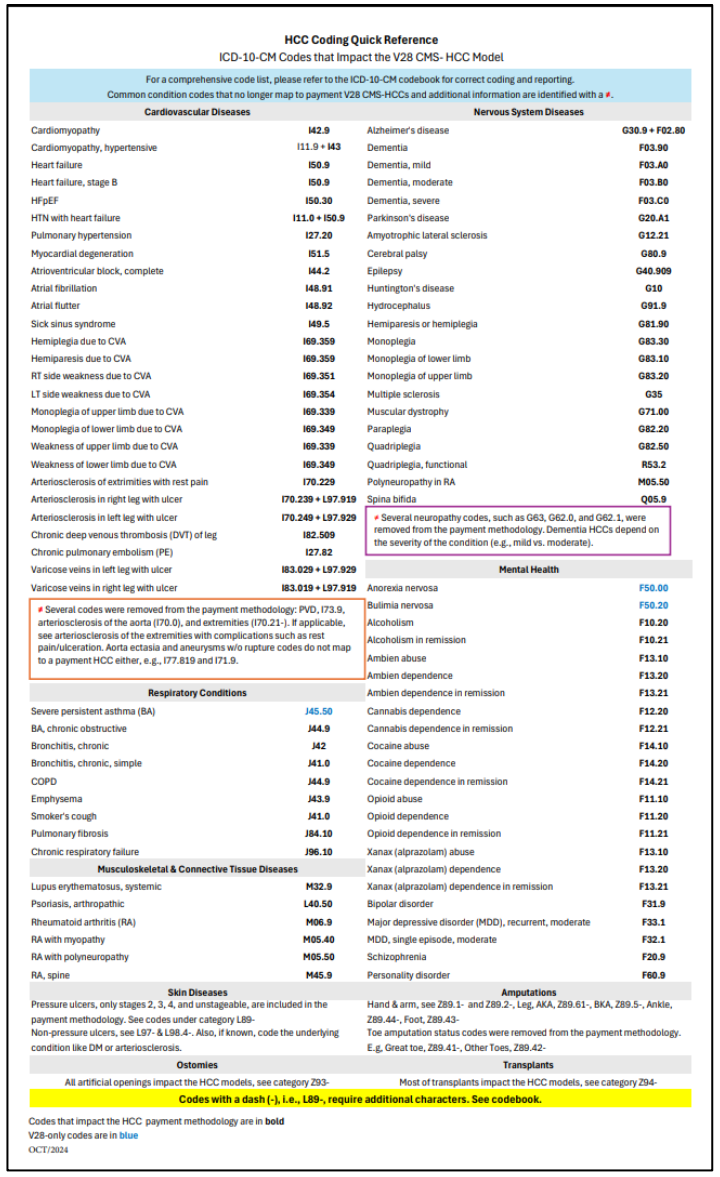

HCC Coding Quick Reference

ICD-10-CM Codes that Impact the V28 CMS- HCC Model

For a comprehensive code list, please refer to the ICD-10-CM codebook for correct coding and reporting.
Common condition codes that no longer map to payment V28 CMS-HCCs and additional information are identified with a #.

Cardiovascular Diseases	
Cardiomyopathy	I42.9
Cardiomyopathy, hypertensive	I11.9 + I43
Heart failure	I50.9
Heart failure, stage B	I50.9
HFpEF	I50.30
HTN with heart failure	I11.0 + I50.9
Pulmonary hypertension	I27.20
Myocardial degeneration	I51.5
Atrioventricular block, complete	I44.2
Atrial fibrillation	I48.91
Atrial flutter	I48.92
Sick sinus syndrome	I49.5
Hemiplegia due to CVA	I69.359
Hemiparesis due to CVA	I69.359
RT side weakness due to CVA	I69.351
LT side weakness due to CVA	I69.354
Monoplegia of upper limb due to CVA	I69.339
Monoplegia of lower limb due to CVA	I69.349
Weakness of upper limb due to CVA	I69.339
Weakness of lower limb due to CVA	I69.349
Arteriosclerosis of extrimities with rest pain	I70.229
Arteriosclerosis in right leg with ulcer	I70.239 + L97.919
Arteriosclerosis in left leg with ulcer	I70.249 + L97.929
Chronic deep venous thrombosis (DVT) of leg	I82.509
Chronic pulmonary embolism (PE)	I27.82
Varicose veins in left leg with ulcer	I83.029 + L97.929
Varicose veins in right leg with ulcer	I83.019 + L97.919

Several codes were removed from the payment methodology: PVD, I73.9, arteriosclerosis of the aorta (I70.0), and extremities (I70.21-). If applicable, see arteriosclerosis of the extremities with complications such as rest pain/ulceration. Aorta ectasia and aneurysms w/o rupture codes do not map to a payment HCC either, e.g., I77.819 and I71.9.

Respiratory Conditions	
Severe persistent asthma (BA)	J45.50
BA, chronic obstructive	J44.9
Bronchitis, chronic	J42
Bronchitis, chronic, simple	J41.0
COPD	J44.9
Emphysema	J43.9
Smoker's cough	J41.0
Pulmonary fibrosis	J84.10
Chronic respiratory failure	J96.10
Musculoskeletal & Connective Tissue Diseases	
Lupus erythematosus, systemic	M32.9
Psoriasis, arthropathic	L40.50
Rheumatoid arthritis (RA)	M06.9
RA with myopathy	M05.40
RA with polyneuropathy	M05.50
RA, spine	M45.9

Skin Diseases	Amputations
Pressure ulcers, only stages 2, 3, 4, and unstageable, are included in the payment methodology. See codes under category L89- Non-pressure ulcers, see L97- & L98.4-. Also, if known, code the underlying condition like DM or arteriosclerosis.	Hand & arm, see Z89.1- and Z89.2-, Leg, AKA, Z89.61-, BKA, Z89.5-, Ankle, Z89.44-, Foot, Z89.43- Toe amputation status codes were removed from the payment methodology. E.g, Great toe, Z89.41-, Other Toes, Z89.42-
Ostomies	**Transplants**
All artificial openings impact the HCC models, see category Z93-	Most of transplants impact the HCC models, see category Z94-

Codes with a dash (-), i.e., L89-, require additional characters. See codebook.

Several neuropathy codes, such as G63, G62.0, and G62.1, were removed from the payment methodology. Dementia HCCs depend on the severity of the condition (e.g., mild vs. moderate).

Nervous System Diseases	
Alzheimer's disease	G30.9 + F02.80
Dementia	F03.90
Dementia, mild	F03.A0
Dementia, moderate	F03.B0
Dementia, severe	F03.C0
Parkinson's disease	G20.A1
Amyotrophic lateral sclerosis	G12.21
Cerebral palsy	G80.9
Epilepsy	G40.909
Huntington's disease	G10
Hydrocephalus	G91.9
Hemiparesis or hemiplegia	G81.90
Monoplegia	G83.30
Monoplegia of lower limb	G83.10
Monoplegia of upper limb	G83.20
Multiple sclerosis	G35
Muscular dystrophy	G71.00
Paraplegia	G82.20
Quadriplegia	G82.50
Quadriplegia, functional	R53.2
Polyneuropathy in RA	M05.50
Spina bifida	Q05.9
Mental Health	
Anorexia nervosa	F50.00
Bulimia nervosa	F50.20
Alcoholism	F10.20
Alcoholism in remission	F10.21
Ambien abuse	F13.10
Ambien dependence	F13.20
Ambien dependence in remission	F13.21
Cannabis dependence	F12.20
Cannabis dependence in remission	F12.21
Cocaine abuse	F14.10
Cocaine dependence	F14.20
Cocaine dependence in remission	F14.21
Opioid abuse	F11.10
Opioid dependence	F11.20
Opioid dependence in remission	F11.21
Xanax (alprazolam) abuse	F13.10
Xanax (alprazolam) dependence	F13.20
Xanax (alprazolam) dependence in remission	F13.21
Bipolar disorder	F31.9
Major depressive disorder (MDD), recurrent, moderate	F33.1
MDD, single episode, moderate	F32.1
Schizophrenia	F20.9
Personality disorder	F60.9

Codes that impact the HCC payment methodology are in **bold**
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Common HCC Reference (1 of 2)

- Constrained Code Methodology: Related HCCs within a hierarchy are assigned the *same* risk adjustment coefficient, regardless of the severity level within that group
- Hierarchical Code Methodology: If a patient is diagnosed with multiple conditions within the same disease family, only the highest-ranking code is used in the risk score calculation

Disease Category	V28 HCC Codes	Common Clinical Examples	How it is Score and Weighted
Diabetes	35,36,37, &38	Type 2 w/o complications (e11.9) Type 2 with CKD (e11.22)	Constrained: HCCs 36, 37, and 38 now carry exact same weight. Only Pancreas Transplant Status (HCC35) scores higher
Heart Failure	221, 222, 223, 224, 225, 226	Heart Failure unspecified (I50.9) Acute Systolic HF (I50.21)	Constrained: HCCs 224 (Acute on Chronic), 225 (Acute), and 226 (Unspecified/Other) all share the same weight
Dementia	125, 126, 127	Unspecified Dementia (F03.90) Vascular Severe F01.A0)	Hierarchical: Weights scale heavily by severity. Dementia (125) carries a significantly higher score that Mild (127)

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Common HCC Reference (2 of 2)

Disease Category	V28 HCC Codes	Common Clinical Examples	How it is Score and Weighted
Cancer/Neoplasms	8, 9, 10, 11, 12, 17	Breast Cancer (C50.919)	Hierarchical: Metastatic cancer (8) carries the highest weight, scaling down to lower weights for Breast/Prostate (12)
Chronic Kidney Disease (CKD)	324, 325, 326, 328, 329	CKD Stage 3 (N18.30) CKD Stage 4 (N18.4)	Hierarchical: Specificity is critical. Stage 4 carries a higher wright than Stage 3 “unspecified” CKD often carries no weight.
Substance/Alcohol Use	135, 136, 137, 138, 139	Alcohol dependence F10.20) Opioid use disorder (F11.20)	Hierarchical: Separates drug use from alcohol use. Diagnoses mapped with psychosis sit at the top of the payment hierarchy.

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