

Clinical Documentation Improvement Desk Reference for ICD-10-CM & Procedure Coding

2021

optum360coding.com

Contents

Section 1: Introduction	1
Origins of Clinical Documentation Improvement (CDI) Efforts	1
The Clinician’s View of CDI	2
Gain Share is Encouraging Documentation Improvement	2
Reasons to Implement Clinical Documentation Improvement	3
Hierarchical Condition Categories and CDI	4
Supporting Documentation for Reporting Procedures and Services	5
How Official Coding Guidelines Influence Documentation	6
How to Use This Book	8
Section 2: Clinical Documentation Improvement Processes—Best Practices	13
Assessment	13
Implementation	15
Query Program Sustainability	22
CDI Success Metrics	22
Using Technology for Clinical Documentation Improvement	23
CDI Brings Many Improvements	24
Section 3: Documentation Issues	27
Abnormal Auditory Perceptions and Acoustic (Auditory) Nerve Disorders	28
Abortion	32
Acute Myocardial Infarction (AMI)	37
Alcohol Abuse	46
Alcohol Dependence	49
Alcohol Use	52
Amyloidosis	55
Anemia — Acquired Hemolytic	58
Anemia — Iron-Deficiency	62
Anemia — Postoperative	64
Arthroscopies	66
Asthma	68
Atelectasis	72
Body Mass Index	74
Bronchoscopy	76
Cataract — Age-related (Senile)	78
Cataract — Complicated	80
Cataract — Removal of	83
Cellulitis and Acute Lymphangitis	85
Cerebrovascular Infarction and Hemorrhage	88
Chemotherapy Administration	94
Chronic Ischemic Heart Disease	101
Chronic Kidney Disease (CKD)	104
Chronic Obstructive Pulmonary Disease (COPD)	108
Chronic Pain	111
Colectomies and Enterectomies	114
Coma	116
Congenital Malformations of Great Arteries	119
Coumadin Toxicity	122
COVID-19	125
Critical Care Services	127

Crohn's Disease	128
Cutaneous Abscess, Furuncle, and Carbuncle	131
Cystoscopies, Urethroscopies and Cystourethroscopies	134
Debridement (Subcutaneous tissue, Muscle and/or Fascia, Bone)	136
Depression — Major	138
Diabetes Mellitus	141
Drug Dependence	148
Drug/Substance Abuse	152
Drug/Substance Use	155
Electrocardiogram	158
Embolectomy/Thrombectomy	161
EMG (Electromyography)	162
Emphysema	164
Encephalopathy	167
Endoscopy — Lower GI	171
Endoscopy — Upper GI	173
Epilepsy and Recurrent Seizures	175
Esophagitis	184
Facet Joint Injections	187
Fine Needle Aspiration (FNA)	190
Foodborne Intoxication and Infection	193
Fracture Care	196
Fracture of Femur	197
Fracture — Nontraumatic of Spine/Vertebra	200
Gastroenteritis (Viral, Bacterial, Protozoal)	204
Gastrointestinal Hemorrhage	208
Glaucoma	211
Hearing Loss	215
Heart Failure	220
Hematuria in Glomerular Disease	224
Hemorrhoids and Perianal Venous Thrombosis	230
Human Immunodeficiency Virus (HIV) Disease	232
Hypertension Complicating Childbirth, Pregnancy, and the Puerperium	235
Hypertensive Diseases	239
Hysterectomy	244
Influenza	248
Injections and Infusions (Non-chemotherapy)	252
Intracranial Injury	253
Intraoperative and Postprocedural Complications and Disorders of Ear and Mastoid Process	260
Intraoperative and Postprocedural Complications and Disorders of Genitourinary System	263
Malignant Neoplasm of Breast	267
Malignant Neoplasm of Liver and Intrahepatic Bile Ducts	270
Malignant Neoplasm of Unspecified Site	275
Malnutrition	278
Mastectomy	283
Migraine	285
Nerve Blocks	293
Nicotine Dependence (Cigarettes, Chewing Tobacco, Other Tobacco Product)	297
Obstetrical Package	300
Other Specified Disorders of Kidney and Ureter	303
Other Symptoms and Signs Involving Cognitive Functions and Awareness	306
Pacemakers and Implantable Defibrillators	309
Pneumonia	311

Preventive Services — Prostate Cancer Screening	315
Prostatectomy	316
Respiratory Distress of Newborn	318
Respiratory Failure	322
Rhythm and Conduction Disorders	328
Sepsis (Systemic, Generalized, Complication)	333
Shoulder Disorders	339
Skin Lesions — Removal of	343
Spinal Disc Disorders (Dorsopathies)	346
Transient Ischemic Attack	351
Trigger Point Injections	354
Ulcer — Nonpressure	355
Ulcer — Pressure	358
Ulcerative Colitis	361
Urinary Tract Infection (UTI)	364
Wound Exploration	366
Wound Repair	367
Section 4: Terminology Translator	369
Appendix 1: Physician Query Samples	379
Anemia Clarification	379
Chest Pain Clarification	380
Chronic Obstructive Pulmonary Disease	381
Confirmation Request for Pathology Findings	382
Debridement by Excision (Subcutaneous tissue, Muscle and/or Fascia, Bone)	383
Intracerebral Bleeding Clarification	384
Pneumonia Clarification	385
Pressure Ulcer Clarification	386
Respiratory Diagnosis Clarification	387
Appendix 2: HCC and QPP Associated Codes	389

population health initiatives (disease or case management). RA is used by the government as well as private and commercial insurance entities, and is needed in any value-based purchasing program.

The ICD-10-CM codes that are associated with an HCC will be identified by the icon **HCC** next to the code. Note, in some instances, where a range of codes are identified under the topic, not all codes may be associated with an HCC. Please refer to appendix 2 for the specific codes within that range that are associated with an HCC.

IMPORTANT

When the HCC icon appears with a range of codes, please refer to appendix 2 as not all codes within the range may be associated with an HCC.

Supporting Documentation for Reporting Procedures and Services

Medical record documentation is also essential for determining the most appropriate CPT® code. The CPT code book contains many code for procedures which, while very similar, have distinct components that differentiate them. This could be something as easily identifiable as the morphology of a lesion, or something more difficult, such as specific instrumentation. The difficulty lies in educating clinicians on the exact information needed for documentation as well as the coder or CDI experts understanding the key terms that identify these components.

Failing to adequately document medical services and procedures can lead to inaccurately reported services, claim delays, claim denials or even, after postpayment review by an insurer, recoupment of payments, or allegations of fraud and abuse.

Representatives of the American Health Information Management Association (AHIMA), American Health Quality Association (AHQA), American Hospital Association (AHA), American Medical Association (AMA), Blue Cross and Blue Shield Association (BCBSA), and America's Health Insurance Plans (AHIP) have developed several principles of medical record documentation, which include:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include the date; reason for the encounter; appropriate history and physical exam; review of lab, x-ray data, and other ancillary services as appropriate; assessment; and plan for care (including discharge plan, as appropriate).
- Past and present diagnoses should be accessible to the treating or consulting healthcare professional.
- The reasons for, and results of, x-rays, lab tests, and other ancillary services should be documented or included in the medical record.
- Relevant health risk factors should be identified.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance should be documented.
- The written plan for care should include, when appropriate, treatments and medications, specifying frequency and dosage; referrals and consultations; patient and family education; and specific instructions for follow-up.

Section 2: Clinical Documentation Improvement Processes—Best Practices

As mentioned earlier, the clinical documentation improvement process should be a collaborative one in order to be successful. The healthcare setting and whether the clinical conditions treated involve only a few, such as in a specialty clinic, or encompass the entire spectrum of diseases and disorders, such as in a full-service acute care hospital, will determine the scope and breadth of the program. However, there are many attributes that are commonly seen in successful programs of any size. Many physicians have found that participating in a CDI program at their local hospital also improves documentation in the office setting as well.

There are three main components to a successful clinical documentation improvement program: assessment, implementation, and sustainability.

Assessment

The first step in any CDI program must be an assessment. The assessment will identify those areas that are compliant as well as areas where improvement is needed.

There are several steps involved in performing the CDI assessment:

- Develop a CDI team
- Develop a review process
- Identify areas of risk
- Identify the root cause

Staffing

Before an assessment can take place, a clinical documentation improvement team must be established. This team should include members from all groups involved (e.g., clinicians, coders, information technology, etc.). Each team member can provide insight into what is needed for his or her particular responsibilities.

Staff members who will work on the CDI program can come from a variety of different backgrounds. Typically they include health information management (HIM) coding professionals, compliance officers, physicians, nursing staff, and other professionals with either a coding or clinical background. Some programs involve a variety of the above-mentioned individuals and job titles are not as important as specific attributes and skills, such as: clinical knowledge of the individual code sets and the reporting guidelines associated with that code set; understanding healthcare compliance as it relates to documentation, coding, and billing; and strong written and verbal communication skills. The importance of strong verbal skills cannot be overemphasized; these staff members will be

Section 3: Documentation Issues

This section is organized in an easy-to-use alphabetic format according to the condition or procedure addressed.

For ICD-10-CM codes, the focus is on those diagnoses with significant differences in the type and specificity required for accurate code assignment. The Code Axes are listed, which may include the component subcategories or each code in the section to be discussed. Information related to the entire section of codes appears next, whether related to the ICD-10-CM classification itself or to the CDI process.

The CPT procedures included are those that have documentation issues as well as those for which multiple coding options are available.

Each topic includes clinical definitions that indicate differentiating factors that can affect code assignment. Clinical data such as physical examination findings, laboratory tests commonly ordered, and/or abnormal laboratory findings, ancillary testing provided, therapeutic procedures performed, common medications, and other significant information that may support reporting the condition may also be included. A Clinician Documentation Checklist that displays the clinical factors that the clinician should document is also provided.

In addition to the elements listed above, within each of the topics covered the following components may also appear:

Clinical Tip: Provides clinical definitions and information that will help classify the condition, service, or procedure to a particular code or ICD-10-CM subcategory.

Documentation Tip: Provides information regarding specific elements that are needed in the documentation to differentiate the condition or procedure from other similar conditions or procedures.

CPT Alert: Identifies information that may be found in the documentation that could possibly affect procedure code assignment.

CDI Alert: Contains helpful tips for the CDI professional or other staff member who may be reviewing the physician documentation. Suggestions for ensuring the most appropriate and complete documentation appear here.

I-10 Alert: Provides information that, when found in the clinical documentation, could affect ICD-10-CM code assignment.

Key Terms: Lists synonyms or other clinical terms that may be documented in the medical record that are also classified to the code.

Clinician Note: Shares tips related to documentation for the physician practice setting, which may impact professional component reimbursement and quality initiatives.

⇒ I-10 ALERT

The *ICD-10-CM Official Guidelines for Coding and Reporting* provides useful information regarding documentation requirements, as well as reporting guidelines for the ICD-10-CM classification system. The official guidelines may be accessed at <https://www.cms.gov/files/document/2021-coding-guidelines.pdf>

CDI ALERT

Contains helpful tips for the CDI professional or other staff member who may be reviewing the physician documentation. Suggestions for ensuring the most appropriate and complete documentation appear here.

⇒ I-10 ALERT

Alerts the user to classification concepts unique to this code subcategory or code section along with assignment tips and/or differentiating factors. Instructions for additional coding requirements may also appear here.

Acute Myocardial Infarction (AMI)

Code Axes

ST elevation (STEMI) myocardial infarction of anterior wall	I21.01, I21.02, I21.09 <small>HCC</small>
ST elevation (STEMI) myocardial infarction of inferior wall	I21.11, I21.19 <small>HCC</small>
ST elevation (STEMI) myocardial infarction of other and unspecified sites	I21.21, I21.29, I21.3 <small>HCC</small>
Non-ST elevation (NSTEMI) myocardial infarction	I21.4 <small>HCC</small>
Acute myocardial infarction, unspecified	I21.9 <small>HCC</small>
Myocardial infarction type 2	I21.A1 <small>HCC</small>
Other myocardial infarction type	I21.A9 <small>HCC</small>
Subsequent ST elevation (STEMI) myocardial infarction of anterior/inferior walls	I22.0, I22.1 <small>HCC</small>
Subsequent non-ST elevation (NSTEMI) myocardial infarction	I22.2 <small>HCC</small>
Subsequent ST elevation (STEMI) myocardial infarction of other/unspecified site	I22.8, I22.9 <small>HCC</small>
Old myocardial infarction	I25.2
Intraoperative acute myocardial infarction, during cardiac surgery	I97.790
Intraoperative acute myocardial infarction, during other surgery	I97.791
Postprocedural acute myocardial infarction, following cardiac surgery	I97.190
Postprocedural acute myocardial infarction, following other surgery	I97.191

Description of Condition

Acute myocardial infarction (AMI) is a leading cause of morbidity and death worldwide. Myocardial infarction occurs when reduced blood supply to the heart (myocardial ischemia) results in irreversible myocardial heart damage. Myocardial infarctions can be categorized as:

Common Clinical Diagnosis

STEMI ST elevation myocardial infarction

NSTEMI Non-ST elevation myocardial infarction

⇒ I-10 ALERT

The ICD-10-CM definition of initial acute myocardial infarction (category I21) is that with a stated duration of four weeks (28 days) or less from onset. A subsequent AMI is defined as one occurring within four weeks (28 days) of a previous AMI.

Classified by Clinical Scenario

- Type 1 Spontaneous MI related to ischemia
- Type 2 Secondary to Ischemia from supply and demand mismatch
- Type 3 MI resulting in sudden cardiac death
- Type 4a MI associated with percutaneous coronary intervention
- Type 4b MI associated with in-stent thrombosis
- Type 4c MI associated with a rise and/or fall of cTn values in patients with $\geq 50\%$ stenosis
- Type 5 MI associated with coronary artery bypass

ST elevation (STEMI) myocardial infarction (I21.0-, I21.1-, I21.2-, I21.3)

An ST elevation myocardial infarction (STEMI) involves electrocardiogram (ECG) evidence of the ST-segment elevation, meaning that there is active and ongoing transmural myocardial damage due to the coronary artery being totally blocked. Patients with STEMI can develop Q-waves, which indicate an area of dead myocardium and irreversible damage. STEMI AMIs reflect a higher severity level than non-STEMI AMIs.

Clinical Tip

AMIs may affect the anterior wall, which includes the following:

- Left main coronary artery
- Left anterior descending coronary artery
- Diagonal coronary artery
- Anteroapical, anterolateral, or anteroseptal AMIs

The inferior wall AMIs include the following:

- Right coronary artery
- Inferolateral AMI

Other areas where AMIs may occur include:

- Left circumflex coronary artery
- Apical-lateral, basal-lateral, high lateral, posterobasal, posterolateral, posteroseptal

Key Terms

Key terms found in the documentation may include:

- AMI with ST elevation
- Cardiac infarction
- Coronary artery embolism, occlusion, rupture, or thrombosis
- Infarction of heart, myocardium, or ventricle
- ST AMI
- Transmural Q-wave infarction
- Type 1 STEMI

**CDI ALERT**

If a STEMI AMI converts to an NSTEMI due to thrombolytic therapy, it is still classified as a STEMI, due to the higher severity level of the STEMI and the fact that the patient was treated for the condition. If an NSTEMI evolves into a STEMI, then it is classified as a STEMI AMI. Review documentation carefully if both STEMI and NSTEMI appear in the medical record.

I-10 ALERT

Codes for nontraumatic fractures require the addition of seventh characters that specify the episode of care, such as that for initial or subsequent encounter, or that for sequela (late effect) of the fracture.

CDI ALERT

Any nontraumatic fracture must be documented specifically, including the type, cause, and age of fracture (new versus old). Specificity of site is also necessary in order to classify these cases appropriately.

I-10 ALERT

The category for collapsed vertebra(e) should only be used when the underlying cause of the fracture has not been documented.

CDI ALERT

Ensure that the underlying cause of any stress or fatigue fracture is clearly documented for appropriate classification.

Fracture — Nontraumatic of Spine/Vertebra

Code Axes

Fatigue fracture of vertebra, site unspecified	M48.40 QPP
Fatigue fracture of vertebra, cervical regions	M48.41, M48.42, M48.43 QPP
Fatigue fracture of vertebra, thoracic regions	M48.44, M48.45 QPP
Fatigue fracture of vertebra, lumbosacral regions	M48.46, M48.47, M48.48 QPP
Collapsed vertebra, NEC, site unspecified	M48.50 HCC
Collapsed vertebra, NEC, cervical regions	M48.51, M48.52, M48.53 HCC
Collapsed vertebra, NEC, thoracic regions	M48.54, M48.55 HCC
Collapsed vertebra, NEC, lumbosacral regions	M48.56, M48.57, M48.58 HCC
Age-related osteoporosis with current pathological fracture, vertebra(e)	M80.08 HCC QPP
Other osteoporosis with current pathological fracture, vertebra(e)	M80.88 HCC QPP
Pathological fracture in neoplastic disease, vertebrae	M84.58
Pathological fracture in other disease, other site	M84.68
Personal history of (healed) osteoporosis fracture	Z87.310

Description of Condition

Fatigue fracture of vertebra (M48.4-)

Clinical Tip

A fatigue fracture is one that results from excessive activity rather than from a specific injury. This type of fracture is most commonly found in people who have engaged in unaccustomed, repetitive, vigorous activity. It is important to note that this type of fracture is not a result of a disease process and is typically found in younger patients than that involving a disease. These fractures may also be referred to as stress fractures, but the mechanism causing the fracture should be indicated.

Key Terms

Stress fracture

Clinician Note

When documentation indicates that an admission or encounter is for a procedure aimed at treating an underlying condition, the code for the underlying condition (such as a vertebral fracture) should be the first listed diagnosis. It is not necessary to indicate any signs or symptoms such as pain or neuropathy that may also be documented.

Collapsed vertebra, NEC (M48.5-)**Key Terms**

Key terms found in the documentation for collapsed vertebra may include:

- Collapsed vertebra NOS
- Compression fracture
- Wedging of vertebra NOS

Clinician Note

Review the medical record for terms such as osteoporosis, fatigue fracture, pathological fracture, stress fracture, or traumatic fracture. If present, query the physician to determine if a more specific type of vertebral fracture code is appropriate.

Age-related osteoporosis with current pathological fracture, vertebra(e) (M80.08-)**Clinical Tip**

Osteoporosis, or a weakened state of bone density, may be caused by a number of conditions. Primary osteoporosis, which includes that designated as "age-related," may relate to a lower level of estrogen in postmenopausal women; men with decreased testosterone levels are also at risk for increased bone loss.

Key Terms

Key terms found in the documentation for age-related osteoporosis with current pathological fracture may include:

- Involitional osteoporosis with current pathological fracture
- Osteoporosis NOS with current pathological fracture
- Osteoporosis with current fragility fracture
- Osteoporotic fracture
- Postmenopausal osteoporosis with current pathological fracture
- Senile osteoporosis with current pathological fracture

Clinician Note

Documentation should be reviewed to determine if any major osseous defect is present as this should be reported separately. Look for terms such as bone loss or bone fragility. However, before assigning a code from M89.7- verify that this is indeed a major osseous defect.

**CDI ALERT**

Review documentation carefully for mention of collapsed vertebra(e) underlying cause. For patients under the age of 50, the condition is most often due to trauma; for patients over age 60, a common cause for females is postmenopausal (age-related) osteoporosis. In elderly patients, other common causes include malignancy and/or infection, and may be the presenting clinical symptom in multiple myeloma patients.

**I-10 ALERT**

Codes in the subcategory for age-related osteoporosis are differentiated by the presence of a current pathological fracture and then by site, including laterality. Seventh characters are required that represent the episode of care, whether initial or subsequent, or whether healing has been routine or delayed, whether any nonunion or malunion has occurred, or whether any sequela (late effect) conditions are present.

Appendix 1: Physician Query Samples

The major purpose of queries is to obtain clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. As noted earlier in this manual, queries should not be leading by eliciting a specific response, introduce new information not documented elsewhere, be “yes/no” in format, or appear to question a provider’s clinical judgment.

The query examples that follow here are intended to provide those actively working with physicians in clinical documentation improvement activities, to encourage accurate and appropriate documentation.

Anemia Clarification

Dr. Davis:

This patient was admitted with a duodenal bleed per your admission note. At that time, her hemoglobin was 7.4gm/dl and her hematocrit was 22.6 percent. The H&P states “anemia.” After admission, the patient was treated with two units packed red blood cells (PRBC).

Can your diagnosis of anemia be further specified to any of the following?:

Acute blood loss anemia: _____

Chronic blood loss anemia: _____

Other type of anemia: _____

Unable to determine: _____

Please document any clarification in the progress notes or on the discharge summary.

Signature _____

Date _____

Thank you,

John Jay

Appendix 2: HCC and QPP Associated Codes

The following lists include the number and official description of the HCC or QPP measures referenced in the table below. To save space the official descriptions have been provided once in this list. The table includes CPT codes, ICD-10-CM codes, and any applicable HCC and/or QPP measures for **topics covered in this book**. Note that to save space, some ICD-10-CM codes ranges are listed within certain topics in the body of this book. The individual code should be verified in this table.

CMS-HCC Model Category

- 1 HIV/AIDS
- 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
- 6 Opportunistic Infections
- 8 Metastatic Cancer and Acute Leukemia
- 9 Lung and Other Severe Cancers
- 10 Lymphoma and Other Cancers
- 11 Colorectal, Bladder, and Other Cancers
- 12 Breast, Prostate, and Other Cancers and Tumors
- 17 Diabetes with Acute Complications
- 18 Diabetes with Chronic Complications
- 19 Diabetes without Complication
- 21 Protein-Calorie Malnutrition
- 22 Morbid Obesity
- 23 Other Significant Endocrine and Metabolic Disorders
- 27 End-Stage Liver Disease
- 28 Cirrhosis of Liver
- 29 Chronic Hepatitis
- 33 Intestinal Obstruction/Perforation
- 34 Chronic Pancreatitis
- 35 Inflammatory Bowel Disease
- 39 Bone/Joint/Muscle Infections/Necrosis
- 40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
- 46 Severe Hematological Disorders
- 47 Disorders of Immunity
- 48 Coagulation Defects and Other Specified Hematological Disorders
- 51 Dementia With Complications
- 52 Dementia Without Complications
- 54 Substance Use with Psychotic Complications
- 55 Substance Use Disorder, Moderate/Severe, or Substance Use with Complications
- 56 Substance Use Disorder, Mild, Except Alcohol and Cannabis
- 57 Schizophrenia
- 58 Reactive and Unspecified Psychosis
- 59 Major Depressive, Bipolar, and Paranoid Disorders
- 60 Personality Disorders
- 70 Quadriplegia
- 71 Paraplegia
- 72 Spinal Cord Disorders/Injuries
- 73 Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
- 74 Cerebral Palsy
- 75 Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- 76 Muscular Dystrophy
- 77 Multiple Sclerosis
- 78 Parkinson's and Huntington's Diseases
- 79 Seizure Disorders and Convulsions
- 80 Coma, Brain Compression/Anoxic Damage

- 82 Respirator Dependence/Tracheostomy Status
- 83 Respiratory Arrest
- 84 Cardio-Respiratory Failure and Shock
- 85 Congestive Heart Failure
- 86 Acute Myocardial Infarction
- 87 Unstable Angina and Other Acute Ischemic Heart Disease
- 88 Angina Pectoris
- 96 Specified Heart Arrhythmias
- 99 Intracranial Hemorrhage
- 100 Ischemic or Unspecified Stroke
- 103 Hemiplegia/Hemiparesis
- 104 Monoplegia, Other Paralytic Syndromes
- 106 Atherosclerosis of the Extremities with Ulceration or Gangrene
- 107 Vascular Disease with Complications
- 108 Vascular Disease
- 110 Cystic Fibrosis
- 111 Chronic Obstructive Pulmonary Disease
- 112 Fibrosis of Lung and Other Chronic Lung Disorders
- 114 Aspiration and Specified Bacterial Pneumonias
- 115 Pneumococcal Pneumonia, Empyema, Lung Abscess
- 122 Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
- 124 Exudative Macular Degeneration
- 134 Dialysis Status
- 135 Acute Renal Failure
- 136 Chronic Kidney Disease, Stage 5
- 137 Chronic Kidney Disease, Severe (Stage 4)
- 138 Chronic Kidney Disease, Moderate (Stage 3)
- 157 Pressure Ulcer w/ Necrosis to Muscle, Tendon, Bone
- 158 Pressure Ulcer with Full Thickness Skin Loss
- 159 Pressure Ulcer of Skin with Partial Thickness Skin Loss
- 161 Chronic Ulcer of Skin, Except Pressure
- 162 Severe Skin Burn or Condition
- 166 Severe Head Injury
- 167 Major Head Injury
- 169 Vertebral Fractures without Spinal Cord Injury
- 170 Hip Fracture/Dislocation
- 173 Traumatic Amputations and Complications
- 176 Complications of Specified Implanted Device or Graft
- 186 Major Organ Transplant or Replacement Status
- 188 Artificial Openings for Feeding or Elimination
- 189 Amputation Status, Lower Limb/Amputation Complications

QPP Measures Category

- 1 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- 12 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- 21 Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- 23 Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- 24 Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older
- 39 Screening for Osteoporosis for Women Aged 65-85 years of Age
- 47 Care Plan
- 52 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy Long-acting
- 117 Diabetes: Eye Exam
- 130 Documentation of Current Medications in the Medical Record
- 134 Preventative Care and Screening: Screening for Depression and Follow-up Plan