OPTUM360®

Risk Adjustment Coding and HCC Guide

Simplifying the RA/HCC systems and optimization opportunities

2021

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Introduction

The traditional fee-for-service payment model has been widely used since the 1930s when health insurance plans initially gained popularity within the United States. In this payment model, a provider or facility is compensated based on the services provided. This payment model has proven to be very expensive. Closer attention is being paid to healthcare spending versus outcomes and quality of care and this has been compared to the healthcare spending of other nations. This has caused a need to develop a system to evaluate the care being given.

In the 1970s, Medicare began demonstration projects that contracted with health maintenance organizations (HMO) to provide care for Medicare beneficiaries in exchange for prospective payments. In 1985, this project changed from demonstration status to a regular part of the Medicare program, Medicare Part C. The Balanced Budget Act (BBA) of 1997 named Medicare's Part C managed care program Medicare+Choice, and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 again renamed it to Medicare Advantage (MA).

Medicare is one of the world's largest health insurance programs, and about one-third of the beneficiaries on Medicare are enrolled in an MA private healthcare plan. Due to the great variance in the health status of Medicare beneficiaries, risk adjustment provides a means of adequately compensating those plans with large numbers of seriously ill patients while not overburdening other plans that have healthier individuals. MA plans have been using the Hierarchical Condition Category (HCC) risk-adjustment model since 2004.

The primary purpose of a risk-adjustment model is to predict (on average) the future healthcare costs for specific consortiums enrolled in MA health plans. The Centers for Medicare and Medicaid Services (CMS) is then able to provide capitation payments to these private health plans. Capitation payments are an incentive for health plans to enroll not only healthier individuals but those with chronic conditions or who are more seriously ill by removing some of the financial burden.

The MA risk-adjustment model uses HCCs to assess the disease burden of its enrollees. HCC diagnostic groupings were created after examining claims data so that enrollees with similar disease processes, and consequently similar healthcare expenditures, could be pooled into a larger data set in which an average expenditure rate could be determined. The medical conditions included in HCC categories are those that were determined to most predictably affect the health status and healthcare costs of any individual.

Section of 1343 of the Affordable Care Act (ACA) of 2010 provides for a risk-adjustment program for non-Medicare Advantage plans that are available in online insurance exchange marketplaces. Beginning in 2014, commercial insurances were able to potentially mitigate increased costs for the insurance plan and increased premiums for higher-risk populations, such as those with chronic illnesses, by using a risk-adjustment model. The risk-adjustment program developed for use by non-Medicare plans is maintained by the Department of Health and Human Services (HHS). This model also uses HCC diagnostic groupings; however, this set of HCCs differs from the CMS-HCCs to reflect the differences in the populations served by each healthcare plan type.

This publication will cover the following:

- History and purpose of risk-adjustment factor (RAF)
- Key terms definitions
- Acceptable provider types
- Payment methodology and timeline
- Coding and documentation

Chapter 1. Risk Adjustment Basics

The need to track and report disease and causes of death was recognized in the 18th century. The various popular methodologies were compiled over the course of the First through Fifth International Statistical Institute Conferences in the 20th century; during the Sixth International Conference, the World Health Organization (WHO) was tasked with revising and maintaining the classifications of disease and death. In the 1930s health insurance coverage gained popularity. Many labor groups and companies started offering this type of benefit to their employees. In 1966, the American Medical Association (AMA) published the first edition of the Current Procedural Terminology (CPT®) to standardize the reporting of surgical procedures. This framework created the fee-for-service payment model, which is currently used.

The fee-for-service model, however, does not account for acuity or morbidity of its patients. A medically complex, chronically ill patient's healthcare provider would receive the same reimbursement for the same procedure done on a healthy patient.

In 1997, the Balanced Budget Act mandated that Medicare begin allowing participants to choose between traditional Medicare and managed Medicare plans (now Medicare Advantage), which would incorporate the risk-adjustment payment methodology no later than January 2000. Initially, these managed Medicare plans were paid a fixed dollar amount to care for Medicare members. In 2007, these MA plans were based 100 percent on risk adjustment. This better allocates resources to populations of medically needy patients.

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

Key Terms

- **Hierarchical condition categories (HCC).** Groupings of clinically similar diagnoses in each risk-adjustment model. Conditions are categorized hierarchically and the highest severity takes precedence over other conditions in a hierarchy. Each HCC is assigned a relative factor that is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.
- **Medicare Advantage (MA) plan.** Sometimes called "Part C" or "MA plans," offered by private companies approved by Medicare. If a Medicare Advantage plan is selected by the enrollee, the plan will provide all of Part A (hospital insurance) and Part B (medical insurance) coverage. Medicare Advantage plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).
- **Risk-adjustment factor (RAF).** Risk score assigned to each beneficiary based on his or her disease burden, as well as demographic factors.
- **Sweeps.** Submission deadline for risk adjustment data that occurs three times annually: January, March, and September. Generally, claims continue to be accepted for two weeks after the deadline.

Chapter 2. Coding and Documentation

Medical record documentation is one of the cornerstones of the current healthcare system. Whether paper or electronic records are used, these records must be accurate, consistent, and complete to provide the information necessary to ensure clinical quality, substantiate medical necessity, and ensure the most appropriate reimbursement. Health records are the foundation for many decisions that are made, regardless of the setting. Therefore documentation improvement efforts have been on-going for many years and the shift in focus to quality of care further emphasizes the need for quality documentation.

It is not uncommon to find providers who practice medicine in their heads. The provider can review his or her notes for a patient and recall the plan of care he or she had in mind. This can cause issues when the patient needs to coordinate care or transfer care should his or her normal provider be unavailable. Nobody anticipates illness, injury, or even death taking them away from work suddenly, but those situations do happen. Best practice for a provider is to have complete documentation that outlines the status and plan of care for every condition affecting the patient documented at least once a year. The annual wellness visit is an ideal time to take inventory of the patient's overall health. Should any unforeseen event take a provider away from practice, that annual wellness note can serve as an excellent resource for any other providers caring for the patient. In addition to better continuity of care, better documentation can validate and better support insurance claims.

The medical record is an essential component of providing quality care to a patient. It serves as the record of what medical services were provided to a patient and why. The medical record also serves as a communication tool for the care team of a patient, which assists with ensuring continuity of care. It is crucial that medical records meet standards for current, complete, and accurate health information. Ensuring the medical record of the patient meets these standards will assist with ensuring that the patient receives quality and continuous care, precise coding and timely billing are performed, and appropriate reimbursement is made.

According to the 2008 RAPS Participant Guide, the Centers for Medicare and Medicaid Services (CMS) requires the following elements to be considered a valid and complete record:

- The date of service, complete with month, day, and year
- Evidence of a face-to-face encounter with an acceptable provider type and setting
- Acceptable provider signature or authentication
- The provider's credentials

While it is not explicitly required by CMS, it is a standard medical record best practice and either required or recommended by many regulatory agencies and payers that at least two patient identifiers should be used to validate that the medical record matches the patient. Additional identifiers may include the date of birth, Social Security number, or insurance subscriber ID.

In addition, CMS's Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance, In effect as of March 20, 2019, states: "All data fields in Section II contain enrollee data that matches the name on the medical record submitted. The birth date may be used as a secondary identifier for common shortened names if it is present on the medical record." A second identifier, such as a date of birth, is recommended to mitigate Risk Adjustment Data Validation (RAD-V) audit risk.

Coding Scenario 2—CMS-HCC Model

Patient Name: Donald Johnson **Visit Date/Time:** 9/3/2018

Sex: M **DOB:** 6/16/1940

Chief Complaint

Presents for annual wellness visit

History of Present Illness

Don is an established patient in our office. He is here today for his annual wellness visit. He is doing well on current medication and treatment and there will be no change to current treatment. He is active but has no formal exercise and was encouraged to increase the current level of exercise. Today, his BMI is 35.16 kg/m2, which is down from the most recent BMI of 36.38 kg/m2. The need for continued weight loss was DAL and current diet was assessed. There have been no hospital stays or injuries since the last visit.

Active Problems

Allergic rhinitis, arthritis, chronic kidney disease IV, chronic obstructive pulmonary disease, congestive heart failure, depression, type 2 diabetes, dizziness, hypertension, thrombocytopenia, restless leg syndrome, and vitamin B12 deficiency.

Medication List

Lisinopril, Lantus, Humalog, test strips, Brovana nebulizer, albuterol, CPAP, gabapentin, Wellbutrin SR, Lasix, Singulair, Tofranil, and Ultram

P/F/S history

No changes from AWV on 9/15/2017. Interval history reviewed with patient.

ROS

12-point system reviewed pertinent findings as below.

Resp—SOB, wheezing, DOE

CV—edema increased in legs

Psych—difficulty concentrating, increased tiredness

Neuro—decreased sensation in fingers/toes

Vital Signs

Date	BP	Position	HR	Temp (F)	WT	HT	BMI	BSA
9/3/18	130/69	sitting	106-r	97.6	259	6′0″	35.16	2.44

Exam

Constitutional: well-nourished/well-developed, NAD

HEENT: WNL, PERRL

Respiratory: labored breathing

CV: regular rate and rhythm

GI: WNL, no HSM

GU: deferred, patient refuses

Extremities: abnormal findings with monofilament on both feet, decreased sensation in fingers as well, marked edema in bilateral legs

Psych: PHQ-9 result 4, depressed mood, AOx3

A/P

Physical Exam V70.0

Severe chronic kidney disease N18.4—sees specialist Dr. Jones

COPD J44.9—stable on current inhalers, considering O2 therapy, uses CPAP as directed

OA left knee M17.12—continues despite replacement surgery in 16, DAL can't take pain meds long term

Chapter 3. Audits and Quality Improvement

A chart audit is a detailed review of the medical record to determine if the services rendered match the services reported. In risk adjustment, this is ensuring that conditions reported are supported by valid medical records. Most often, audits are performed to ensure accuracy and compliance; however, quality improvement measure audits are increasingly popular.

It is advisable to regularly audit the documentation being used as well as the coding for risk adjustment to ensure compliance.

Step 1
Determine who will perform the audit. An internal audit is typically performed by coding staff within the practice that are proficient in coding and interpreting payer guidelines. Depending upon the size of the practice and the number of services provided annually, a compliance department with full-time auditors may be established. If not, the person performing the audit should not audit claims that he or she coded.

Step 2
Define the scope of the audit. Determine what types of services to include in the review. Use the most recent Office of Inspector General (OIG) Work Plan, recovery audit contractor (RAC) issues, and third-party payer provider bulletins, which will help identify areas that can be targeted for upcoming audits. Review the OIG Work Plan, which is now a web-based work plan updated monthly rather than yearly, to determine if there are issues of concern that apply to the practice. Determine specific coding issues or claim denials that are experienced by the practice. The frequency of coding or claims issues and potential effect on reimbursement or potential risk can help prioritize which areas should be reviewed. Services that are frequently performed or have complex coding and billing issues should also be reviewed, as the potential for mistakes or impact to revenue could be substantial.

Step 3
Determine the type of audit to be performed and the areas to be reviewed. Once the area of review is identified, careful consideration should be given to the type of audit performed. Reviews can be prospective or retrospective. If a service is new to the practice, or if coding and billing guidelines have recently been revised, it may be advisable to create a policy stating that a prospective review is performed on a specified number of claims as part of a compliance plan. The audit should include ensuring the medical record coded meets administrative requirements, such as patient name and date of service are on the record, accuracy of diagnosis codes, compliance of any queries generated, and whether the source document supports code assignment.

Step 4
Assemble reference materials. Reference materials, such as current editions of coding manuals and Centers for Medicare and Medicaid Services (CMS) or other third-party policies pertinent to the services being reviewed, should be collected.

Step 5
Develop customized data capture tools. Use an audit worksheet, see example on page 83. Audit worksheets can aid in the audit process. They help verify that signatures were obtained and that patient identifying information (e.g., complete name, date of birth) is correct.

Step 6
Develop a reporting mechanism for findings. Once the audit is complete, written recommendations should be made. The recommendations can include conducting a more frequent focused audit, implementing improved documentation templates, or conducting targeted education on ICD-10-CM coding. Each practice should have benchmarks set up that

ICD-10-CM Code	ICD-10-CM Code Description	CY 2021 V24 CMS-HCC	CY 2021 V24 CMS-HCC Disease Group	CY 2021 V24 CMS-HCC Hierarchies	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
C34.00	Malignant neoplasm of unspecified main bronchus	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.01	Malignant neoplasm of right main bronchus	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.02	Malignant neoplasm of left main bronchus	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.2	Malignant neoplasm of middle lobe, bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C37	Malignant neoplasm of thymus	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C38.0	Malignant neoplasm of heart	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C38.1	Malignant neoplasm of anterior mediastinum	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C38.2	Malignant neoplasm of posterior mediastinum	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C38.3	Malignant neoplasm of mediastinum, part unspecified	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C38.4	Malignant neoplasm of pleura	9	Lung and Other Severe Cancers	10,11,12	1.024	0.910	1.010	1.001	1.001	0.880	0.623
C38.8	Malignant neoplasm of overlapping sites of heart, mediastinum and pleura	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C39.0	Malignant neoplasm of upper respiratory tract, part unspecified	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C39.9	Malignant neoplasm of lower respiratory tract, part unspecified	11	Colorectal, Bladder, and Other Cancers	12	0.307	0.345	0.317	0.355	0.330	0.351	0.294
C40.00	Malignant neoplasm of scapula and long bones of unspecified upper limb	10	Lymphoma and Other Cancers	11,12	0.675	0.663	0.717	0.756	0.648	0.667	0.461
C40.01	Malignant neoplasm of scapula and long bones of right upper limb	10	Lymphoma and Other Cancers	11,12	0.675	0.663	0.717	0.756	0.648	0.667	0.461
C40.02	Malignant neoplasm of scapula and long bones of left upper limb	10	Lymphoma and Other Cancers	11,12	0.675	0.663	0.717	0.756	0.648	0.667	0.461

ICD-10-CM Code	ICD-10-CM Code Description	CY 2021 V24 CMS-HCC	CY 2021 V24 CMS-HCC Disease Group	CY 2021 V24 CMS-HCC Hierarchies	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
L97.513	Non-pressure chronic ulcer of other part of right foot with necrosis of muscle	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.514	Non-pressure chronic ulcer of other part of right foot with necrosis of bone	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.515	Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.516	Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.518	Non-pressure chronic ulcer of other part of right foot with other specified severity	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.519	Non-pressure chronic ulcer of other part of right foot with unspecified severity	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.521	Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.522	Non-pressure chronic ulcer of other part of left foot with fat layer exposed	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.523	Non-pressure chronic ulcer of other part of left foot with necrosis of muscle	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.524	Non-pressure chronic ulcer of other part of left foot with necrosis of bone	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.525	Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.526	Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.528	Non-pressure chronic ulcer of other part of left foot with other specified severity	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.529	Non-pressure chronic ulcer of other part of left foot with unspecified severity	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.801	Non-pressure chronic ulcer of other part of unspecified lower leg limited to breakdown of skin	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.802	Non-pressure chronic ulcer of other part of unspecified lower leg with fat layer exposed	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.803	Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of muscle	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.804	Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294
L97.805	Non-pressure chronic ulcer of other part of unspecified lower leg with muscle involvement without evidence of necrosis	161	Chronic Ulcer of Skin, Except Pressure		0.515	0.592	0.727	0.583	0.541	0.542	0.294

ICD-10-CM Code	ICD-10-CM Code Description	CY 2021 V24 CMS-HCC	CY 2021 V24 CMS-HCC Disease Group	CY 2021 V24 CMS-HCC Hierarchies	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
T87.40	Infection of amputation stump, unspecified extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.41	Infection of amputation stump, right upper extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.42	Infection of amputation stump, left upper extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.43	Infection of amputation stump, right lower extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.44	Infection of amputation stump, left lower extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.50	Necrosis of amputation stump, unspecified extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.51	Necrosis of amputation stump, right upper extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.52	Necrosis of amputation stump, left upper extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.53	Necrosis of amputation stump, right lower extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.54	Necrosis of amputation stump, left lower extremity	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.81	Dehiscence of amputation stump	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.89	Other complications of amputation stump	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
T87.9	Unspecified complications of amputation stump	189	Amputation Status, Lower Limb/Amputation Complications		0.519	0.437	0.795	0.934	0.697	0.626	0.357
X71.0XXA	Intentional self-harm by drowning and submersion while in bathtub, initial encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.0XXD	Intentional self-harm by drowning and submersion while in bathtub, subsequent encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.0XXS	Intentional self-harm by drowning and submersion while in bathtub, sequela	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.1XXA	Intentional self-harm by drowning and submersion while in swimming pool, initial encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.1XXD	Intentional self-harm by drowning and submersion while in swimming pool, subsequent encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.1XXS	Intentional self-harm by drowning and submersion while in swimming pool, sequela	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.2XXA	Intentional self-harm by drowning and submersion after jump into swimming pool, initial encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.2XXD	Intentional self-harm by drowning and submersion after jump into swimming pool, subsequent encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.2XXS	Intentional self-harm by drowning and submersion after jump into swimming pool, sequela	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.3XXA	Intentional self-harm by drowning and submersion in natural water, initial encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187
X71.3XXD	Intentional self-harm by drowning and submersion in natural water, subsequent encounter	59	Major Depressive, Bipolar, and Paranoid Disorders	60	0.309	0.164	0.299	0.127	0.306	0.109	0.187