Optum

Insider

Documentation and coding information for providers

October 2023

Focus on: Cancer

October is National Breast Cancer Awareness Month

Medicare Advantage*	
• **HCC 8 (17,18,22):** Metastatic cancer and acute leukemia • **HCC 9 (17,19,20,22):** Lung and other severe cancers • **HCC 10 (17,18,19,20,21,22,23):** Lymphoma and other cancers • **HCC 11 (20,21,22):** Colorectal, bladder and other cancers and tumors • **HCC 12 (17,21,23):** Breast, prostate and other cancers and tumors	**Prevalent conditions that fall into this category are:** Primary and secondary malignant neoplasms; primary and secondary carcinoid tumors; Merkel cell carcinoma; neuroendocrine tumors, disseminated malignant neoplasms; leukemias, melanomas, hepatoblastomas, mesotheliomas, plasmacytomas, sarcomas, hemangiomas, benign neoplasms, neoplasms of uncertain behavior; benign neoplasm of meninges; benign neoplasm of brain and other parts of central nervous system; benign neoplasm of pituitary gland; benign neoplasm of craniopharyngeal duct; benign neoplasm of pineal gland; neurofibromatoses and others. **Unique to the ACA model:** Benign neoplasm of heart; tumor lysis syndrome.
Affordable Care Act*	
• **HCC 8:** Metastatic cancer • **HCC 9:** Lung, brain and other severe cancers, including pediatric acute lymphoid leukemia • **HCC 10:** Non-Hodgkin's lymphomas and other cancers and tumors • **HCC 11:** Colorectal, breast (age <50), kidney and other cancers • **HCC 12:** Breast (age 50+) and prostate cancer, benign/uncertain brain tumors and other cancers and tumors • **HCC 13:** Thyroid cancer, melanoma, neurofibromatosis and other cancers and tumors	

*The conditions listed in the table above do not represent an inclusive list. Please check the CMS and HHS mappings for a complete list of conditions. HCC information is provided for educational purposes on the differences between the CMS and HHS models and is not intended to affect patient care. CMS requires submission of all diagnosis codes within the reporting period each calendar year based on what is documented in the medical record.

The hierarchical condition categories listed above in parentheses are the new HCCs in the 2024 CMS-HCC model. The 2020 model and the 2024 model are blended 67%/33%, respectively, for PY 2024, and 33%/67%, respectively, for PY 2025. Please see the 2024 Announcement for details.

Documentation should be clear, concise and legible. All conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment and/or management should be documented.

Patients who are receiving active treatment for cancer should be reported with the malignant neoplasm code corresponding to the affected site. When documenting conditions related to **cancer,** specify:

- **Behavior:** Malignant (primary, secondary, unknown), neuroendocrine, carcinoma in situ, benign, uncertain behavior or unspecified behavior
- **Morphology:** Histological type, stage and grade
- **Anatomic site(s):** Location, quadrants, multiple and contiguous sites
- **Laterality:** Right, left or bilateral for paired organs and the extremities

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy,assign a code from category Z85.- *Personal history of malignant neoplasm*, to indicate the former site of the malignancy.

Cancer (partial listing)

ICD-10-CM	Description
C17.-	Malignant neoplasm of small intestine
C18.-	Malignant neoplasm of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C34.-	Malignant neoplasm of bronchus and lung
C50.-	Malignant neoplasm of breast
C61	Malignant neoplasm of prostate
C7A.-	Malignant neuroendocrine (carcinoid) tumors
C77.-	Secondary and unspecified malignant neoplasm of lymph nodes
C78.-	Secondary and malignant neoplasm of respiratory and digestive organs
C79.-	Secondary malignant neoplasm of other and unspecified sites
C80.-	Malignant neoplasm without specification of site
D05.-	Carcinoma in situ of breast
D3A.-	Benign neuroendocrine (carcinoid) tumors
Z17.0	Estrogen receptor positive status [ER+]
Z17.1	Estrogen receptor negative status [ER-]
Z19.1	Hormone sensitive malignancy status
Z19.2	Hormone resistant malignancy status
Z79.810	Long term (current) use of selective estrogen receptor modulators (SERMs)
Z79.811	Long term (current) use of aromatase inhibitors
Z85.-	Personal history of malignant neoplasm

For additional information on cancer, please refer to our Documention and coding tips: Cancer.

HEDIS measures

Breast cancer screening (BCS, BCS-E)

- **Recommended for female patients ages 50–74, who have not had a mammogram in the 27 months prior to 12/31 of the current year**
- **To close the quality gap, the medical record documentation should state the date mammogram was completed or diagnostic report**
- **Exclusions:**
  - Members with two unilateral mastectomies or bilateral mastectomy
  - Members in hospice or using hospice services
  - Members who died
  - Members receiving palliative care
  - Frailty and advanced illness

Colorectal cancer screening (COL, COL-E)

- **Screening is recommended for patients ages 50–75, who have not had any of the following:**
  - Fecal occult blood test (FOBT) during the measurement year
  - Immunological fecal occult blood test (iFOBT) or guaiac fecal occult blood test (gFOBT) are acceptable. Documentation of one or more samples is acceptable
  - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
  - Colonoscopy during the measurement year or the nine years prior to the measurement year
  - CT colonography during the measurement year or the four years prior to the measurement year
  - FIT-DNA test (Cologuard®) during the measurement year or the two years prior to the measurement year
- **To close the quality gap, the medical record documentation should state the specific date the screening was completed with/without result or radiology/lab report**
- **Member refusal will not make them ineligible for this measure**
- **Digital rectal exam (DRE) and FOBT tests performed in an office setting or performed on a sample collected via DRE do not count as evidence of colorectal screening**
- **Exclusions:**
  - Documented colorectal cancer or total colectomy
  - Members in hospice or using hospice services
  - Members receiving palliative care
  - Members who died
  - Frailty and advanced illness

Cervical cancer screening (CCS, CCS-E) [this measure is specific to ACA and Medicaid population]

- **Screening is recommended for:**
  - Women 21–64 years of age who had cervical cytology performed during the current calendar year or two years prior
  - Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing during the current calendar year or four years prior
- **To close the quality gap, the medical record should include a notation indicating the date and type of screening performed. This quality measure or gap can also be closed via claims as permitted by the health plan.**
- **Exclusions:**
  - Members in hospice services, using hospice or who die during measurement year
  - Member receiving palliative care any time during the measurement year
  - Documented hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix

For additional information on closing HEDIS measures, please refer to our Closing gaps in quality measures.

Training opportunities

Optum offers a variety of documentation and coding courses for Medicare Advantage (MA) and the Affordable Care Act (ACA). Some sessions offer continuing education units (CEUs) and can be used for continuing medical education (CME) credits, depending on your credentialing organization.

National trainings: Please speak with your Optum representative for a schedule of virtual trainings on documenting and coding prevalent chronic conditions.

If you are not sure who your Optum representative is, please contact the Optum Provider Support Center at 1-877-751-9207 between 8 a.m. and 7 p.m. ET, Monday–Friday.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

* Optum360 ICD-10-CM: Professional for Physicians 2023. Salt Lake City, UT: 2022.

1. The Centers for Medicare and Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2024: "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2024, using both the 2020 model and the 2024 model, which is currently a blended model.

This guidance is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. This presentation supplies general information regarding HEDIS and the Five-Star Quality Rating System, but NCQA administers HEDIS and CMS administers the Five-Star Quality Rating System, and you should consult the NCQA and CMS websites for further information. Lastly, on March 31, 2023, the Centers for Medicare & Medicaid Services (CMS) announced that 2023 dates of service for the 2024 payment year model are based on the Centers for Medicare & Medicaid Services Announcement.

For the Affordable Care Act (ACA): The Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) model applies in the health exchange risk adjustment program under the Affordable Care Act. This model differs significantly from the CMS-HCC model, which applies in the Medicare Advantage risk adjustment program. For more information, please visit: Regulations and guidance. HHS also issues an annual notice of benefit and payment parameters, which may contain additional guidance on risk adjustment coding and other related issues under the Affordable Care Act.

For more information on Optum and the products and services we offer, contact us at 1-877-751-9207 or email providersupport@optum.com. If you have questions or wish to be removed from this email, please contact your Optum representative.

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