2024 Risk Adjustment

Documentation and Coding Reference Guide

PRIVIA HEALTH

This Clinical Guide serves only as a partial listing of those diagnoses frequently encountered in the senior population with long-term or advanced illnesses, and is intended to assist providers to accurately code and document clinically relevant chronic conditions.

This Clinical Pocket Guide is not intended to be comprehensive, and you should reference additional resources to accurately code and report identified diagnoses that are not included in this list.

CMS expects the documentation and coding of diagnoses must be complete, accurate, and specific.

The diagnoses listed in this Clinical Pocket Guide are not to be interpreted as a replacement for your independent clinical diagnostic decision-making. The overarching intent of this coding tool is to assist in quickly locating the most common outpatient conditions with complimentary ICD-10-CM codes that may be pertinent to your patient.

For more information please see the FY2024 ICD-10-CM Code classification located at https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm, effective October 1, 2023 through October 1, 2024

PLEASE NOTE:

CODE Diagnosis codes that are **BOLDED** IN BLACK represent fully reportable codes that risk-adjust in the CMS-HCC risk adjustment model.

***** Diagnosis codes that are flagged with a blue asterisk (*****) represent fully reportable codes that risk-adjust in the Commercial HCC risk adjustment model.

- Diagnosis codes with a **dash** (**-**) after the decimal point signify the need for additional characters to specify etiology, severity, type, and other specific details, expanding the code's description.

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Amputations (ACQUIRED)

Diagnosis
Amputation is defined by "Cutting off all or portions of upper or lower extremities." Acquired absence is the ICD-10 CM description of a patient's status following an amputation.

Z89 - Acquired absence of limb (amputation status)

Codes in category Z89 describe the post-procedural and post-traumatic absence of a limb, when no complications of the amputation or treatment directed toward the site. Documentation should include anatomical location and laterality.

ICD-10-CM Code	ICD-10-CM Descriptor
Acquired Absence of Upper Limb *(6th character is used to indicate laterality: 1=right; 2=left: 9=unspecified)*	
Z89.01-	Acquired absence of thumb
Z89.02-	Acquired absence of other finger(s)
Z89.11-*	Acquired absence of hand
Z89.12-*	Acquired absence of wrist *(includes disarticulation at wrist)*
Z89.20-*	Acquired absence of upper limb, unspecified *(includes absence of arm)*
Z89.21-*	Acquired absence of upper limb, below elbow
Z89.22-*	Acquired absence of upper limb, above elbow *(includes disarticulation at elbow)*

Z89.23-	Acquired absence of shoulder *(includes acquired absence of shoulder joint following explanation of shoulder joint prosthesis)*
Acquired Absence of Lower Limb	
Z89.41-	Acquired absence of great toe
Z89.42-	Acquired absence of other toe(s)
Z89.43-*	Acquired absence of foot
Z89.44-*	Acquired absence of ankle *(includes disarticulation of ankle)*
Z89.51-*	Acquired absence of leg, below knee
Z89.52-	Acquired absence of knee *(includes acquired absence of knee joint following explanation of knee joint prosthesis)*
Z89.61-*	Acquired absence of leg, above knee *(includes acquired absence of leg NOS, Disarticulation at knee)*
Z89.62-	Acquired absence of hip *(includes acquired absence of hip joint following explanation of hip joint prosthesis, Disarticulation at hip)*
Z89.9-*	Acquired absence of limb, unspecified

DOCUMENTATION
Annually, providers should include the date of amputation, underlying reason or cause (e.g., diabetes mellitus, trauma, tumor), associated medical problems, use of durable medical devices and/or prosthetics.

Artificial Openings/Ostomies

Diagnosis
An artificial opening (ostomy) replaces or bypasses a normal organ opening and include tracheostomy, colostomy, gastrostomy, ileostomy, cystostomy, ureterostomy, and nephrostomy. Stomas are artificial openings leading to hollow organs, like the gut or trachea, which include devices like NG tubes, indwelling urethral catheters, chest tubes, etc., and are not to be coded as artificial openings.

ICD-10-CM Code	ICD-10-CM Descriptor
Encounter for Attention to Artificial Openings *(includes closure of artificial openings, passage of sounds or bougies through artificial openings, reforming artificial openings, removal of catheter from, or or cleansing of artificial openings)*	
Z43.0*	Encounter for attention to tracheostomy
Z43.1*	Encounter for attention to gastrostomy
Z43.2*	Encounter for attention to ileostomy
Z43.3*	Encounter for attention to colostomy
Z43.4*	Encounter for attention to other artificial openings of digestive tract
Z43.5*	Encounter for attention to cystostomy
Z43.6*	Encounter for attention to other artificial openings of urinary tract *(includes attention to nephrostomy, ureterostomy, and urethrostomy)*
Z43.8*	Encounter for attention to other artificial openings
Z43.9*	Encounter for attention to unspecified artificial opening

Artificial Opening Status
(Codes in category **Z93** *describe functional artificial opening status. These codes are appropriate when no treatment is directed at the site)*

Z93.0*	Tracheostomy status
Z93.1*	Gastrostomy status
Z93.2*	Ileostomy status
Z93.3*	*Colostomy status, unspecified*
Z93.4*	Other artificial opening of GI tract status
Z93.50*	Unspecified *Cystostomy status*
Z93.51*	Cutaneous-vesicostomy status
Z93.52*	Appendico-vesicostomy status
Z93.59*	Other cystostomy status
Z93.6*	Other artificial opening of urinary tract status
Z93.8*	Other artificial opening status
Z93.9*	Artificial opening status, unspecified

DOCUMENTATION
Verify any ostomies present as current problem(s); and note status, attention to, or complications.

Chronic Kidney Disease

Documentation

Always record the highest known stage of CKD, note the underlying cause, and provide details on current medication management and GFR/eGFR in your status or plan. The diagnosis of CKD cannot be based solely on diagnostic reports. Include a review of reports and relevant findings, especially GFR/eGFR measurements.

Document and code any associated conditions such as HTN, CHF, or diabetes. Also document and code dialysis dependence, kidney transplant status, or the presence of an A/V fistula or shunt for status dialysis when applicable.

Document & code chronic kidney disease with **secondary hyperparathyroidism of renal origin** (**N25.81**) if clinically relevant, the following represents current prevalence:

- **N18.3-** Chronic kidney disease, stage 3 (34% prevalent)
- **N18.4*** Chronic kidney disease, stage 4 (74% prevalent)
- **N18.5*** Chronic kidney disease, stage 5, and **N18.6*** ESRD (90% prevalent)

CKD Classification and Staging

GREEN: Low Risk (LR) — **Treat in Office**

YELLOW: Moderate Risk (MR) — **Treat in Office**

ORANGE: High Risk (HR) — **Refer to Nephrology**

RED: Very High Risk (VHR) — **Refer to Nephrology**

					Kidney damage stage urine albumin/creatinine ratio Description and range		
					A1	**A2**	**A3**
					Normal to mild increase **<30mg/g**	Moderately increased **30-299 mg/g**	Severely increased **≥ 300 mg/g**
Kidney function stage GRF (ml/min/1.73²) Description and range	G1	Normal or high	≥ 90	N18.1	LR	MR	HR
	G2	Mild decrease	60-89	N18.2	LR	MR	HR
	G3	Moderate unspecified	30-59	**N18.30**	MR	HR	VHR
	G3a	Mild to moderate decrease	45-59	**N18.31**	MR	HR	VHR
	G3b	Moderate to severe decrease	30-44	**N18.32**	HR	VHR	VHR
	G4	Severe decrease	15-29	**N18.4***	VHR	VHR	VHR
	G5	Chronic kidney failure	<15	**N18.5***	VHR	VHR	VHR
		End Stage Renal Disease		**N18.6***	VHR	VHR	VHR
		Dependence on Renal Dialysis		**Z99.2**	VHR	VHR	VHR

Kidney Disease — Improving Global Outcomes (KDIGO) Clinical Practice Guideline For Evaluation & Management of CKD in the primary care setting

- **G1 and G2 represents** — (CKD Stage 1 & 2), which must support evidence of kidney damage in the plan of care
- **Kidney damage** — is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests (e.g., untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick) or imaging studies.
- **Abnormal GFR/eGFRs** — There must be at least two abnormal GFRs greater than or equal to three months apart if clinically relevant for diagnosing CKD stages 1 & 2.
- **G5 represents** — “Chronic kidney failure” and not “Kidney failure,” which is coded as N19 Unspecified kidney failure (or Uremia NOS)

Sequelae of Cerebral Vascular Accident (CVA)

Diagnosis

Sequelae represents the residual effects of conditions produced after the acute phase of a CVA.

Sequelae from a CVA has no time limit and can arise at any time. In order to accurately code a sequelae, documentation of laterality is essential. Documentation in the medical record should clearly state whether a neurological deficit is directly related to the cerebrovascular disease or cerebrovascular accident.

Example:

- ☐ *If the right side is affected, the default is dominant.*
- ☐ *If the left side is affected, the default is non-dominant.*
- ☐ *For ambidextrous patients, the default should be dominant.*

Sequelae of Cerebral Infarction	I69.30 – I69.359	Sequelae of Stroke NOS
I69.31-	Cognitive deficits following a CVA	Includes attention & concentration, memory deficit, visual, etc.
I69.32-	Speech and language deficits following a cerebral infarction	Includes aphasia, dysphasia, dysarthria, fluency disorder, other

I69.33-*	Monoplegia of upper limb following cerebral infarction *(includes weakness of one upper limb documented as secondary to stroke)*	State laterality and dominance or non-dominance
I69.34-*	Monoplegia of the lower limb following a cerebral infarction *(includes weakness of one lower limb documented as secondary to stroke)*	State laterality and dominance or non-dominance
I69.35-*	Hemiplegia and hemiparesis following a cerebral infarction *(includes weakness on one side of the body documented as secondary to stroke)*	State laterality and dominance or non-dominance
I69.36-*	Other paralytic syndrome following cerebral infarction	Use additional code to identify type of paralytic syndrome, such as: locked-in state (**G83.5***); quadriplegia (**G82.5-***)
I69.39-	Other sequelae of cerebral infarction	This subcategory includes apraxia, dysphagia (include type), facial weakness, and ataxia

DOCUMENTATION

When documenting sequelae of stroke, describe the lasting effects or complications resulting from the stroke, including neurological deficits (e.g., hemiparesis, aphasia, apraxia), cognitive impairments (e.g., memory loss, executive dysfunction), emotional or behavioral changes (e.g., depression, anxiety), and functional limitations (e.g., mobility, activities of daily living). Provide details on the severity and impact of these sequelae on the patient's quality of life and daily functioning. Include any ongoing treatment, therapy, or support services aimed at managing these sequelae.

Diabetes Mellitus

Type 2 diabetes mellitus becomes complex when other co-morbid conditions exist. These codes below are common complications effecting patient care related to DM2.

Code also long-term current use of insulin (**Z79.4***); and/or, oral antidiabetic hypoglycemic medications (Z79.84*); and/or, non-insulin injectable antidiabetic medications (Z79.85).

Documented	ICD-10-CM Code Selection #1	Add Second Code (if required)
Type 2 DM w/ diabetic CKD	**E11.22*** Type 2 DM w/ diabetic CKD	Assign CKD code N18.- *(Use 4th characters to identify stage 1-5, and 6 for ESRD)*
Type 2 DM w/ diabetic nephropathy	**E11.21*** Type 2 DM w/ nephropathy	2nd code for nephropathy not required
Type 2 DM w/ diabetic retinopathy	**E11.31-*** Type 2 DM w/ diabetic retinopathy *(6th character describes w/ or w/o macular edema)*	2nd code for retinopathy not required
Type 2 DM w/ diabetic cataract	**E11.36*** Type 2 DM w/ diabetic cataract	Us an additional code to describe the type of cataract *(e.g., senile, snowflake, etc.)*
Type 2 DM w/ diabetic neuropathy	**E11.40*** Type 2 DM w/ diabetic neuropathy, unspecified	2nd code for neuropathy not required
Type 2 DM w/ diabetic mononeuropathy	**E11.41*** Type 2 DM w/ diabetic mononeuropathy	2nd code for mononeuropathy not required

Type 2 DM w/ diabetic polyneuropathy	**E11.42*** Type 2 DM w/ diabetic polyneuropathy	2nd code for polyneuropathy not required
Type 2 DM w/ diabetic amyotrophy	**E11.44*** Type 2 DM w/ diabetic amyotrophy	2nd code amyotrophy not required
Type 2 DM w/ diabetic atherosclerosis of extremities	**E11.5-*** Type 2 DM w/ diabetic peripheral angiopathy *(5th character describes w/o, w/ gangrene, or other)*	**I70.2-** Atherosclerosis of native arteries of the extremities. *(5th & 6th characters identify location & severity)*
Type 2 DM w/ diabetic w/ dermatitis	**E11.620*** Type 2 w/ diabetic dermatitis	2nd code for dermatitis is not required
Type 2 DM w/ diabetic Ulcers	**E11.621*** Type 2 DM w/ diabetic foot ulcer **E11.622*** Type 2 DM w/ other diabetic skin ulcer *(requires documented linkage)*	Use additional code to identify the type of ulcer (pressure or non-pressure). **L97- L98*** codes require 4th, 5th & 6th characters *(4th= location; 5th= laterality; 6th= severity)*
Type 2 DM w/ other skin conditions	**E11.628*** Type 2 DM w/ other diabetic skin complications	Use additional code to identify the skin condition (e.g., cellulitis, eczema)*(requires documented linkage)*
Type 2 DM w/ diabetic oral complications	**E11.630*** Type 2 DM w/ diabetic periodontal disease **E11.638*** Type 2 DM w/ other diabetic oral complications	Use additional code to identify the oral condition with documented linkage

Documented	ICD-10-CM Code Selection #1	Add Second Code (if required)
Type 2 DM w/ diabetic hyperglycemia and hypoglycemia	**E11.65*** Type 2 w/ hyperglycemia **E11.649*** Type 2 w/ hypoglycemia	**E11.65*** is used only for hyperglycemia poorly controlled. *(Assignment of this codes means HgA1c is out of control; therefore, do not assign this code if under control)*
Type 2 DM w/ other diabetic complications	**E11.69*** Type 2 DM w/ other complications *(Document and code complications due to diabetes other than kidney, ophthalmic, neurological, or circulatory with documented linkage)*	Examples: E78.5 Hyperlipidemia unspecified; E78.4 Other hyperlipidemia; E78.2 Mixed hyperlipidemia

Secondary Diabetes ICD-10-CM Codes	Secondary diabetes is always caused by another condition or event, described by the following:
E08.-* DM due to underlying conditions	Code first — the underlying condition, such as: • *Congenital rubella (P35.0)* • *Cushing's syndrome (**E24.-**)* • *Cystic fibrosis (**E84.-**)* • *Malignant neoplasm (**C00-C96**)* • *Malnutrition (**E40-E46**)* • *Pancreatitis and other diseases of the pancreas (K85-K86.-)*

E09.-* Drug or chemical induced diabetes	Code First — Poisoning due to drug or toxin, if applicable *(T36-T65 with fifth or sixth character 1-4 or 6)* Use Additional Code — For adverse effect, if applicable, to identify drug *(T36-T50 with fifth or sixth character 5)*
E13.-* Other specified DM	Other Specified diabetes mellitus includes: • *Diabetes due to genetic defects of beta-cell function* • *Diabetes due to genetic defects in insulin action* • *Postpancreatectomy diabetes mellitus* • *Post procedural diabetes mellitus* • *Secondary diabetes mellitus NEC*

DOCUMENTATION

When documenting diabetes, specify the type (e.g., Type 1, Type 2, etc.), control status (controlled, inadequately controlled, out of control, or poorly controlled with hyperglycemia; the term uncontrolled requires a statement to include hyperglycemic or hypoglycemic), complications or other affected body systems, and any treatment including insulin use, oral antidiabetic or hypoglycemic drugs, and non-insulin injectables. Ensure clear documentation of complications, their relationships, and details (e.g., “diabetes with chronic kidney disease” specifying the stage of CKD or “diabetes with an ulcer” detailing type, laterality, site, and depth).

Diabetes Mellitus

Dementia screening and cognitive assessment are required for reimbursement during initial and subsequent annual wellness visits (AWVs). In confirmed dementia cases, use a brief structured cognitive assessment tool to correctly classify patients with cognitive impairment and link relevant etiology, like Alzheimer's or Parkinson's related dementia. This ensures comprehensive care during AWVs.

ICD-10-CM Code	ICD-10-CM Descriptor

Dementia with Complications
(5th & 6th characters identify without or with agitation; other behavioral disturbance; psychotic or mood disturbance; or anxiety); Use additional code, if applicable, to identify wandering for "other behavioral disturbance" (Z91.83)

- ☐ For all **F01.-** code subcategories *(Code first the underlying physiological condition or sequelae of cerebrovascular disease)*
- ☐ For all **F02.-** code subcategories *(Code first the underlying physiological condition, such as: Alzheimer's (**G30.**); dementia with Lewy bodies (**G31.83**); Parkinson's disease (**G20.-**); Huntington's disease (**G10***), etc.)*
- ☐ For all **F03.-** code subcategories *(Includes major neurocognitive disorder, presenile dementia, presenile psychosis, senile dementia, etc.)*

F01.5-	Vascular dementia, unspecified severity
F01.A-	Vascular dementia, mild severity
F01.B-	Vascular dementia, moderate severity
F01.C-	Vascular dementia, severe
F02.8-	Dementia in other diseases classified elsewhere, unspecified severity
F02.A-	Dementia in other diseases classified elsewhere, mild severity

F02.B-	Dementia in other diseases classified elsewhere, moderate severity
F02.C-	Dementia in other diseases classified elsewhere, severe
F03.9-	Unspecified dementia, unspecified severity
F03.A-	Unspecified dementia, mild severity
F03.B-	Unspecified dementia, moderate severity
F03.C-	Unspecified dementia, severe
G31.83	Neurocognitive disorder with Lewy bodies (Lewy body dementia)
Dementia Without Complications	
F01.50	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety *(Code first the underlying physiological condition or sequelae of cerebrovascular disease)*
F02.80	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety *(Assign **F02.8-** with **G30.-** when Alzheimer's disease is documented, even in the absence of documented dementia)*
FO3.90	Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety *(Includes major neurocognitive disorder, presenile dementia or psychosis , senile dementia)*

DOCUMENTATION

When documenting dementia, specify the type (e.g., Alzheimer's, vascular, Lewy body, frontotemporal, mixed, or other), stage or severity (e.g., mild, moderate, severe), underlying causes or contributing factors, behavioral and psychological symptoms (e.g., agitation, psychosis, depression), and relevant treatment approaches including medications, non-pharmacological interventions, and support services. It's important to provide a comprehensive and detailed account of the dementia diagnosis and its management.

Hypertension

HYPERTENSION (ESSENTIAL & RESISTANT)

ICD-10-CM Code	ICD-10-CM Descriptor
I10	Essential (primary) hypertension
I1A.0	Resistant hypertension *(Code first specific type of existing hypertension, if known, such as essential hypertension I10, or secondary hypertension I15.-)*

Essential (primary) hypertension (I10) is used to close the HEDIS Controlling High Blood Pressure (CBP) measure. The metric utilizes most recent BP reading to maintain adequate control of <140/90 yearly (systolic must be less then 140 and the diastolic must be less than 90)

- ☐ Metric for members 18–85 years of age with the most recent BP reading during the current calendar year on or after the second diagnosis of hypertension I10 completed on a specific date with result *(refer to the Quality tab in Athena (or other EMR system) during each patient visit)*
- ☐ Patients coded to HTN with CHF, and HTN with CHF and CKD are excluded from the HEDIS performance measure
- ☐ Avoid defaulting all patients with HTN to I10 essential hypertension if heart failure and/ or CKD is present

Hypertension with Heart Failure

I11.0*Hypertensive heart disease with HF – requires a heart failure code to define the type and severity

I11.9 Hypertensive heart disease without heart failure

ICD-10-CM Code	ICD-10-CM Descriptor
Heart Failure (HF)	
*(4th character is used to identify the type of failure (e.g., systolic, diastolic, combined). Also, identify the underlying cause. 5th or 6th character to **I50.81-*** is used to identify: 0= unspecified; 1= acute; 2= chronic; 3= acute on chronic)*	
I50.1-*	Left ventricular failure, unspecified
I50.2-*	Systolic (congestive) heart failure
I50.3-*	Diastolic (congestive) heart failure
I50.4-*	Combined systolic (congestive) and diastolic (congestive) heart failure
I50.8-*	Other heart failure *(e.g., right heart failure, biventricular, right and left heart failure)*
I50.9-*	Heart failure, unspecified

Hypertensive Chronic Kidney Disease

I12.0* Hypertensive CKD stage 5 or ESRD – requires a CKD code to define the stage.

I12.9 Hypertensive CKD stage 1-4, or unspecified – requires a CKD code to define the stage.

CD-10-CM Code	ICD-10-CM Descriptor
Chronic Kidney Disease (CKD) *(Use an additional code for dialysis status (**Z99.2**); or, non compliance with dialysis (**Z91.15**) if relevant)*	
N18.1	CKD, stage 1
N18.2	CKD, stage 2 (mild)
N18.3-	CKD, stage 3 (moderate) *(5th character: 0=unspecified; 1=stage 3a; 2=stage 3b)*
N18.4*	CKD, stage 4 (severe)
N18.5*	CKD, stage 5 *(requiring chronic dialysis use **N18.6** instead)*
N18.6*	End stage renal disease (ESRD)
N18.9	CKD, unspecified *(e.g., chronic renal disease; chronic renal failure, chronic renal insufficiency, chronic uremia)*

Hypertension with Heart Failure & Chronic Kidney Disease

There is a presumed causal relationship between HTN with heart involvement and HTN and kidney involvement.

I13.0* Hypertensive heart and CKD (with HF) stage 1-4, or unspecified – requires both a HF code and CKD code

I13.10 Hypertensive heart and CKD (without HF) stage 1-4, or unspecified – requires both (other heart disease condition) and CKD code

I13.11* Hypertensive heart and CKD (without HF), with stage 5 CKD, or ESRD – requires both (other heart disease condition) and CKD code

I13.2* Hypertensive heart and CKD (with HF), with stage 5 CKD, or ESRD – requires both HF and CKD code

ICD-10-CM Code	ICD-10-CM Descriptor
Heart Failure (HF)	
*(4th character is used to identify the type of failure (e.g., systolic, diastolic, combined). Also, identify the underlying cause. 5th or 6th character to **I50.81-** is used to identify: 0= unspecified; 1= acute; 2= chronic; 3= acute on chronic)*	
I50.1*	Left ventricular failure, unspecified
I50.2*	Systolic (congestive) heart failure
I50.3-*	Diastolic (congestive) heart failure

I50.42-*	Combined systolic (congestive) and diastolic (congestive) heart failure
I50.8-*	Other heart failure *(e.g., right heart failure, biventricular, right and left heart failure)*
I50.9*	Heart failure, unspecified

Chronic Kidney Disease (CKD)
*(Use an additional code for dialysis status (**Z99.2**); or, non compliance with dialysis (**Z91.15**) if relevant)*

N18.1	CKD, stage 1
N18.2	CKD, stage 2 (mild)
N18.3-*	CKD, stage 3 (moderate) *(5th character: 0=unspecified; 1=stage 3a; 2=stage 3b)*
N18.4-*	CKD, stage 4 (severe)
N18.5-*	CKD, stage 5 *(requiring chronic dialysis use **N18.6** instead)*
N18.6-*	End stage renal disease (ESRD)
N18.9	CKD, unspecified *(e.g., chronic renal disease; chronic renal failure, chronic renal insufficiency, chronic uremia)*

DOCUMENTATION

When documenting HTN, specify the type (e.g., essential HTN, secondary to renal artery stenosis, renovascular HTN, drug-resistant, accelerated, etc.), acuity (e.g., HTN urgency), systemic involvement (e.g., HTN with ventricular hypertrophy, diastolic dysfunction, heart failure with details on type and severity, or HTN with chronic kidney disease with the stage of CKD), and any underlying causes.

Major Depressive Disorder

According to the American Psychiatric Association, major depressive disorder (MDD) can be seen in patients who have suffered a depressive episode lasting at least two weeks, as manifested by at least 5 of the following symptoms, which must include at least one of the first two.

- ☐ Depressed mood
- ☐ Loss of interest or pleasure in most or all activities
- ☐ Insomnia or hypersomnia
- ☐ Significant weight loss or gain (altered appetite)
- ☐ Fatigue or low energy
- ☐ Poor concentration
- ☐ Psychomotor retardation or agitation
- ☐ Thought of worthlessness or guilt
- ☐ Recurrent thoughts of death or suicidal ideation

Partial remission: Occasional symptoms from a previous MDD episode with a hiatus lasting less than two months without any significant symptoms

Full remission: No significant signs or symptoms of the disturbance present during the past two months

MAJOR DEPRESSIVE DISORDER

MILD
Symptoms (2-3) that are clinically relevant

- Few if any symptoms
- in excess of (3)
- Accuracy & specificity of symptoms are manageable
- Minor or no social or occupational impairment

MODERATE
Symptoms (4-5) that are clinically relevant

- Symptoms increased between mild and severe
- Accuracy & specificity is partially or markedly manageable
- Social and/or occupational impairment increased between mild and severe

SEVERE
Symptoms (6 or more) that are clinically relevant

- Symptoms substantially increased
- Accuracy & specificity is seriously distressing and unmanageable
- Social and/or occupational functioning is markedly disrupted

ICD-10-CM Code	ICD-10-CM Descriptor
F32.A	Depression, unspecified (as single or recurrent)
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2*	Major depressive disorder, single episode, severe without psychotic features
F32.3*	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8-	Other depressive episodes, single (atypical or marked depression)
F32.9	Major depressive disorder, single episode, unspecified

F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2*	Major depressive disorder, recurrent, severe without psychotic features
F33.3*	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other Recurrent depressive disorders (brief depressive episodes)
F33.9	Major depressive disorder, recurrent, unspecified
F34.81*	Disruptive mood dysregulation disorder
F39	Unspecified mood [affective] disorder *(use when not sufficient as hypomanic or mild depressive episodes, but cause significant distress or social, occupational or other important areas of functioning if clinically relevant)*

PHQ-9 Score	Interpretation
5 to 9	Mild depression symptoms
10 to 14	If ≤ 12: Mild depression If ≥ 13: Mild– major depression
15 to 19	Moderate – major depression
Greater than 20	Severe – major depression

IMPORTANT DOCUMENTATION NOTES (Major Depressive Disorder)

The clinical diagnosis needs to include the severity and occurrence to support major depressive codes. Using these codes without mentioning the acuity will result in false claims.

If a member is actively taking prescribed medication and/or receiving counseling/therapy consider MDD recurrent.

If member has diagnosis of depression and diagnosis of anxiety, and if there is a causal relationship between the two conditions, then documentation must establish the relationship by stating depression "with," "due to," or "related to" anxiety to capture the code that encompasses both diagnoses (F34.1 or F41.8).

Morbid (Severe) Obesity

E66.01 Morbid (severe) obesity due to excess calories

E66.2 Morbid (severe) obesity with alveolar hypoventilation

If the provider states the patient is morbidly obese, the appropriate code is used, regardless of the BMI in addition to supportive documentation and any comorbid conditions.

DOCUMENT type, cause, weight and BMI, and any associated comorbid conditions.

Body mass index (BMI) should be coded secondary to the underlying condition (overweight, obesity, morbid obesity, protein-calorie malnutrition). BMI codes can be assigned from the dietician or other caregiver's documentation; however, the provider must mention and confirm the condition (i.e., morbid obesity).

- Morbid obesity is generally recognized as a person with a BMI of ≥ 40.
- Morbid obesity can be recognized as a person with a BMI of 35.0-39.9 with one or more clinically relevant comorbid conditions.

OBESITY
(BMI 30-39.9)

- E66.9 Obesity, unspecified
- Z68.30-Z68.34 BMI

MORBID OBESITY
(BMI 35-35.9)

- **E66.01** or **E66.2** Severe obesity
- Z68.35–Z68.39 BMI
- With one or more relevant comorbid conditions
- Establish a confirmed diagnosis

MORBID OBESITY
(BMI 40 or greater)

- **E66.01** or **E66.2** Severe obesity
- **Z68.41**–**Z68.45** BMI
- Establish a confirmed diagnosis

Neoplasms

Correctly Reporting Cancer

Determines whether the patient's cancer has been eradicated or is currently being treated. There are three established categories of malignancy: primary, secondary and in situ. Select the code that describes the category (primary or secondary).

Current Cancer vs. History of Cancer

Code active cancer or cancer in remission if the patient:

- Is being treated with long-term adjunctive and/or adjuvant therapy (e.g., breast/prostate cancer on hormonal treatment)
- Has metastatic cancer: code both the primary (only if active) and secondary site(s)
- Is on brachytherapy (radioactive seed implants) that are still active
- Has confirmed cancer with active surveillance (watchful waiting) and only attempting treatment as necessary

Code personal history of cancer Z85.- if all treatment has been completed and the condition has resolved with no active disease or metastases; or, if medications are used to prevent recurrence. If the cancer returns then code it as active.

ICD-10-CM Code	ICD-10-CM Descriptor
Breast Cancer	
C50.-	Malignant neoplasm of breast (by site and laterality) • *4th characters identify: 0= nipple/areola; 1= central region; 2-5= quadrants; 8= overlapping boundaries.* • *5th characters identify: 1= female; 2= male.* • *6th characters identify: 1= laterality; 1= right; 2= left; 0= unspecified*
C50.811*	Malignant neoplasm of overlapping sites of right female breast
C50.812*	Malignant neoplasm of overlapping sites of left female breast
C50.911*	Malignant neoplasm of unspecified site of right female breast
C50.912*	Malignant neoplasm of unspecified site of left female breast
Long-term Use of Agents Affecting Estrogen Receptors and Estrogen Levels	
Z17.0	Estrogen receptor positive status [ER+]
Z17.1	Estrogen receptor negative status [ER-]
Z79.810	Long-term (current) use of SERMs *(includes tamoxifen, raloxifene and toremifene)*
Prostate Cancer	
D07.5	Carcinoma in situ of prostate
C61*	Malignant neoplasm of prostate *(Use additional code, if applicable, to identify: hormone sensitivity status (Z19.1-Z19.2); rising PSA following treatment for malignant neoplasm of prostate (R97.21)*

EXAMPLES

Primary Site with Unknown Secondary Site

A 65-year-old female with metastatic scirrhous carcinoma at the 12 o'clock position of left breast, SBR 3-grade, ER+; PR+; HER2+/-, lobular-invasive large cell.

- **C50.812*** Malignant neoplasm of overlapping sites of left female breast
- **C79.9*** Secondary malignant neoplasm of unspecified site
- Z17.0 Estrogen receptor positive status [ER+] (codes are currently not available for PR, HR and HER2 +/- status)

Secondary Site with Active Primary Site

A patient was admitted with metastatic bone cancer with left breast mastectomy two months ago and is currently undergoing radiation treatments for RUOQ breast cancer.

- **C79.51*** Secondary malignant neoplasm of bone
- **C50.411*** Malignant neoplasm of upper outer quadrant of right female breast
- Z90.12 Acquired absence of left breast and nipple

CANCER PROGRESS NOTE DOCUMENTATION TIPS

History of Present Illness

Distinction between the type of cancer and behavior, morphology (histological type, stage, or grade), anatomic site, and laterality. Signs or symptoms of the neoplasm pain, fever, noticeable swelling or growth, cough, neurologic or bowel changes, and/or side effects of treatment.

Exam

- Attention to any specific body areas/organ systems affected by the neoplasm or search for metastatic disease (e.g., exam of the liver, lymph nodes, spine).

Evaluation

- Any type of diagnostic study or referral related to neoplasm, commonly:
- Imaging studies (PET scans almost exclusively for metastatic disease)

- A tumor marker (PSA for prostate cancer or CEA for colon cancer)
- Lab: CBC, liver profile, other specific for types and locations of the neoplasm.
- Biopsy
- Specialty referrals for evaluation of neoplasm

Treatment

- Administering or referring for chemotherapy, immunotherapy, radiotherapy, other modalities
- Initiating or modifying prescriptions for the neoplasm or for symptoms and Planning or referring for surgery or other procedures
- Planning or referring for surgery or other procedures
- Other referrals related to the neoplasm (e.g., hospice or community resource and support)

Evaluation

- Implications, management options, and modalities, side effects of treatment, test results, community resources and support, advanced directives, hospice.

CANCER DOCUMENTATION AND CODING TIPS

The term cancer and malignant neoplasm are often used interchangeably. However, a documented "neoplasm" without specificity is not synonymous with metastatic cancer. There are several general ICD-10-CM official coding guidelines related to metastatic neoplasms. These include (but are not limited to) the following:

1. When the diagnostic statement indicates **"metastatic to,"** this means that the site mentioned is secondary.
2. If the primary site is still present, a code for it should also be reported.

3. The statement **“metastatic from”** indicates that the site mentioned is the primary site and the coder should ascertain whether that malignancy still exists.
4. Codes are assigned when it is unclear from test results where the cancer originated or where it is spreading to:
    - Assign code **C80.1*** Malignant (primary) neoplasm, unspecified for an unknown
    - primary site.
    - Assign code **C79.9*** Malignant (secondary) neoplasm of unspecified site for a metastatic cancer to an unknown secondary site with a code describing a known primary site.

1. If two or more sites are documented as **“metastatic,”** each of the designated sites should be coded as secondary.
2. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis. The only exception is if a patient is admitted solely for chemotherapy or radiation therapy.
3. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

DOCUMENTATION OVERVIEW

When documenting cancer, specify the type (e.g., carcinoma, sarcoma, lymphoma, leukemia), site or organ of origin (e.g., breast, lung, colon, prostate), stage or extent (including TNM staging when available), histological grade or differentiation (well-differentiated, moderately-differentiated, poorly-differentiated), presence or absence of metastasis, treatment modalities (surgery, chemotherapy, radiation, immunotherapy), and any relevant genetic markers or mutations (e.g., HER2-positive, EGFR mutation).

Respiratory Conditions

Cigarette smoking is the most significant determinant of the development and progression of COPD. Use additional code to identify: Exposure to environmental tobacco smoke (Z77.22); History of tobacco dependence (Z87.891); Occupational exposure to environmental tobacco (Z57.31); Tobacco dependence (F17.-); Tobacco use (Z72.0)

ICD-10-CM Code	ICD-10-CM Descriptor
Chronic Obstructive Pulmonary Disease (COPD) (Includes chronic obstructive asthma, chronic asthmatic bronchitis, chronic obstructive bronchitis, and chronic bronchitis with emphysema)	
J41.0*	Simple chronic bronchitis *(smokers' cough)*
J44.0*	COPD with acute lower respiratory infection
J44.1*	COPD with (acute) exacerbation
J44.81*	Bronchiolitis obliterans and bronchiolitis obliterans syndrome *(Code first, if applicable complications of bone marrow, stem cell transplants, lung or heart-lung transplant, grafts, etc)*
J44.89*	Other specified COPD *(e.g., chronic asthmatic (obstructive) bronchitis, or emphysematous bronchitis)*
J44.9*	COPD, unspecified
J4A.-*	Chronic lung allograft dysfunction *4th characters identify: 0= restrictive; 1= other; 2= unspecified*
J96.1-*	Chronic respiratory failure *5th characters identify: 0= unspecified; 1= with hypoxia; 2= with hypercapnia*

R05	Cough
Z99.81	Dependence on supplemental (long-term) oxygen *(this code is not to be used for CPAP)*
Emphysema	
J43.0*	Unilateral pulmonary emphysema [MacLeod's syndrome] *(e.g., unilateral emphysema, hyperlucent lung, pulmonary artery functional hypoplasia)*
J43.1*	Panlobular emphysema *(e.g., panacinar emphysema)*
J43.2*	Centrilobular emphysema
J43.8*	Other emphysema
J43.9*	Emphysema, unspecified

DOCUMENTATION

Providers should review and include the interpreting provider's notes from diagnostic imaging and other pulmonary function studies in the current progress note when relevant. Ensure clear documentation of the type (e.g., COPD with asthma), severity (e.g., acute exacerbation, hypoxia), circumstances (e.g., sepsis, shock, emphysema), known infectious microorganisms, and any dependency on oxygen or mechanical ventilation. Also include any related tobacco use, abuse, dependence, past history, or exposure.

Secondary Immunodeficiency

Document and code the presence of immunodeficiency or immunocompromised condition due to underlying conditions such as autoimmune diseases, immunodeficiencies, recurrent infections, and hypersensitivities, or due to drugs when clinically relevant. Also, code the underlying cause of the deficiency to include verbiage that links the underlying cause to the immunodeficiency or immunocompromised disorder.

Immunodeficiency may be prevalent in patients diagnosed with Stage 5 CKD, diabetes mellitus, malnutrition, substance use, cancer treatments, microorganism and parasitic infections, chronic gum disease (gingivitis, periodontal disease), yeast infections, oral thrush, sinus infections, conjunctivitis, pneumonia, HIV, etc.

Consider if clinically relevant for patient taking the following medications for immunosuppression if not diagnosed in the progress note: *Humera; Prednisone; Dexamethasone; Methotrexate; Adalimumab; Infliximab; Etanercept; Rituximab; Azathioprine; Cyclosporine; Glatiramer acetate; Interferon-alpha; Interferon-beta; lHydrocortisone; Mycophenolate; Tacrolimus; Sirolimus; Everolimus; Etanercept; Cyclophosphamide; Vinblastine; Doxorubicin; Thioguanine; Interleukin-2* (and others)

ICD-10-CM Code	ICD-10-CM Descriptor
Disorders of Immunity	
(Secondary immunodeficiency)	
D84.81*	Immunodeficiency due to conditions classified elsewhere *(Code first underlying condition, such as: hemoglobinopathy (e.g., sickle cell disease); diabetes mellitus; malignant neoplasms; malnutrition; autoimmune disease (e.g., rheumatoid arthritis, lupus); ulcerative colitis; Crohn's disease; cirrhosis*

D84.821*	Immunodeficiency due to drugs *(Use additional code for adverse effect if applicable, to identify adverse effect of drug (T36-T50); long-term (current) drug therapy or medication such as:* • Systemic steroids *(≥ 20 mg/day of prednisone (or equivalent) for more than 14 days)* • Disease-modifying anti-rheumatic drugs *(e.g., methotrexate, hydroxychloroquine)* • Biologic response modifiers *(e.g., abatacept (Orencia), adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), rituximab (Rituxan), tofacitinib (Xeljanz)* • Chemotherapeutic agents *(e.g., adriamycin; carboplatin)*
D84.822*	Immunodeficiency due to external causes • *Code also, if applicable: radiological procedure and radiotherapy (Y84.2).* • *Use additional code for external causes such as exposure to ionizing radiation, bone marrow transplant, dialysis, organ transplant, etc.*
D89.82*	Autoimmune lymphoproliferative syndrome *(Used for rare genetic alteration of the Fas protein that impairs normal cellular apoptosis (normal cell death), causing abnormal accumulation of lymphocytes in the lymph glands, liver, and spleen. Symptoms include neutropenia, anemia, and thrombocytopenia)*
D89.89*	Other specified disorders involving the immune mechanism, not elsewhere classified

Specified Heart Arrhythmias

When documenting arrhythmias, specify the type, underlying causes or contributing factors, duration and frequency of arrhythmic episodes, symptoms (e.g., palpitations, dizziness, syncope), diagnostic tests (e.g., electrocardiogram, Holter monitor, stress test), and treatment approaches (e.g., medications, catheter ablation, pacemaker implantation).

Incorporate specialist notes into your active progress note, and include a comprehensive plan of care, which may involve referrals, dietary recommendations, monitoring, and diagnostic testing. Notably, refrain from using arrhythmia codes when the condition has been resolved through catheter-based ablation.

ICD-10-CM Code	ICD-10-CM Descriptor
144.2*	Atrioventricular block, complete
147.1-*	Supraventricular tachycardia *5th characters identify: 0= unspecified; 1= so stated (e.g. IST); 9= other (e.g., atrial or atrioventricular or junctional or nodal (paroxysmal) tachycardia*
147.2-*	Ventricular tachycardia *5th characters identify: 0= unspecified; 1= Torsades de pointes (TdP); 9= other*
147.9*	*Paroxysmal tachycardia, unspecified (e.g., Bouveret (-Hoffman) syndrome)*
148.-*	Atrial fibrillation and flutter *Add 4 and/or 5th characters: 0= paroxysmal atrial fibrillation; 1= persistent atrial fibrillation; 2= chronic (permanent) atrial fibrillation; 3= typical (type 1) atrial flutter; 4= atypical (type 2) atrial flutter; 91= unspecified atrial fibrillation; 92= unspecified atrial flutter*

I49.01*	Ventricular fibrillation
I49.02*	Ventricular flutter
I49.40	Unspecified premature depolarization
I49.5*	Sick sinus syndrome *(Assign also code Z95.0 Presence of cardiac pacemaker, which should be reported, even in the absence of any notable changes or management. If accessing the pacemaker, document as stable if relevant and assign the code)*

Seizure Disorders and Convulsions

Document findings that support the diagnosis of specified seizure disorder by merging specialist notes with your active progress note to include a plan of care supporting seizure type (e.g., tonic and/or clonic, myoclonic, absence, atonic), signs and symptoms, neurologic exams, lab tests, medications, other treatments (e.g., ketogenic diets, vagus nerve stimulation, etc.), and brain function tests (e.g., electroencephalogram (EEG), high-density EEG, computerized tomography (CT) scan, magnetic resonance imaging (MRI), positron emission tomography (PET), etc.).

ICD-10-CM Code	ICD-10-CM Descriptor
Epilepsy and Recurrent Seizures	
(5th character is used to identify: 0=non intractable; 1=intractable; 6th character is used to identify: 1=with status epilepticus; 2=without status epilepticus)	
G40.0-*	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset;
G40.1-*	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures;
G40.2-*	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures;
G40.3-*	Generalized idiopathic epilepsy and epileptic syndromes;
G40.A-*	Absence epileptic syndrome
G40.B-*	Juvenile myoclonic epilepsy [impulsive petit mal];
G40.C-*	Lafora progressive myoclonus epilepsy, *(Add 4th and 5th characters: 0= not intractable; 1= intractable; and 1= with status epilepticus; 9= without status epilepticus)*
G40.4-*	Other generalized epilepsy and epileptic syndromes;
G40.5-*	Epileptic seizures related to external causes;
G40.8-*	Other epilepsy and recurrent seizures *(Include epilepsies and epileptic syndromes undetermined as to whether they are focal or generalized, or Landau-Kleffner syndrome)*

G40.9-*	Epilepsy, unspecified
R56.0-*	Febrile convulsions *(Includes atypical, complex and complicated)*
R56.1*	Post-traumatic seizures
R56.9*	Unspecified convulsions *(Includes fits, recurrent convulsions and seizures NOS)*

Important Points About Risk Adjustment Documentation

Accurate, specific and complete documentation and coding provides program planning and evaluation data, helps facilitate compliance with federal guidelines, and supports appropriate payment for services rendered. Improved documentation is important to protect your patients, and promote patient safety and quality of care.

DO enter diagnosis code(s) for the condition(s) noted in the medical record according to CMS risk adjustment guidelines, which encourages complete diagnosis code submission to the highest level of specificity. Include the main reason for the episode of care and all acute conditions, problem pertinent chronic conditions, any co-existing and pertinent past conditions that impact clinical evaluation and therapeutic treatment.

DO NOT enter diagnosis codes for diagnoses that you ***do not*** consider in your evaluation of the patient, or that you have not noted in the medical record.

Each applicable value-based care diagnosis code must be submitted on at least one face-to-face or telehealth (audio/visual capability) in a calendar year.

Provider (physician, qualified non-physician practitioner or medical professional) responsibilities:
Providers should report all diagnoses that impact the patient's care and ensure that these diagnoses are accurately documented in the medical record. Coding to the highest degree of specificity provides the most accurate coding and helps ensure appropriate grouping within the risk adjustment model.

- Report ICD-10-CM codes to the highest level of specificity, and report these codes correctly (accurately and completely)
- Maintain accurate and complete medical record documentation
- Follow the procedures for correcting erroneous data
- Report data in a timely manner

References Cited

1. 2022. NHS Reports See: https://www.cdc.gov/nchs/data/nhsr/nhsr158-508.pdf. [October 25, 2023].
2. Obesity, H. and Health, N., 2022. Health Risks of Overweight & Obesity | NIDDK. See: https://www.niddk.nih.gov/health-information/weight-management/adult-overweight-obesity/health-risks?msclkid=9ad2f787d09b11ec819aade653ba061a, [October 25, 2023].
3. AHA Coding Clinic for ICD-10-CM. Body Mass Index. Vol 5, Q4, 2018
4. Cms.gov. 2022. Regulations & Guidance | CMS. Pub 100 Department of Health & Human Services (DHHS) 03 Medicare National Coverage Determinations: Transmittal 142, See: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance. [October 25, 2023].
5. National Kidney Foundation. 2022. Guidelines and Commentaries. [online] Available at: <https://www.kidney.org/professionals/guidelines/guidelines_commentaries [October 25, 2023]
6. KDIGO.org. "Kidney Disease-Improving Global Outcomes (KDIGO), Vol. 3, Issue 1." Journal of the International Society of Nephrology, 14 Jan. 2023, https://kdigo.org/wp-content/uploads/2017/02/KDIGO_2012_CKD_GL.pdf. [October 25, 2023].
7. Cancer.org. 2022. Observation or Active Surveillance for Prostate Cancer. See: https://www.cancer.org/cancer/prostate-cancer/treating/watchful-waiting.html#:~:text=Observation%20or%20Active%20Surveillance%20for%20Prostate%20Cancer%20Because. [October 25, 2023].

8. Urologyhealth.org. 2022. Ask the Experts: Difference between Active Surveillance and Watchful Waiting when Treating Prostate Cancer? See: https://www.urologyhealth.org/healthy-living/urologyhealth-extra/magazine-archives/winter-2017/ask-the-experts-whats-the-difference-between-active-surveillance-and-watchful-waiting-when-treating-prostate-cancer#:~:text=Active%20surveillance%20may%20require%20you%20to%20have%20many,not%20involve%20regular%20biopsies%20or%20other%20frequent%20testing. [October 25, 2023].
9. American Brachytherapy Society. 2022. What is Brachytherapy? See: https://www.americanbrachytherapy.org/resources/for-patients/what-is-brachytherapy/. [October 25, 2023].
10. Clinical Documentation Improvement Desk Reference For ICD-10-CM & Procedure Coding. Salt Lake City, UT: Optum360; 2024.
11. Optumcoding.com ICD-10-CM: Professional for Physicians 2024. Salt Lake City, UT; 2023.
12. APA. Diagnostic and Statistical Manual of Mental Disorders. 5th ed.-TR. Arlington, VA: American Psychiatric Association; 2021.
13. AHA Coding Clinic for ICD-10-CM. Bipolar Disorder and Recurrent Major Depressive Disorder. Vol 7, Q1, 2020.
14. AHA Coding Clinic for ICD-10-CM. Continuous PAP Status, Q1, p. 11. 2020.
15. AHA Coding Clinic for ICD-10-CM. Diabetic ulcers with neuropathy (Necrotic Pressure Ulcer of Heel). Vol 5, Q3, 2018.
16. AHA Coding Clinic for ICD-10-CM. Alzheimer's Disease and Dementia, Vol 4. Q1, 2017.
17. AHA Coding Clinic for ICD-10-CM. Sick Sinus Syndrome Controlled with Implanted Cardiac Device. Vol 6, Q1, 2019.

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