ACA HHS RADV Protocols for Benefit Year 2021*

CMS intends that this information be used only for reference. CMS expects medical coders to comply with the following coding resources, in sequential order:

- Conventions in the ICD-10-CM classification
- ICD-10-CM Official Guidelines for Coding and Reporting
- AHA Coding Clinic®
- Professional judgement

Medical Record Requirements

- Date of service for the encounter
- Patient first and last name and identifier (i.e., date of birth, medical record number, or account number)
- Valid signature and credentials of the provider, including a valid attestation for electronic or digital records
- Signature within 180 days from the date of service
- Use of (standard) abbreviations that may be discerned from context (e.g., CRF)
    - If the discernment cannot be made, the record fails, i.e., diagnosis not validated

Coding Examples

- "Discharge summary states: A 77-year-old woman was intubated upon arrival for acute respiratory failure resulting from ARDS due to urosepsis. On day 5 of her stay her oxygen requirements declined such that she is now on an FIO2 of 0.4 with a PEEP of 5 cm H2O. She has been doing poorly and remains vent dependent. She will be transferred to a long-term care facility as per her family's request." Vent dependence may be coded in this scenario.
- "A patient was admitted for elective aortic valve replacement. Before the surgery, the patient was intubated and placed on a ventilator and cardiopulmonary bypass. The patient went into postoperative respiratory failure and remained on the vent for 3 days. The patient was extubated on day 4 with the ability to breathe on her own with no further complications. On day 10, the patient was stable enough for discharge to home." Vent dependence may **not** be coded.
- "The assessment portion of an inpatient progress note states patient had a recent stem cell transplant and was prescribed anti-rejection medications Cellcept and Tacrolimus." Code D84.822, Immunodeficiency due to external causes. D84.821, Immunodeficiency due to drugs.
- "Discharge summary states the patient has ulcerative colitis and has an immunosuppressed status." Code D84.9, Immunodeficiency, unspecified.

*ACA Protocols are published annually in May of the year following the benefit year; they are not published in advance of the benefit year. ACA Protocols may be accessed via CMS' Registration for Technical Assistance Portal (REGTAP).

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