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Risk Adjustment Coding and HCC Guide

Simplifying the RA/HCC systems and optimization opportunities

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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 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
- Tools for risk adjustment
- Coding scenarios
- Guidance for developing internal risk adjustment coding polices
- Audits
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Risk adjustment model tables

Coding is an increasingly complex business. The movement from the fee-for-service payment model to more qualitative models has increased rapidly since 2004. The demand for quality-focused payment models has gained more attention since the ACA introduced a risk-adjustment model to the online insurance exchange marketplace plans in 2017. Coding staff must have knowledge of risk- adjustment practices in this rapidly changing environment. This book provides conceptual and practical knowledge of risk adjustment to coders, coding managers, medical staff, clinical documentation improvement (CDI) professionals, payers, educators, and students. The goal is to develop and enrich the knowledge of the user's understanding of this payment methodology.

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General Standards

Documentation is the recording of pertinent facts and observations about a patient's health history, including past and present illnesses, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient to:

- Enable a physician or other healthcare professional to plan and evaluate the patient's treatment
- Enhance communication and promote continuity of care among physicians and other healthcare professionals involved in the patient's care
- Facilitate claims review and payment
- Assist in utilization review and quality of care evaluations
- Reduce hassles related to medical review
- Provide clinical data for research and education
- Serve as a legal document to verify the care provided (e.g., as defense in the case of a professional liability claim)
- Validate that treatments are appropriate for treating the patient's condition
- Document medical necessity of the diagnosis

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

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

Acceptable Sources

CMS requires that Medicare Advantage (MA) organizations use the following sources for risk-adjustment data collection:

- Hospital inpatient facilities

Type of Hospital Inpatient Facility
Short-term (general and specialty) hospitals
Medical assistance facilities/critical access hospitals
Religious nonmedical healthcare institutions
Long-term hospitals
Rehabilitation hospitals
Children's hospitals
Psychiatric hospitals

There is an increasing need for hospital inpatient coders to learn the outpatient coding rules in order to properly capture and report HCC diagnoses. In addition, inpatient coders may not routinely assign codes for chronic conditions that do not qualify as a complication or comorbidity (CC) or a major complication or comorbidity (MCC) for MS-DRG assignment. These chronic conditions are now important elements that can affect the total risk score for the patient. There are also conditions that are only captured in the acute setting, such as stroke and acute exacerbations of chronic illnesses such as chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

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Queries

ICD-10-CM Official Guidelines for Coding and Reporting, section I.A.19 has caused a lot of controversy. *AHA Coding Clinic*, fourth quarter 2016, p 147 clarified this saying: "This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. *Coding Clinic* and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in *Coding Clinic* over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can 'diagnose' the patient." This guideline emphasizes that the physician or provider's documentation of a condition is required to code it and that it is the responsibility of the physician or provider to ensure that documentation is complete, accurate, and appropriate; not the coder or other staff. In a recent American Health Information Management Association (AHIMA) brief, the guidance given states:

"When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility's escalation policy." Similar advice was also given by the *AHA Coding Clinic* and CMS.

The bottom line is that when the documentation is unclear, incomplete, or conflicting, the provider needs to be queried for more information, if possible.

The following five criteria should be used when reviewing documentation and in determining whether a query is necessary:

- **Legibility:** Poor penmanship, improper use of photocopies, poor document scans, "cut and paste" errors, use of templates, or improperly correcting an error in a medical record can cause problems with legibility, omissions, or additions in text that can result in errors of documentation and code assignment. Does a condition warrant reporting that is a result of "cut and paste" documentation from a previous encounter problem list not addressed on the current encounter?
- **Consistency:** Documentation that is conflicting, inadequate, incomplete, ambiguous, or inconsistent: is the condition exacerbated or is it stable; was the suspected condition ruled out; what is the clinical significance of the abnormal test results; or, does the provider confirm the consultant's diagnosis?
- **Relationships:** Clinical indicators noted without a stated related diagnosis, diagnostic work-up without stated reason, treatment without identified indication or manifestations not linked to an underlying cause: does the notation ↑Na represent a clinically significant diagnosis; what is the reason for the need of continuous O2; what was the indication and final conclusion for the performance of a glucose test; is the ulcer due to a complication of the underlying diabetes?
- **Specificity:** Clinical results, including pathology reports, response to treatment, and/or the patient's clinical condition suggest a more specific diagnosis or level of severity than is documented: based on culture and sensitivity and patient response to treatment, can the condition be further specified as to a causative organism; can the post-op/final diagnosis be further specified due to the pathology report findings; based on the pathology report findings, which additional sites of metastasis are clinically significant?
- **Clinical validation:** There is lack of clinical data or insufficient indicator(s) are met to support a diagnosis or its degree of specificity; the decision to query may require a review by a clinician: does the PACU note stating "post-op respiratory failure" during the routine post-op intubation period without correlating clinical indicators represent a complication due to surgery, other condition, or an expected outcome immediately post-surgery; is the diagnosis of acute exacerbation supported by clinical findings, adjustment of regimen/treatment or clinical manifestation?

After determining that a query is needed, there is additional guidance that should be followed. The main concern is not initiating leading queries. A leading query could cause incorrect code assignment. A leading query is considered to be a query that is not supported by clinical elements within the health record and/or that directs a provider to a specific diagnosis.

A query should not:

- Lead the clinician to a specific diagnosis
- Introduce new information
- Directly or indirectly reference any financial impact of the query response

In risk adjustment, this would include indicating:

- The HCC status of a condition
- The RAF value or HCC category of the HCCs included in the query

Example

Documentation: CXR revealed RLL PNA. Clindamycin ordered.

Dr. Diaz,

Is the patient's pneumonia due to aspiration?

Thanks,

HIM Dept.

This query is an example of a leading query because the coder is directing the provider to a specific diagnosis.

AHIMA provided a practice brief on queries, which was updated in 2022. Within this brief, the use of open-ended queries was indicated as being the preferred format but that multiple choice and/or "yes/no" queries are also acceptable under certain circumstances.

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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 63. 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 all providers must meet. For example, if 10 charts are reviewed, 90 percent must be correct. It is also important to identify claims that may need to be corrected or payments that need to be refunded to the payer.

Step 7

Determine recommendations and corrective actions. The next step is to schedule meetings with the providers to provide feedback, recommendations, and education. Typically it works best to meet with a provider on an individual basis and have his or her audit results and charts available as examples so that they can be reviewed and discussed. The provider should be given the opportunity to explain the rationale behind his or her coding, and perhaps even provide additional information to help the coder further understand a particular clinical term. Allowing the provider to give feedback also helps build a better auditor-provider relationship. This relationship may make the provider feel comfortable enough with the auditor to ask questions about future coding issues, instead of reporting incorrect codes to payers. A word to the wise, when discussing a coding error with a provider, it is a good idea to have a copy of the official source document supporting discussion of the error.

Step 8

Implement quality improvement initiatives. After addressing the identified issues, set up a process to monitor these areas. Formal training programs, one-on-one coaching, and regularly scheduled audits can be beneficial. After an audit process is in place, it may be necessary to update practice policies and procedures that need to be monitored on a regular basis. Lastly, designate an individual who is responsible for each area of compliance and document the follow-through so that providers stay on the right track with billing practices.

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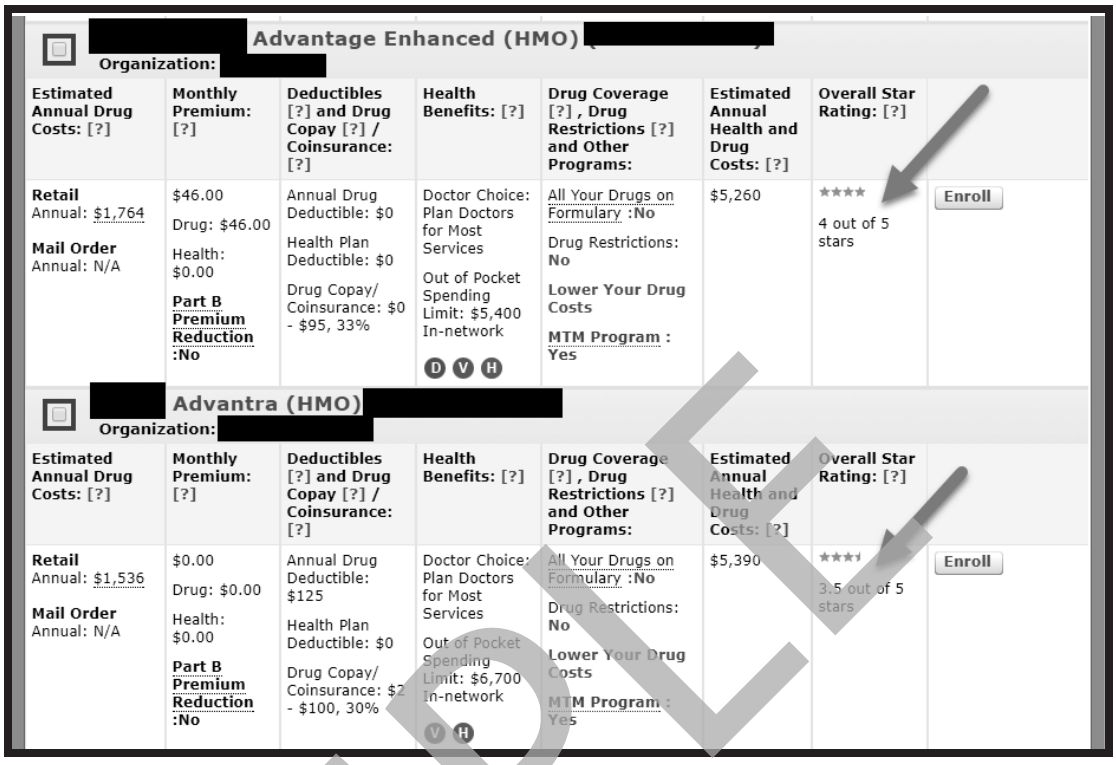

[redacted] Advantage Enhanced (HMO) [redacted]
Organization: [redacted]

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]	
Retail Annual: $1,764 **Mail Order** Annual: N/A	$46.00 Drug: $46.00 Health: $0.00 **Part B Premium Reduction :No**	Annual Drug Deductible: $0 Health Plan Deductible: $0 Drug Copay/ Coinsurance: $0 - $95, 33%	Doctor Choice: Plan Doctors for Most Services Out of Pocket Spending Limit: $5,400 In-network D V H	All Your Drugs on Formulary :No Drug Restrictions: No **Lower Your Drug Costs** MTM Program : Yes	$5,260	★★★★ 4 out of 5 stars	Enroll

[redacted] Advantra (HMO) [redacted]
Organization: [redacted]

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]	
Retail Annual: $1,536 **Mail Order** Annual: N/A	$0.00 Drug: $0.00 Health: $0.00 **Part B Premium Reduction :No**	Annual Drug Deductible: $125 Health Plan Deductible: $0 Drug Copay/ Coinsurance: $2 - $100, 30%	Doctor Choice: Plan Doctors for Most Services Out of Pocket Spending Limit: $6,700 In-network V H	All Your Drugs on Formulary :No Drug Restrictions: No **Lower Your Drug Costs** MTM Program : Yes	$5,390	★★★½ 3.5 out of 5 stars	Enroll

Internal Care and Quality Improvement Audits

Performing chart audits requires careful planning.

Each practice should implement an internal auditing program. Auditing provider charges and billing practices is a large task to undertake, but the results typically lead to improved claims management processes, cash flow, and compliance with payer rules and regulations. Chart audits can serve many purposes, from compliance to research to administrative to clinical. A practice can conduct a chart audit on virtually any aspect of care that is documented in the medical record. Auditing charts allows practices to identify specific coding issues that may occur in claims submissions. There may be a high number of similar types of claim errors that can be identified and, in this case, pre-submission monitoring and review of these may safeguard against repeated errors that result in a claim denial and decreased revenue.

Strategies for risk-adjustment auditing can include an abstract audit of a sample of patients or focusing on a specific condition. It is advisable to incorporate the HHS targeted conditions as well as OIG work plans into internal audits. These work plans and lists are based on widespread trending issues. An internal audit allows the provider and staff to identify incorrect billing patterns before claims are denied or payer audits arise and penalties are assessed.

An audit can be conducted on virtually any aspect of the chart, including diagnostic coding and reporting. The data should be complete, accurate, and must be available in the chart. A chart audit also involves reviewing data that may be deemed confidential; therefore, it is necessary that the internal privacy guidelines be consulted prior to reviewing charts. While most frequently performed to determine compliance with coding and billing requirements, chart audits may also be performed for clinical care quality improvement. A chart audit for quality improvement measures how often and how well something is being done (or not done). For example, a chart audit may involve reviewing a senior citizen care practice's charts to see how often the pneumonia vaccine is offered, administered, or declined. If the audit determines that the vaccine is not being offered or administered as recommended, then there is room for improvement. The HEDIS measures that are appropriate to the practice's population are an excellent source of actionable areas for improvement. Additionally, a practice or institution may develop internal improvement items, such as increasing correct practice for taking a patient's blood pressure.

There are a few steps that can be taken by clinical staff to help avoid mistakes, including:

- Developing written policies and procedures and distributing them to the clinical and administrative staff.
- Creating a written compliance plan and educate all employees on its content.
- Ensuring adherence with internal compliance policies and procedures by all clinical and administrative staff.
- Providing coding and billing education to clinical staff on a regular basis (i.e., annual code and guideline changes).
- Providing access to current coding books and regulation manuals as references.
- Conducting periodic internal audits and documenting the results.

It is imperative to ensure the most accurate coding and billing that staff receive on-going education and training to stay up to date on the annual code updates and changes as well as any updates to guidelines. A thorough understanding of the code

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Chapter 4.
CY2025 CMS-HCC Model Category V28

Disease Coefficient Relative Factors and Hierarchies for Continuing Enrollees Community and Institutional Beneficiaries with Midyear Final ICD-10-CM Mappings

According to the Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies published on March 31, 2023, CMS has finalized the updated risk adjustment model and will phase it in over 3 years. Risk scores will be calculated as a blend of 67 percent of the risk scores calculated with the current model (the 2020 model) and 33 percent of the risk scores calculated with the updated model (the 2024 model).

ICD-10-CM Code	ICD-10-CM Code Description	V28 CMS-HCC	V28 CMS-HCC Disease Group	V28 CMS-HCC Hierarchies	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
A01.04	Typhoid arthritis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A01.05	Typhoid osteomyelitis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A02.1	Salmonella sepsis	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A02.23	Salmonella arthritis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A02.24	Salmonella osteomyelitis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A06.5	Amebic lung abscess	283	Empyema, Lung Abscess		0.204	0	0.131	0.074	0	0	0
A07.2	Cryptosporidiosis	6	Opportunistic Infections		0.435	0.704	0.548	0.919	0.482	0.765	0.58
A20.7	Septicemic plague	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A22.7	Anthrax sepsis	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A26.7	Erysipelothrix sepsis	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A31.0	Pulmonary mycobacterial infection	6	Opportunistic Infections		0.435	0.704	0.548	0.919	0.482	0.765	0.58
A31.2	Disseminated mycobacterium avium-intracellulare complex (DMAC)	6	Opportunistic Infections		0.435	0.704	0.548	0.919	0.482	0.765	0.58
A32.7	Listerial sepsis	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A36.81	Diphtheritic cardiomyopathy	227	Cardiomyopathy/Myocarditis		0.189	0.2	0.173	0.198	0.145	0.186	0.189
A39.2	Acute meningococcemia	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A39.3	Chronic meningococcemia	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A39.4	Meningococcemia, unspecified	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A39.83	Meningococcal arthritis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A39.84	Postmeningococcal arthritis	92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis		0.479	0.529	0.611	0.632	0.471	0.539	0.556
A40.0	Sepsis due to streptococcus, group A	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346
A40.1	Sepsis due to streptococcus, group B	2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock		0.455	0.532	0.596	0.811	0.409	0.417	0.346

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Chapter 5.
CY2025 CMS RxHCC Model Category V08

ICD-10-CM Code	ICD-10-CM Code Description	V08 RxHCC	V08 RX HCC Description	V08 RxHCC Hierarchy	Community Non-Low Income, Age>=65	Community Non-Low Income, Age<65	Community Low Income, Age>=65	Community Low Income, Age<65	Institutional
A07.2	Cryptosporidiosis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
A31.0	Pulmonary mycobacterial infection	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
A31.2	Disseminated mycobacterium avium-intracellulare complex (DMAC)	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
A36.81	Diphtheritic cardiomyopathy	186	Heart Failure	187	0.210	0.148	0.270	0.195	0.234
A39.1	Waterhouse-Friderichsen syndrome	43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders		0.062	0.165	0.000	0.141	0.068
A81.00	Creutzfeldt-Jakob disease, unspecified	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.01	Variant Creutzfeldt-Jakob disease	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.09	Other Creutzfeldt-Jakob disease	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.1	Subacute sclerosing panencephalitis	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.2	Progressive multifocal leukoencephalopathy	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.81	Kuru	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.82	Gerstmann-Straussler-Scheinker syndrome	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.83	Fatal familial insomnia	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.89	Other atypical virus infections of central nervous system	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
A81.9	Atypical virus infection of central nervous system, unspecified	112	Dementia, Except Alzheimer's Disease		0.096	0.038	0.000	0.000	0.000
B00.82	Herpes simplex myelitis	155	Spinal Cord Disorders		0.094	0.080	0.053	0.000	0.018
B01.12	Varicella myelitis	155	Spinal Cord Disorders		0.094	0.080	0.053	0.000	0.018
B02.21	Postherpetic geniculate ganglionitis	168	Trigeminal and Postherpetic Neuralgia		0.124	0.257	0.201	0.245	0.207
B02.22	Postherpetic trigeminal neuralgia	168	Trigeminal and Postherpetic Neuralgia		0.124	0.257	0.201	0.245	0.207
B02.23	Postherpetic polyneuropathy	168	Trigeminal and Postherpetic Neuralgia		0.124	0.257	0.201	0.245	0.207
B02.24	Postherpetic myelitis	155	Spinal Cord Disorders		0.094	0.080	0.053	0.000	0.018
B02.29	Other postherpetic nervous system involvement	168	Trigeminal and Postherpetic Neuralgia		0.124	0.257	0.201	0.245	0.207
B17.10	Acute hepatitis C without hepatic coma	55	Acute or Unspecified Viral Hepatitis C		0.317	0.363	0.453	0.359	0.434
B17.11	Acute hepatitis C with hepatic coma	55	Acute or Unspecified Viral Hepatitis C		0.317	0.363	0.453	0.359	0.434
B18.0	Chronic viral hepatitis B with delta-agent	56	Chronic Viral Hepatitis B and OtherSpecified Chronic Viral Hepatitis		0.307	0.443	0.748	0.446	0.170
B18.1	Chronic viral hepatitis B without delta-agent	56	Chronic Viral Hepatitis B and OtherSpecified Chronic Viral Hepatitis		0.307	0.443	0.748	0.446	0.170
B18.2	Chronic viral hepatitis C	54	Chronic Viral Hepatitis C	55	0.317	0.363	0.453	0.359	0.434
B18.8	Other chronic viral hepatitis	56	Chronic Viral Hepatitis B and OtherSpecified Chronic Viral Hepatitis		0.307	0.443	0.748	0.446	0.170
B19.20	Unspecified viral hepatitis C without hepatic coma	55	Acute or Unspecified Viral Hepatitis C		0.317	0.363	0.453	0.359	0.434
B19.21	Unspecified viral hepatitis C with hepatic coma	55	Acute or Unspecified Viral Hepatitis C		0.317	0.363	0.453	0.359	0.434
B20	Human immunodeficiency virus [HIV] disease	1	HIV/AIDS		4.759	5.738	4.549	4.793	2.773
B25.0	Cytomegaloviral pneumonitis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B25.1	Cytomegaloviral hepatitis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B25.2	Cytomegaloviral pancreatitis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B25.8	Other cytomegaloviral diseases	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B25.9	Cytomegaloviral disease, unspecified	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B33.24	Viral cardiomyopathy	186	Heart Failure	187	0.210	0.148	0.270	0.195	0.234
B37.1	Pulmonary candidiasis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270
B37.7	Candidal sepsis	5	Opportunistic Infections		0.337	0.409	0.335	0.262	0.270

SAMPLE

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Demographic Relative Factors for New Enrollees, Institutional

VARIABLE	Not Concurrently ESRD	Concurrently ESRD
Female		
0–34 Years	2.882	2.939
35–44 Years	2.882	2.939
45–54 Years	2.882	2.939
55–59 Years	2.437	2.939
60–64 Years	2.437	2.939
65 Years	2.447	2.939
66 Years	2.061	2.939
67 Years	2.061	2.939
68 Years	2.061	2.939
69 Years	2.061	2.939
70–74 Years	1.856	2.939
75–79 Years	1.505	2.939
80–84 Years	1.461	2.939
85–89 Years	1.206	2.939
90–94 Years	0.977	2.939
95 Years or Over	0.977	2.939
Male		
0–34 Years	2.729	2.846
35–44 Years	2.586	2.846
45–54 Years	2.523	2.846
55–59 Years	2.413	2.846
60–64 Years	2.151	2.846
65 Years	2.227	2.846
66 Years	1.873	2.846
67 Years	1.873	2.846
68 Years	1.873	2.846
69 Years	1.873	2.846
70–74 Years	1.873	2.846
75–79 Years	1.699	2.846
80–84 Years	1.464	2.846
85–89 Years	1.246	2.846
90–94 Years	1.246	2.846
95 Years or Over	1.246	2.846

SAMPLE

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