



Medical Coding ICD-10-CM

Diagnosis Coding

General Coding Conventions & Official Guidelines

SECTION I

- The ICD-10-CM alphabetic index includes: Index to Diseases and Injuries; Neoplasm Table; Table of Drugs & Chemicals; and Index to External Causes.
- The ICD-10-CM Tabular List includes all codes A-Z.
- Never code directly from the alphabetic index. Always check the Tabular List to confirm the code is accurate and complete.
- Codes must be reported to their highest level of specificity. When a coder cannot determine the appropriate specificity from the documentation, the physician should be queried for the detail required.
- ICD-10-CM codes are three to seven alphanumeric characters. Codes must be reported with the required number of digits, including the seventh character, when applicable.
EX: S57.01XA Crushing injury of right elbow, initial encounter
- INCLUDES, EXCLUDES1, and EXCLUDES2 notations:**
A. **INCLUDES** provides additional diagnostic statements that are included in this code description.
EX: C93 Monocytic leukemia **INCLUDES** monocytoid leukemia
B. **EXCLUDES1** is the same as **EXCLUDES** in ICD-9-CM, directing you to a more appropriate code category for this condition. This means that this code and the referenced alternative code are mutually exclusive (i.e., they cannot exist in the same patient at the same time).
EX: S02.5 Fracture of tooth (traumatic) **EXCLUDES1** cracked tooth (nontraumatic) (K03.81)
C. **EXCLUDES2** identifies conditions that are not included in the code category. The referenced alternative codes may or may not be appropriate to report in addition to this code.
EX: O22 Venous complications and hemorrhoids in pregnancy **EXCLUDES2** placental pulmonary embolism (O88.-)
- NEC** (not elsewhere classifiable) means no other codes are appropriate (same as "other specified").
EX: Dependence, drug NEC F19.20
- NOG** (not otherwise specified) means that the documentation does not provide more detail (same as "unspecified").
EX: R03.2 Hypertension NOS
9. Brackets [] indicate alternative terms (i.e., synonyms, abbreviations, acronyms) in the Tabular List.
EX: E05 Thyrotoxicosis [hyperthyroidism]
- Brackets [] can also indicate secondary manifestation codes in the alphabetic index.
EX: Disorder, liver, malarial B54 [K77]
- Italicized brackets [] appear in the alphabetic index to signal a second, mandatory code.
EX: Retinopathy, arteriosclerotic I70.8 [H35.0-]
- Colons (:) are used in the Tabular List to shorten a list by providing a repeated term only once, prior to the colon, to be paired with each of the terms following the colon.
- Parentheses () are shown surrounding nonessential modifiers—that is, optional terms that may or may not be included in the documentation.
EX: R68.11 Excessive crying of infant (baby)
- Signs and symptoms should only be reported with separate codes when there is no documentation of a confirmed diagnosis that includes those signs and symptoms.
- Combination codes (i.e., codes that report two diagnoses, a diagnosis with a complication, or a diagnosis with a manifestation) must be used in preference to multiple coding, when appropriate.
EX: H46.011 Acute suppurative otitis media with spontaneous rupture of ear drum, right ear
- Combination codes do not preclude the use of additional codes to report additional details about that condition if they are not provided by the combination code.
- Each diagnosis code may only be reported once per encounter. This applies to bilateral conditions and when two conditions are reported with the same code.

- The word "and" should be translated as "and/or."
- The word "with" also means "due to," as well as "associated with."
- When the alphabetic index directs you to "see" or "see also," it is providing alternate main terms that might lead to the correct code.
Examples:
Inflammation, sinus – see Sinusitis Fibrocystic disease – see also Fibrosis, cystic
- When the direction "see condition" appears in the alphabetic index (typically after a main term that is an anatomical site), it means that you should turn to the main term describing the condition or problem with that anatomical site.
EX: Lung – see condition
- A "Code first..." notation appearing in the Tabular List directs you to do two things:
A. Find a second code to completely report this circumstance
B. Sequence this second code after the first code
EX: H54 Blindness and low vision. Code first any associated underlying cause of the blindness
- A "Use additional code..." notation appearing in the Tabular List directs you to do two things:
A. Find a second code to completely report this circumstance
B. Sequence this second code first (list first, before the other code)
EX: K94.32 Esophagostomy infection. Use additional code to identify the infection
- A "Code also..." notation appearing in the Tabular List directs you to determine from the documentation if a second code may be necessary to completely report this circumstance. This note relates nothing about how to sequence these codes.
EX: Q93.7 Deletions with other complex rearrangements. Code also any associated duplications due to unbalanced translocations, inversions, and insertions (Q92.5)
- The "Code, if applicable, any causal condition..." notation appearing in the Tabular List directs you to report an additional code only when the documentation states that the additional manifestation is present.
EX: M13.8 Other obstructive and reflux uropathy. Code, if applicable, any causal condition first, such as: enlarged prostate (N40.1)
- A code description that includes the phrase "in diseases classified elsewhere" indicates that this code is reporting the existence of a manifestation and should be reported after the code reporting the underlying condition or disease.
EX: N22 Calculus of urinary tract in diseases classified elsewhere
- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. Coding of sequela often requires two codes: first the condition or nature of the sequela, followed by the sequela code.
- A "borderline" diagnosis at the time of discharge is coded as confirmed unless the classification provides a specific entry (e.g., borderline diabetes). If it is a specific borderline code, that specific code should be reported.
- Body Mass Index (BMI), degree of non-pressure, chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, the code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified health care practitioner legally accountable for establishing the patient's diagnosis).
- For a patient diagnosed with a bilateral condition, when each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides) for the encounter to treat the first side. For the second encounter for treatment (after one side has previously been treated and no longer exists on that side), assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters).
- Present-on-admission (POA) guidelines: Present on admission is defined as present at the time the order for patient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

Instructional Notations

SECTION I (continued)

INCLUDES

The word "includes" appears immediately under certain categories to further define, or give examples of, the content of the category.

EXCLUDES Notes

The ICD-10-CM has two types of excludes notes. Each note has a different definition for use, but they are both similar in that they indicate that codes excluded from each other are independent of each other.

EXCLUDES1

A type 1 excludes note is a pure excludes. It means "Not coded here." This note indicates that the code excluded should never be used at the same time as the code above the EXCLUDES1 note. It is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

EXCLUDES2

A type 2 excludes note represents "Not included here." It indicates that the condition excluded is not part of the condition it is excluded from, but a patient may have both conditions at the same time. When an EXCLUDES2 note appears under a code, it is acceptable to use both the code and the excluded code together.

Code First/Use Additional Code Notes

Certain conditions have both an underlying etiology and multiple body system

manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation. Whenever such a combination exists, there is a "Use additional code" note at the etiology code, and a "Code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases, the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed following the underlying condition.

Code Also

A Code also note instructs that two codes may be required to fully describe a condition, but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.

7th Characters & Placeholder 'X'

For codes less than 6 characters that require a 7th character, a placeholder X should be assigned for all characters less than 6. The 7th character must always be the 7th character of a code.

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Medical Coding Guidelines (MCG®) Manual, 2025 Edition

Camille Jackson, 2025-04-28 AMCI Coding's MCG™ Manual The Ultimate Guide to Medical Coding Success The MCG™ Manual Medical Coding Guidelines by AMCI Coding is an essential resource designed to help medical coding professionals students and exam candidates master the complexities of medical coding Whether you are preparing for a certification exam starting a new career or looking to refine your skills this comprehensive guide provides the tools and knowledge necessary to excel in an ever evolving industry Unlike generic coding textbooks the MCG™ Manual focuses not only on memorization but also on a deep understanding of coding principles ensuring users develop the critical thinking skills needed for accurate and efficient coding practices Why Is AMCI's MCG™ Manual Essential Medical coding is a highly specialized field that requires proficiency in multiple coding systems including ICD 10 CM CPT PCS and HCPCS Level II The MCG™ Manual is meticulously crafted to break down these complex coding systems into clear easy to understand concepts This resource goes beyond simple guidelines it provides structured step by step instructions on proper code sequencing selection and application The manual emphasizes the how and why behind coding helping users build confidence and clarity when working with medical codes This guide is particularly beneficial for those preparing for medical coding certification exams as it includes AMCI's proven test taking techniques and strategies These methods help candidates approach exams with

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Medical Coding Online (Classroom) for Step-by-Step Medical Coding 2006 (User Guide and Access

Code) Carol J. Buck, 2005-12 Medical Coding Online represents a complete course on advanced coding combining content self study and assessment into one product that can be immediately implemented as part of a distance learning program or used to enhance a traditional classroom. The course book provides all the content in detail while the online component reinforces the important concepts in concise lessons incorporating figures, photographs, audio narrated slide shows, and links to relevant web sites. Self study includes a variety of interactive activities including unique case-based exercises designed specifically for medical coding. Includes a variety of student and instructor communication options such as real time chat, class calendar, e-mail connections, bulletin board, digital drop box, discussion board. Instructor syllabus and gradebooks to allow for flexibility and enhanced learning. Uses a unique case approach to advanced coding so students will get a more accurate feel for what a coder does on the job as well as matching fill in the blank, multiple choice, and true/false. Each online chapter includes engaging synopses of all the lessons in the textbook. Includes approximately 18 slide shows with audio narration to explain physical processes being demonstrated. Hot concept key terms within text provides definitions of key concepts/terms at a single click to enable student to access correct definitions instantly. Lesson Lectures contain hypertext links opening pop up boxes with further explanations to enable students to dig deeper into the content. Automatically scores end of chapter assessments to allow instructors to evaluate their students' comprehension and know their grades at any time during the progression through the course. Extensive glossary provides definitions of approximately 650 key terms. All content has been updated to current industry standards and for use with Step by Step Medical Coding 2006 edition. The entire design has been updated to make the course more easy to use. *Evaluation and Management Coding Reference Guide - First Edition* AAPC, 2020-06-30. Defeat the challenges that threaten your E/M claims and compliance success. Evaluation and management E/M services are the lifeblood of your revenue stream and yet they're the most problematic to report. Claim denials remain high. E/M coding errors in fact rose from 11.9% in 2018 to account for 12.8% of CMS's overall 2019 improper payment rate. How much E/M revenue are you losing? Safeguard your organization from claim denials and audit scrutiny with the Evaluation Management Coding Reference Guide. Our experts break down E/M coding rules and requirements into simple, manageable steps written in everyday language to boost your E/M reporting skills. Learn how to capture the key components of medical history, physical exam, and medical decision making and capitalize on real-world clinical scenarios to prevent over or under coding. The Evaluation Management Coding Reference Guide will help you prep for 2021 E/M guideline changes, overhauling new and established office and outpatient services and walk you through online digital E/M services, remote physiologic monitoring, and more. Master the ins and outs of E/M coding, CPT guidelines, level of service, modifiers, regulations, and documentation guidelines. Put an end to avoidable denials and optimize your E/M claims for full and prompt reimbursement. Benefit from expert tutorials covering the spectrum of E/M reporting concepts and challenges. Prep for 2021 guideline changes and their impact on your organization. Master the ins and outs of E/M guidelines in CPT. Capture the seven

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Insurance Handbook for the Medical Office Marilyn Takahashi Fordney, 2002 INSURANCE HANDBOOK FOR THE MEDICAL OFFICE is a key text for medical administrative assisting medical front office programs or those who wish to become insurance billing specialists claims assistance professionals or electronic claims processors for physicians practices and hospital outpatient clinics Those already practicing in this area will also find this text beneficial as will health claims examiner programs The goal of this extremely up to date text is to increase efficiency and streamline administrative procedures for the most exasperating aspect of the doctor s office routine insurance billing This text offers guidance for all aspects of submitting tracing appealing and transmitting claims for today s full range of health plans Important coverage of diagnostic coding procedural coding office and insurance collection strategies Medicare Managed Care and more is presented Additionally a free CD ROM featuring the HCFA 1500 claim form is included with the book The CD ROM contains 10 scored patient case studies with related insurance information so that the student can practice completing the HCFA 1500 claim form in a fun interactive format **Directory of Computerized Data Files 1989** Kathleen Thacker, 1989

Medical Coding ICD-10-CM Shelley C. Safian, 2017-11 Updated for 2018 ICD 10 CM International Classification of Diseases Clinical Modification guidelines this 6 page laminated guide covers core essentials of coding clearly and succinctly Author Shelley C Safian PhD RHIA CCS P COC CPC I AHIMA approved ICD 10 CM PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages designed for you to find answers fast with color coded sections and bulleted lists A must for students seeking coding certification and a great desktop refresher for professionals for classifying and coding diagnoses symptoms and procedures recorded in conjunction with hospital care 6 page laminated guide includes General Coding Conventions Official Guidelines Instructional Notations Chapter Specific Official Guidelines Selection of Principal Diagnosis Reporting Additional Diagnoses Diagnostic Coding Reporting Guidelines for Outpatient Services Steps to Coding Diagnoses Using the ICD 10 CM Manual Documentation of Complications of Care Rules of Compliance External Cause Codes Sequencing Multiple Codes Correctly What to Code What Not to Code The Process of Abstracting Medical Coding ICD 10 PCS Selection of Principal Procedure ICD 10 PCS Coding Conventions ICD 10 PCS Sections Subsections Medical Surgical Section Guidelines Obstetrics Section Guidelines New Technology Section Guidelines ICD 10 PCS Terms **Monthly Catalog of United States Government Publications** United States. Superintendent of Documents, 1993 February issue includes Appendix entitled Directory of United States Government periodicals and subscription publications September issue includes List of depository libraries June and December issues include semiannual index

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Table of Contents User Guide Of Medical Coding

1. Understanding the eBook User Guide Of Medical Coding
 - The Rise of Digital Reading User Guide Of Medical Coding
 - Advantages of eBooks Over Traditional Books
2. Identifying User Guide Of Medical Coding
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an User Guide Of Medical Coding
 - User-Friendly Interface
4. Exploring eBook Recommendations from User Guide Of Medical Coding
 - Personalized Recommendations
 - User Guide Of Medical Coding User Reviews and Ratings
 - User Guide Of Medical Coding and Bestseller Lists
5. Accessing User Guide Of Medical Coding Free and Paid eBooks
 - User Guide Of Medical Coding Public Domain eBooks
 - User Guide Of Medical Coding eBook Subscription Services

- User Guide Of Medical Coding Budget-Friendly Options
- 6. Navigating User Guide Of Medical Coding eBook Formats
 - ePub, PDF, MOBI, and More
 - User Guide Of Medical Coding Compatibility with Devices
 - User Guide Of Medical Coding Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of User Guide Of Medical Coding
 - Highlighting and Note-Taking User Guide Of Medical Coding
 - Interactive Elements User Guide Of Medical Coding
- 8. Staying Engaged with User Guide Of Medical Coding
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers User Guide Of Medical Coding
- 9. Balancing eBooks and Physical Books User Guide Of Medical Coding
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection User Guide Of Medical Coding
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine User Guide Of Medical Coding
 - Setting Reading Goals User Guide Of Medical Coding
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of User Guide Of Medical Coding
 - Fact-Checking eBook Content of User Guide Of Medical Coding
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends

-
- Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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