



Medical Coding ICD-10-CM

Diagnosis Coding

General Coding Conventions & Official Guidelines

SECTION I

1. The ICD-10-CM alphabetic index includes: Index to Diseases and Injuries; Neoplasm Table; Table of Drugs & Chemicals; and Index to External Causes.
2. The ICD-10-CM Tabular List includes all codes A-Z.
3. Never code directly from the alphabetic index. Always check the Tabular List to confirm the code is accurate and complete.
4. 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.
5. 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
6. 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.-)
7. **NEC** (not elsewhere classifiable) means no other codes are appropriate (same as "other specified").
EX: Dependence, drug **NEC** F19.20
8. **NO5** (not otherwise specified) means that the documentation does not provide more detail (same as "unspecified").
EX: R03.2 Hypertension **NO5**
9. Brackets [] indicate alternative terms (i.e., synonyms, abbreviations, acronyms) in the Tabular List.
EX: E05 Thyrotoxicosis [hyperthyroidism]
10. Brackets [] can also indicate secondary manifestation codes in the alphabetic index.
EX: Disorder, liver, malarial B54 [K77]
11. Italicized brackets [] appear in the alphabetic index to signal a second, mandatory code.
EX: Retinopathy, arteriosclerotic I70.8 [H35.0-]
12. 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.
13. 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)
14. 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.
15. 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: H66.011 Acute suppurative otitis media with spontaneous rupture of ear drum, right ear
16. 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.
17. 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.

18. The word "and" should be translated as "and/or."
19. The word "with" also means "due to," as well as "associated with."
20. 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
21. 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
22. 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
23. 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
24. 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)
25. 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 (H62.1)
26. 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
27. 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.
28. 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.
29. 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).
30. 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).
31. 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.

User Guide Of Medical Coding

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Clinical Documentation Reference

Guide - First Edition AAPC,2020-03-12 It's not the quantity of clinical documentation that matters it's the quality Is your clinical documentation improvement CDI program identifying your outliers Does your documentation capture the level of ICD 10 coding specificity required to achieve optimal reimbursement Are you clear on how to fix your coding and documentation shortfalls Providing the most complete and accurate coding of diagnoses and site specific procedures will vastly improve your practice's bottom line Get the help you need with the Clinical Documentation Reference Guide This start to finish CDI primer covers medical necessity joint shared visits incident to billing preventative care visits the global surgical package complications and comorbidities and CDI for EMRs Learn the all important steps to ensure your records capture what your physicians perform during each encounter Benefit from methods to effectively communicate CDI concerns and protocols to your providers Leverage the practical and effective guidance in AAPC's Clinical Documentation Reference Guide to triumph over your toughest documentation challenges Prevent documentation deficiencies and keep your claims on track for optimal reimbursement Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra specificity specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR

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The Essential Guide to Coding in Otolaryngology Seth M. Brown, Kimberley J. Pollock, Michael Setzen, Abtin Tabaei, 2021-09-07 The Essential Guide to Coding in Otolaryngology Coding Billing and Practice Management Second Edition is a comprehensive manual on how to properly and compliantly code for both surgical and non surgical services It is a practical guide for all otolaryngology providers in the United States including physicians early in their career requiring a working knowledge of the basics experienced providers looking to understand the latest updates with ICD 10 CM and CPT changes related specialists audiology speech pathology and physician extenders providing otolaryngologic health care and office administrative teams managing coding and billing Included are sections on how to approach otolaryngology coding for all subspecialties in both the office and operating room Foundational topics such as understanding the CPT and ICD 10 CM systems use of modifiers managing claim submissions and appeals legal implications for the provider coding for physician extenders and strategies to optimize billing are presented by experts in the field Focused on a practical approach to coding billing and practice management this text is user friendly and written for the practicing physician audiologist speech pathologist physician extender and coder The income and

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