



# 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) (D03.81)  
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** obstetric pulmonary embolism (O26.1)
- NEC** (not elsewhere classifiable) means no other codes are appropriate (same as "other specified").  
**EX:** Dependence, drug NEC F19.20
- NOS** (not otherwise specified) means that the documentation does not provide more detail (same as "unspecified").  
**EX:** R63.2 Hyperalimentation NOS  
a. 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:** D02.020 Liver, material B54 [C77]
- Italicized brackets [ ] appear in the alphabetic index to signal a second, mandatory code.  
**EX:** R01.01 Hemiparesis, arteriosclerotic [I70.8 (D23.0)]
- 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.  
**EX:** R01.01 Hemiparesis, arteriosclerotic (I70.8 (D23.0))
- Parentheses ( ) are shown surrounding modifiers—that is, optional terms that may or may not be included in the documentation.  
**EX:** R65.11 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.  
**Example:**  
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 Esophagomyotomy 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 (Q93.3)
- 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:** N13.8 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 ICD-9 (Speedy Study Guides) Speedy Publishing,2014-07-03 A medical coding ICD 9 book or software program contains detailed information concerning a variety of health conditions along with a numerical set of numbers Each disease or health condition is assigned a specialized code that is used for identification purposes when submitting documents to insurance carriers for reimbursement Health care employees such as medical coders and secretaries require a medical coding ICD 9 as part of their job while working in medical facilities including physician s offices hospitals and nursing homes

**Medical Coding Basic ICD-9 CM Coding** American Health Information Management Association,2009 Medical Coding Speedy Study Guides Speedy Publishing,2014-07-15 Medical coding is a process where you enter abbreviations on medical charts A pamphlet can be helpful in learning the words and the abbreviations for those words The abbreviations can be written on index cards so that the student can study for quizzes Students learn the medical lingos seen on charts where medical coding is used such as a doctor s office or a hospital **Medical Coding: Icd-10-Pcs** BarCharts, Inc,Shelley C. Safian,2012-05-31 The health care industry is moving toward a major change in the code set or language used to report the reasons why a physician or health care professional provided care to a patient Since 1978 the industry has used codes from ICD 9 CM volume 3 to report the procedures services and treatments provided to inpatients in acute care facilities Within the next few years the transition will be made to ICD 10 PCS The transition from ICD 9 CM volume 3 to ICD 10 PCS will only affect those health information management professionals and those getting ready to enter this profession working on hospital inpatient procedure coding but it will require even the most seasoned professionals to learn how to accurately report what has been provided to patients With the use of tabular examples and color coded text this QuickStudy guide helps make the transition smoother and promote better understanding and greater comfort with the new code set *Medical Coding ICD-9 (Speedy Study Guide)* Speedy Publishing LLC,2014-06-27 A medical coding ICD 9 book or software program contains detailed information concerning a variety of health conditions along with a numerical set of numbers Each disease or health condition is assigned a specialized code that is used for identification purposes when submitting documents to insurance carriers for reimbursement Health care employees such as medical coders and secretaries require a medical coding ICD 9 as part of their job while working in medical facilities including physician s offices hospitals and nursing homes **Icd-9 Coding for Home Health** Joan L. Usher,2010 *Medical Coding: Icd-10-Cm* BarCharts, Inc,Shelley C. Safian,2012-05-31 The health care industry is moving toward a major change in the code set or language used to report the reasons why a physician or health care professional provided care to a patient Since 1978 the ICD 9 CM code set has been used to report these diagnoses Within the next few years the code set will be changing to ICD 10 CM While there are many similarities there are changes that those in the health information management profession and those getting ready to enter this profession must know and understand With the use of color coded text this QuickStudy guide helps make the transition

easier to understand and simpler to incorporate into work behaviors      Medical Coding: Icd-10-Pcs Speedy Study Guides Speedy Publishing,2014-07-16 ICD 10 PCS is a kind of medical coding that is used to identify what kinds of treatment a patient received and used for billing a patient Medical coding requires a person to get an education and there is a huge amount of information a person needs to know in order to get a coding certification One great way to learn the information is with the use of a study pamphlet The pamphlet can be used to learn the basic information and can keep a student focused on what they need to learn      **Medical Coding: Icd-10-Cm Speedy Study Guides** Speedy Publishing,2014-07-16 Every known illness disease and condition has a specific number that goes along with the word describing the person s medical problem Every physician and their office staff must know medical codes for the sake of billing purposes If the doctor and office staff does not code a specific illness condition or disease correctly the insurance company may not pay for treatment medication in hospital stays outpatient treatment and a number of surgical and other procedures performed for the patient making it impossible for the patient to receive the proper treatment Common illnesses diseases and conditions listed in a pamphlet would enable the medical student to become familiar and able to memorize with the more common medical codes The bottom line for using proper ICD codes is money reimbursement for the medical community and patient      *The Essential Guide to ICD-9 Coding for Therapy Professionals* Kate Brewer,2008 Accompanying CD ROM includes list of ICD 9 codes link to CMS web site and list of national coverage decisions      *Medical Coding (Speedy Study Guides* Speedy Publishing Llc,2014-05 The administrative side in healthcare is where medical coding comes in to play In order to bill for an injury or a procedure the coding has to be correct or the insurance company could reject it and no payment will be issued Coding is used in the medical field in a variety of ways Those studying medicine need to learn the diagnosis of an injury or sickness so the medical coding can be put in a system so the doctor or facility can be paid Coding is more behind the scenes and is an integral part of the medical field      Medical Coding Online 2012 for Step-by-Step Medical Coding 2012 Carol J. Buck,2011-12-16 Get the flexibility to decide when and where you want to learn medical coding with Medical Coding Online 2012 for Step by Step Medical Coding 2012 Edition Perfect for reinforcing the important concepts of the Step by Step textbook this complete online coding course offers self study assessment and the latest coverage of ICD 10 CM ICD 9 CM CPT HCPCS reimbursement and inpatient coding all in one Concise lessons incorporate narrated slide shows hotlinked concepts figures photographs interactive exercises professional insights and more to help you effectively master the basics of medical coding right from your own computer ICD HCPCS illustrations familiarize you with professional level code books From the Trenches quotes offer valuable up to date insights from instructors and professionals in the medical coding field Unique interactive exercises include a specially created case based coding activity including sequencing as well as matching fill in the blank multiple choice and true false questions Lesson synopses reinforce learning and serve as helpful review tools Full color art program features more than 125 figures throughout the program to enhance your learning Approximately 10 15

slide shows with audio narration communicate complex concepts that are difficult to convey with static illustrations  
Hypertext links offer additional resources to further your learning Hot terms concepts within the text provide definitions in a single click Glossary includes approximately 650 terms and definitions Chapter assessment questions allow you to demonstrate your mastery of chapter content online Updated content gives you practice with the most current coding information available Primary focus on ICD 10 CM prepares you for the upcoming transition from ICD 9 CM to ICD 10 CM in October 2013 Dual coding in chapters 13 31 where both ICD 10 CM and ICD 9 CM answers are provided for every question with an ICD answer ensures you can code using the systems of both today and tomorrow *Medical Coding Speedy Publishing LLC, 2014-07-18* ICD 10 PCS is a kind of medical coding that is used to identify what kinds of treatment a patient received and used for billing a patient Medical coding requires a person to get an education and there is a huge amount of information a person needs to know in order to get a coding certification One great way to learn the information is with the use of a study pamphlet The pamphlet can be used to learn the basic information and can keep a student focused on what they need to learn *ICD-9-CM Coding: Theory and Practice with ICD-10, 2013/2014 Edition - E-Book* Karla R. Lovaasen, Jennifer Schwerdtfeger, 2012-08-20 Learn to code effectively with ICD 9 CM medical coding and gain a thorough introduction to ICD 10 CM PCS coding with one book ICD 9 CM Coding 2013 2014 Edition combines basic coding principles with proven practical insight and the ICD 9 CM and ICD 10 CM ICD 10 PCS Official Guidelines for Coding and Reporting to prepare you for the upcoming implementation of ICD 10 CM PCS Whether you re learning to code for the first time or making the transition from ICD 9 CM to ICD 10 CM PCS leading medical coding authors Karla Lovaasen and Jennifer Schwerdtfeger deliver the fundamental understanding you need to succeed in hospital and physician settings Both ICD 9 CM codes and ICD 10 CM ICD 10 PCS codes are shown in all coding exercises and examples including answer keys Emphasis on ICD 10 CM and ICD 10 PCS coding prepares you for the upcoming implementation of ICD 10 MS DRG documentation and reimbursement details guide you through this key component of the coding process Line coding exercises and activities challenge you to apply concepts to solve problems ICD 10 Official Guidelines for Coding and Reporting OGCR are included in each coding chapter immediately following the ICD 9 CM coding guidelines Full color A P content disease coverage procedure guidelines and drug data ensure that you re familiar with key topics affecting medical coding Medical record coverage introduces the records and documents you ll encounter on the job Updated Coding Clinic references direct you to the definitive coding resource from the American Hospital Association AHA A companion Evolve website provides convenient online access to the OGCR medical and surgical root operations definitions a MS DRG list partial answer keys and more **Medical Coding ICD-10-PCs (Speedy Study Guides** LLC Publishing, Speedy Publishing LLC, 2014-05 Medical Coding ICD 10 PCS is the newest procedure coding system There are a total of 72 081 codes included in ICD 10 PCS Each of the seven alphanumeric characters used in each code represents something specific A chart would be very beneficial in trying to decipher what each

code's letter or number represents. For example, the first number of the code represents the type of service that was rendered. Other characters used represent a body system, body part, or region, root operation, etcetera. **ICD-9 Professional**

**Medical Coding and Billing - Foundation** Career Step, 2014-07-11 *Medical Coding* Speedy Publishing LLC, 2014-07-18

Every known illness, disease, and condition has a specific number that goes along with the word describing the person's medical problem. Every physician and their office staff must know medical codes for the sake of billing purposes. If the doctor and office staff does not code a specific illness, condition, or disease correctly, the insurance company may not pay for treatment, medication, in-hospital stays, outpatient treatment, and a number of surgical and other procedures performed for the patient, making it impossible for the patient to receive the proper treatment. Common illnesses, diseases, and conditions listed in a pamphlet would enable the medical student to become familiar and able to memorize with the more common medical codes. **ICD-9-CM Coding Theory and Practice 2011 With ICD-10** Karla R. Lovaasen, Jennifer

Schwerdtfeger, 2011-08-26 Learn to code effectively with ICD 9 CM medical coding and gain a thorough introduction to ICD 10 CM PCS coding all in one text. Whether you're learning to code for the first time or beginning the transition from ICD 9 CM to ICD 10 CM PCS 2012, ICD 9 CM Coding Theory and Practice with ICD 10 delivers the fundamental understanding you need to succeed in hospital and physician settings and prepare for the October 2013 ICD 10 CM PCS implementation. Leading medical coding authorities Karla Lovaasen and Jennifer Schwerdtfeger combine basic coding principles with proven practical insight, and the ICD 9 CM and ICD 10 CM ICD 10 PCS Official Guidelines for Coding and Reporting OCGR to equip you for complete professional success in the changing medical coding field. Coverage of both ICD 9 CM and ICD 10 CM PCS coding equips you for coding success today and in your future career. ICD 9 CM and ICD 10 CM ICD 10 PCS Official Guidelines for Coding and Reporting OCGR provide fast, easy access to the latest codes and examples for proper application. Integrated medical record coverage familiarizes you with records and documents you'll encounter on the job. MS-DRG documentation and reimbursement details guide you through this key component of the coding process. Line coding exercises and activities challenge you to apply chapter concepts to solve problems. Appendix content in each coding chapter includes full-color illustrations and clarifies important anatomy and physiology concepts. Disease coverage details commonly encountered conditions related to ICD 9 CM coding. Updated Coding Clinics references guide you to the latest coding insights from the American Hospital Association. AHA Procedure guidelines help you effectively apply ICD 9 CM Volume 3 codes for success in inpatient facility settings. Drug data familiarizes you with medication names you may encounter in medical records for greater coding accuracy. Companion Evolve website provides convenient online access to the Official Guidelines for Coding and Reporting OCGR, medical and surgical root operations definitions, MS-DRG list, and answer keys. Introduction to ICD 10 PCS chapter prepares you to code in inpatient facility settings after the October 2013 ICD 10 CM PCS implementation date. [The CCDS Exam Study Guide](#), 2010 **Basic ICD 9 -CM Coding 2006** Lou Ann Schraffenberger, 2005-07-01 A solid introduction to ICD 9

coding fully updated for the Oct 1 2006 proposed code changes Includes many exercises and a coding self test

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