



# 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) (D03.81)
7. **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)
8. **NEC** (not elsewhere classifiable) means no other codes are appropriate (same as "other specified").  
**EX:** Dependence, drug NEC F19.20
9.  **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]
10. Brackets [ ] can also indicate secondary manifestation codes in the alphabetic index.  
**EX:** D02.02 Liver, material B54 [C77]
11. Italicized brackets [ ] appear in the alphabetic index to signal a second, mandatory code.  
**EX:** R01.01 Hemiparesis, arteriosclerotic [I70.8] (D23.0)
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.  
**EX:** R01.01 Hemiparesis, arteriosclerotic (I70.8) (D23.0)
13. 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)
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:** H46.011 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.  
**Example:**  
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 Esophagomyotomy 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 (Q93.3)
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:** N13.8 Other obstructive and reflux uropathy. Code, if applicable, any causal condition first, such as, enlarged prostate (N40.1)
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.

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**Medical Coding Basic ICD-9 CM Coding** American Health Information Management Association,2009 **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

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familiar and able to memorize with the more common medical codes      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      **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      **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

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