

# **Format AND Conventions AND Current Coding Practices FOR ICD-10-CM AND ICD-10-PCS**

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## CHAPTER 1

# Introduction to the ICD-10-CM Classification

## CHAPTER OVERVIEW

- ICD-10-CM is a medical diagnosis classification system.
- The Tabular List of Diseases and Injuries displays codes in alphanumeric order. There are three-, four-, five-, six-, and seven-character codes.
- The Alphabetic Index of Diseases and Injuries uses a specific pattern to the indentions.
  - Main terms are flush to the left-hand margin.
  - Subterms are indented. The more specific the subterm is, the farther the indent.
  - Carryover lines are two indents from the indent level of the preceding line.
  - There are also strict alphabetization rules.

## LEARNING OUTCOMES

After studying this chapter, you should be able to:

- Explain the basic principles of the medical classification system ICD-10-CM.
- Demonstrate understanding of the three-, four-, five-, six-, and seven-character subdivisions.
- Explain the alphabetization rules and indention patterns.

## TERM TO KNOW

### ICD-10-CM

*International Classification of Diseases, Tenth Revision, Clinical Modification*; a medical classification system used for the collection of information regarding disease and injury

# INTRODUCTION

The *International Classification of Disease, Tenth Revision, Clinical Modification* (ICD-10-CM) is a clinical modification of the World Health Organization's (WHO's) ICD-10. It expands ICD-10 codes to facilitate more precise coding of clinical diagnoses. ICD-10-CM is a closed classification system—it provides only one place to classify each condition. Despite the large number of different conditions to be classified, the system must limit its size to be usable. Certain conditions that occur infrequently or are of low importance are often grouped together in residual codes labeled "other" or "not elsewhere classified." A final residual category is provided for diagnoses not stated specifically enough to permit more precise classification. Occasionally, these two residual groups are combined in one code.

Medical coding professionals must understand the basic principles behind the classification system to use ICD-10-CM appropriately and effectively. It is therefore important for medical coding professionals in all health care settings to keep current with the *ICD-10-CM Official Guidelines for Coding and Reporting*, as well as the *AHA Coding Clinic*®, a quarterly newsletter published by the Central Office of the American Hospital Association (AHA). *Coding Clinic* presents official advice that is developed through the editorial board for the *Coding Clinic* and approved by the four cooperating parties: the AHA, the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS), and the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics (NCHS). In addition, representatives from several physician specialty groups provide the *Coding Clinic* editorial advisory board with clinical input.

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## Placeholder Character

ICD-10-CM uses the letter "x" as a placeholder character in certain codes to allow for future expansion. An example of this may be seen at the poisoning, adverse effect, underdosing (T36–T50), and toxic effects (T51–T65) codes. For these categories, the sixth character represents the intent: accidental, intentional self-harm, assault, undetermined, adverse effect, or underdosing. Where a placeholder exists, the "x" must be used for the code to be considered valid.

For example, "x" is used as the fifth character in the following codes where the sixth character of "1" represents accidental, and "2" represents intentional self-harm:

T37.5x1 Poisoning by antiviral drugs, accidental (unintentional)

T37.5x2 Poisoning by antiviral drugs, intentional self-harm

T52.0x1 Toxic effect of petroleum products, accidental (unintentional)

T52.0x2 Toxic effect of petroleum products, intentional self-harm

Codes in certain categories include a seventh-character value. The applicable seventh-character value is required for all codes within the category, or as the notes in the Tabular List instruct. The seventh-character value must always be the seventh character in the code. If a code is not a full six characters and a seventh-character value is required, a placeholder character "x" must be used to fill in the empty characters. Codes with seventh-character values are found in [chapter 15](#) of ICD-10-CM, Pregnancy, Childbirth and the Puerperium (O00–O9A), as well as in [chapter 19](#) of ICD-10-CM, Injury, Poisoning and Certain Other Consequences of External Causes (S00–T88), and in [chapter 20](#) of ICD-10-CM, External Causes of Morbidity (V00–V99).

An example of the use of the placeholder character "x" and the seventh-character value is shown here with an excerpt from the Tabular List:

### Foreign body in ear

Includes: foreign body in auditory canal

The appropriate 7th character values are to be added to each code from category T16:

**T16** A initial encounter

D subsequent encounter

S sequela

**T16.1 Foreign body in right ear**

**T16.2 Foreign body in left ear**

**T16.9 Foreign body in ear, unspecified ear**

A child presents to the emergency department with a bean in the right ear. The mother has brought the child because she was not able to remove the bean at home. This encounter would be assigned code T16.1xxA. The Tabular List shows subcategory T16.1 as the descriptor best fitting this scenario. Category T16 requires a seventh-character value. Because the code subcategory has only four characters (T16.1), the placeholder "x" is inserted twice to preserve the code structure before the seventh character "A" is added to report this as the initial encounter.

## ALPHABETIC INDEX

The Alphabetic Index consists of the Index of Diseases and Injuries, the Index to External Causes, the Neoplasm Table, and the Table of Drugs and Chemicals.

The Alphabetic Index includes entries for main terms, subterms, and more specific subterms. An indented format is used for ease of reference.

Main terms identify disease conditions or injuries. Subterms indicate site, type, or etiology for conditions or injuries. For example, acute appendicitis is listed under Appendicitis, acute, and stress fracture is listed under Fracture, traumatic,

stress. Occasionally, it is necessary to think of a synonym or another alternative term in order to locate the correct entry. There are, however, exceptions to this general rule, including the following:

- Congenital conditions are often indexed under the main term **Anomaly** rather than under the name of the condition.
- Conditions that complicate pregnancy, childbirth, or the puerperium are usually found under such terms as **Delivery**, **Pregnancy**, and **Puerperal**. They may also appear under the main term for the condition causing the complication by referencing the subterm “complicating childbirth (labor),” “complicating pregnancy,” or “complicating puerperium.” (Examples of these types of entries appear under the main term **Hypertension** in the Alphabetic Index.)
- Many of the complications of medical or surgical care are indexed under the term **Complications** rather than under the name of the condition.
- Late effects of an earlier condition can be found under **Sequelae**, or under the condition (as in the case of traumatic injuries).

A clear understanding of the format of the Alphabetic Index is a prerequisite for accurate coding. Understanding the indentation pattern of the entries is a very important part of learning how to use the Index. A variety of vendors provide printed versions and others have computer programs for coding, but the format may not be consistent across versions. The PDF version of the Index from the NCHS represents each indentation level by a hyphen. In general, however, the following pattern is used by several codebook publishers:

- Main terms are set flush with the left-hand margin. They are printed in bold type and begin with a capital letter.
- Subterms are indented one standard indentation (equivalent to about two word-processing spaces) to the right under the main term. They are printed in regular type and begin with a lowercase letter.
- More specific subterms are indented farther and farther to the right as needed, always indented by one standard indentation from the preceding subterm and listed in alphabetical order.
- A dash (-) at the end of an index entry indicates that additional characters are required.

Carryover lines are indented two standard indentations from the level of the preceding line. Carryover lines are used only when the complete entry cannot fit on a single line. They are indented farther to avoid confusion with subterm entries.

In printed versions, entries are presented in two, three, or four columns per page, dictionary style.

The subterms listed under the main term **Metrorrhagia** in the following entry provide an example:

<b>Metrorrhagia</b> N92.1	[main term]
climacteric N92.4	[subterm]
menopausal N92.4	[subterm]
perimenopausal N92.4	[subterm]
postpartum NEC (atonic) (following delivery of placenta) O72.1	[subterm]
	[carryover line]
delayed or secondary O72.2	[more specific subterm]
preclimacteric or premenopausal N92.4	[subterm]
psychogenic F45.8	[subterm]

Each of the subterms (climacteric, menopausal, perimenopausal, postpartum, preclimacteric or premenopausal, and psychogenic) is indented one standard indentation from the level of the main term and is listed in alphabetical order. The sixth line is a carryover line set two standard indentations from the preceding line. The seventh line is a more specific entry (“delayed or secondary” under the subterm “postpartum”).

### Exercise 1.1

A reproduction of a page from the Alphabetic Index is shown below. Label the numbered lines as either main terms, subterms, or carryover lines. Each hyphen is meant to represent one level of indentation.

## CHAPTER 2

# ICD-10-CM Conventions

### CHAPTER OVERVIEW

- A variety of notes appear in ICD-10-CM.
  - *General notes* commonly provide general information on usage in a specific section.
  - *Inclusion notes* and *exclusion notes* indicate when certain conditions are or are not included in a subdivision.
  - Additional instructional notes direct the coding professional to create a complete statement on the condition.
- Two main abbreviations (NEC and NOS) are used in ICD-10-CM.
- Cross-reference notes advise the coding professional to look elsewhere before assigning a code.
- Punctuation marks and relational terms have specialized meanings in ICD-10-CM.

### LEARNING OUTCOMES

After studying this chapter, you should be able to:

- List the different types of instructional notes.
- Explain the importance of additional notes to the coding process.
- Describe the difference between the abbreviations NEC and NOS.
- Use your knowledge of cross-reference notes to navigate ICD-10-CM.
- Define the specialized meanings of punctuation marks and relational terms in ICD-10-CM.

### TERMS TO KNOW

#### NEC

not elsewhere classified; used in the Alphabetic Index to indicate that there is no separate code for the condition even though the diagnostic statement is specific

#### NOS

not otherwise specified; equivalent to the term "unspecified"

### REMEMBER ...

These conventions are not just helpful; they are necessary to successful coding.

# INTRODUCTION

ICD-10-CM follows certain conventions to provide large amounts of information in a succinct and consistent manner. A thorough understanding of these conventions is fundamental to accurate coding. The conventions and instructions of the classification are applicable to all health care settings, unless otherwise indicated.

ICD-10-CM conventions include the following:

- Instructional notes
- Abbreviations
- Cross-reference notes
- Punctuation marks
- Relational terms (“and,” “with,” “without,” “due to”)

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## F90 Attention-deficit hyperactivity disorders

1. Excludes2:  
anxiety disorders (F40.-, F41.-)
2. mood [affective] disorders (F30–F39)

In this example, the “excludes2” note serves as a warning that if a patient has an anxiety disorder, rather than attention-deficit hyperactivity disorder, the user should go to categories F40–F41 rather than remain in category F90. However, if a patient has both attention-deficit hyperactivity and an anxiety disorder, a code from category F90 could be used along with a code from category F40 or F41.

## “Code First” and “Use Additional Code”

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. In the Tabular List, “code first” and “use additional code” instructional notes indicate the proper sequencing order of these conditions—etiology (underlying condition) followed by manifestation. The “use additional code” note is found at the etiology code as a clue to identify the manifestations commonly associated with the disease. The “code first” note is found at the manifestation code to provide instructions that the underlying condition, if present, should be sequenced first.

The manifestation codes usually have the phrase “in diseases classified elsewhere” as part of the code title. Codes with this phrase are never used as a first-listed or principal diagnosis code. For such codes, a “use additional code” note appears at the etiology code, and a “code first” note appears at the manifestation code. An example of this convention is category F02, Dementia in other diseases classified elsewhere.

Other notes of this type provide a list introduced by the phrase “such as,” meaning that any of the listed codes or any other appropriate code can be assigned first. Code J99, Respiratory disorders in diseases classified elsewhere, provides a list of conditions that may be the underlying disease.

It is not necessary to report the code identified in a “use additional code” note in the diagnosis field immediately following the primary code. There is no strict hierarchy inherent in the guidelines, nor in the ICD-10-CM classification, regarding the sequencing of secondary diagnosis codes.

## “Code Also”

“Code also” notes in ICD-10-CM indicate that two codes may be required to fully describe a condition. This note does not provide sequencing direction. The sequencing order will depend on the circumstances of admission (i.e., reason for the encounter). An example of this note can be found under code G47.01, Insomnia due to medical condition, where the instructional note tells the coding professional to code also the associated medical condition.

# ABBREVIATIONS

ICD-10-CM uses two main abbreviations:

- NEC, for “not elsewhere classified”
- NOS, for “not otherwise specified”

Although their meanings appear simple, these abbreviations are often misunderstood and misapplied. It is very important to understand not only their meanings but also their differences, because they provide guidance for correct code selection.

## NEC

The abbreviation NEC is used in the Alphabetic Index and the Tabular List to indicate that there is no separate code for the condition, even though the diagnostic statement may be very specific. NEC is used when the information in the medical

record provides detail for which a specific code does not exist. It represents “other specified.” In the Tabular List, such conditions are ordinarily classified to a code with a fourth or sixth character 8 (or a fifth character 9) with a title that includes the words “other specified” or “not elsewhere classified,” which permits the grouping of related conditions to conserve space and limit the size of the classification system. For example, a disease of the pleura specified as hydropneumothorax is included in code J94.8, Other specified pleural conditions.

## NOS

The abbreviation NOS is the equivalent of “unspecified” and is used in the Alphabetic Index and the Tabular List. Codes so identified are to be used only when neither the diagnostic statement nor the medical record provides information that permits classification to a more specific code. The codes in these cases are ordinarily classified to codes with a fourth or sixth character 9 (or a fifth character 0). Conditions listed as both “not elsewhere classified” and “unspecified” are sometimes combined in one code.

Note that a main term followed by a list of subterms in the Alphabetic Index usually displays the unspecified code; the subterms must always be reviewed to determine whether a more specific code can be assigned. For example, in the Index, the main term Cardiomyopathy displays code I42.9. Subterms such as “alcoholic” and “congestive” are provided for more specific cardiomyopathies. Code I42.9 should be assigned only when there is no information in the medical record to identify one of these subterms.

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## CROSS-REFERENCE NOTES

Cross-reference notes are used in the Alphabetic Index to advise the coding professional to look elsewhere before assigning a code. The cross-reference instructions include “see,” “see also,” “see category,” and “see condition.”

### “See”

The “see” cross-reference indicates that the user must refer to an alternative term. This instruction is mandatory; coding cannot be completed without following this advice. For example, the entry for Hemarthrosis, traumatic, uses a “see” cross-reference to advise the user to reference the entry for Sprain, by site.

### “See Also”

The “see also” cross-reference advises the coding professional that there is another place in the Alphabetic Index that must be checked when the entries under consideration do not provide a code for the specific condition or procedure. It is not necessary to follow this cross-reference when the original entries provide all the information necessary.

For example, the cross-reference for the term Psychoneurosis advises the user to “see also Neurosis” when none of the specific subterms provides a code. To locate the code for neurasthenic psychoneurosis, it would not be necessary to follow this cross-reference because there is a subterm “neurasthenic” under the term Psychoneurosis. However, if the diagnosis were psychasthenic

psychoneurosis, the code could be located only by following the “see also” reference to the term **Neurosis** and then looking for the subterm “psychasthenic.”

## **“See Category”**

The “see category” variation of the “see” cross-reference provides the three-character alphanumeric identifier for a category. The coding professional must refer to that category in the Tabular List and select a code from the options provided there. For example, a cross-reference under the Index entry for main term **Mononeuropathy**, subterm “in diseases classified elsewhere,” refers the user to category G59.

## **“See Condition”**

Occasionally, the Index advises the user to refer to the main term of a condition. For example, when a user looks up the main term **Arterial** to find the code for arterial thrombosis, the Index advice is to “see condition.” Therefore, the user should then go to the main term **Thrombosis**. This cross-reference ordinarily appears when the adjective rather than the term (in noun form) has been referenced for the condition itself.

# **PUNCTUATION MARKS**

Several of the punctuation marks used in ICD-10-CM have a specialized meaning in addition to the usual English language usage.

## **Parentheses**

Parentheses are used in ICD-10-CM to enclose supplementary words or explanatory information that may be either present or absent in the statement of diagnosis without affecting the code to which it is assigned. Such terms are considered to be “nonessential modifiers” and are used to suggest that the terms in parentheses are included in the code but need not be stated in the diagnosis. This is a significant factor in correct code assignment. Terms enclosed in parentheses in either the Tabular List or the Alphabetic Index do not affect the code assignment in any way; they serve only as reassurance that the correct code has been located.

For example, refer to the main term **Pneumonia**, which has several nonessential modifiers enclosed in parentheses. Unless a more specific subterm is located, this code will be assigned for pneumonia described by any of the terms in parentheses. Diagnoses of acute pneumonia and purulent pneumonia, for example, are both coded J18.9 because both terms appear in parentheses as nonessential modifiers. Pneumonia not otherwise specified is also assigned to code J18.9 because none of the terms in parentheses is required for this code assignment.

It is important to distinguish between the uses of nonessential and essential modifiers. Essential modifiers are listed as subterms in the Alphabetic Index, not in parentheses, and they do affect code assignment. In contrast, words in parentheses are nonessential and do not affect the code assignment. For example, scoliosis described as acquired or postural is classified as M41.9, as the words “acquired” and “postural” are nonessential modifiers and do not affect the code; on the other hand, the term “congenital” is an essential modifier, and the code for this type of scoliosis is Q67.5.

The nonessential modifiers in the Index to Diseases apply to subterms following a main term, except when a nonessential modifier and a subentry are mutually exclusive, in which case the subentry takes precedence. For example, in ICD-10-CM’s Alphabetic Index under the main term **Enteritis**, “acute” is a nonessential modifier, and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic.”

## Commas

When commas are used in the Alphabetic Index, they have different meanings based on the context of the Index entry. For example, the comma may indicate alternate verbiage, a modifier (essential and nonessential), or an alternative to "and/or."

### Exercise 2.2

Referring only to the title and inclusion notes provided for the four-character code D04.5, mark an "X" next to each diagnosis listed below that is included in code D04.5.

## RELATIONAL TERMS

### "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a code title. For example, cases of "tuberculosis of bones," "tuberculosis of joints," and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints.

### "With" and "In"

The words "with" and "in" should be interpreted to mean "associated with" or "due to" when they appear in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or the Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated, or unless another guideline exists that specifically requires a documented linkage between two conditions (for example, a sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis"). If conditions are not specifically linked by these relational terms in the classification, or if a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order for them to be coded as related. The word "with" in the Alphabetic Index is sequenced immediately following the main term or subterm and is not in alphabetical order.

The following example from the Alphabetic Index for the main term **Diabetes** and the subterm "with" demonstrates the linkage between conditions:

- Diabetes, diabetic (mellitus) (sugar) E11.9
- -with
- --amyotrophy E11.44
- --arthropathy NEC E11.618
- --autonomic (poly) neuropathy E11.43
- --cataract E11.36
- --Charcot's joints E11.610
- --chronic kidney disease E11.22

The diagnoses of diabetes and chronic kidney disease are coded as E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease. This link can be assumed because chronic kidney disease is listed under the subterm "with."

The following example from the Alphabetic Index for the main term **Anemia** and the subterm "in" demonstrates the linkage between conditions:

- Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound) D64.9 ...
- -in (due to) (with)
- --chronic kidney disease D63.1
- --end stage renal disease D63.1
- --failure, kidney (renal) D63.1
- --neoplastic disease (*see also* Neoplasm) D63.0

The diagnoses of anemia and chronic kidney disease are coded as D63.1, *Anemia in chronic kidney disease*. This linkage can be assumed because the chronic kidney disease is listed under the subterm “in (due to) (with).”

## “Due To”

The phrase “due to” in either the Alphabetic Index or the Tabular List indicates that a causal relationship between two conditions is present. ICD-10-CM occasionally makes such an assumption when both conditions are present. For example, certain conditions affecting the mitral valve are assumed to be rheumatic in origin, regardless of whether or not the diagnostic statement specifies this causal relationship. However, for other combinations of conditions, a causal relationship should not be presumed if it is not indicated in the diagnostic statement. When the physician’s statement indicates a causal relationship, the coding professional should locate the subterm “due to” under the relevant term in the Alphabetic Index to select the appropriate code to look up in the Tabular List.

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## CHAPTER 3

# Uniform Hospital Discharge Data Set

## CHAPTER OVERVIEW

- The Uniform Hospital Discharge Data Set (UHDDS) is used for reporting inpatient data.
- The following items are always found in the UHDDS:
  - General demographic information
  - Expected payer
  - Hospital identification
  - Principal diagnosis
  - Other diagnoses that have specific significance
  - All significant procedures
- The rules for identifying the first-listed diagnosis for an outpatient encounter differ from those for selecting the principal diagnosis for an inpatient encounter.
- Following all the coding guidelines will ensure accurate and ethical coding.

## LEARNING OUTCOMES

After studying this chapter, you should be able to:

- Correctly identify a principal diagnosis.
- Understand the guidelines for assigning a principal diagnosis.
- Understand when other diagnoses have significance and should be reported.
- Explain the difference between a principal diagnosis and an admitting diagnosis.
- Explain the importance of accurate and ethical coding.

## TERMS TO KNOW

### MS-DRG system

Medicare Severity Diagnosis-Related Group system; a patient classification system used in hospital inpatient reimbursement

### Other reportable diagnoses

conditions that coexist with the principal diagnosis at the time of admission, develop subsequently, or affect patient care during the hospital stay

### Principal diagnosis

the condition established after study to be chiefly responsible for admission of the patient to the hospital

hospital

**UHDDS**

Uniform Hospital Discharge Data Set; information used for reporting inpatient data

**REMEMBER ...**

The admitting diagnosis is not an element of the UHDDS. Diagnoses that have no impact on patient care or that are related to an earlier episode are not reported on the UHDDS.

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## INTRODUCTION

The Uniform Hospital Discharge Data Set (UHDDS) is used for reporting inpatient data in acute care, short-term care, and long-term care hospitals. It uses a minimum set of items based on standard definitions that could provide consistent data for multiple users. Only those items that meet the following criteria have been included in the UHDDS:

- Easily identified
- Readily defined
- Uniformly recorded
- Easily abstracted from the medical record

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## INTRODUCTION

The Uniform Hospital Discharge Data Set (UHDDS) is used for reporting inpatient data in acute care, short-term care, and long-term care hospitals. It uses a minimum set of items based on standard definitions that could provide consistent data for multiple users. Only those items that meet the following criteria have been included in the UHDDS:

- Easily identified
- Readily defined
- Uniformly recorded
- Easily abstracted from the medical record

The UHDDS must be used for claims reporting for Medicare and Medicaid patients. In addition, many other health care payers use most of the UHDDS as a uniform billing system.

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## PROCEDURES

The UHDDS requires that all significant procedures be reported. The UHDDS definitions of significant procedures and other reporting guidelines are discussed in [chapter 9](#) of this handbook, along with other information on coding operations and procedures.

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*Example 3:*

A nursing home resident is transferred to the hospital for treatment of pneumonia. She returns to the nursing home while still receiving antibiotics for the pneumonia. However, the main reason she is returning to the nursing home is because it has been her residence since she had a cerebrovascular accident (CVA) with residuals several years ago. The appropriate code from subcategory I69.3, Sequelae of cerebral infarction, is assigned as the principal diagnosis to identify the neurological deficits that resulted from the acute CVA. The appropriate code for the pneumonia is assigned as a secondary diagnosis for as long as the patient receives treatment for the condition.

## ETHICAL CODING AND REPORTING

Although coded medical data are used for a variety of purposes, they have become increasingly important in determining payment for health care. Medicare reimbursement depends on the following:

- The correct designation of the principal diagnosis
- The presence or absence of additional codes that represent complications, comorbidities, or major complications or comorbidities as defined by the Medicare Severity Diagnosis-Related Group system
- Procedures performed

Other third-party payers may apply slightly different reimbursement methods, but the accuracy of ICD-10-CM and ICD-10-PCS coding is always vital.

Accurate and ethical ICD-10-CM and ICD-10-PCS coding depends on correctly following all instructions in the coding manuals as well as all official guidelines developed by the cooperating parties and coding advice published in the quarterly *AHA Coding Clinic®*. Accurate and ethical reporting requires the correct selection of those conditions that meet the criteria set by the UHDDS and the official guidelines mentioned above. Over-coding and over-reporting may result in higher payment, but those practices are unethical and may be considered fraudulent. On the other hand, it is important to be sure that all appropriate codes are reported, as failure to include all diagnoses or procedures that meet reporting criteria may result in financial loss for the health care provider.

It is important to abide by the American Health Information Management Association Standards of Ethical Coding, which are available at <https://bok.ahima.org/topics/coding-compliance-and-revenue-cycle/american-health-information-management-association-standards-of-ethical-coding-2016-version>.

Occasionally, certain codes are identified by Medicare or another payer as being unacceptable as the principal diagnosis. This does not mean that the code should not be assigned when it is correct; it means that the third-party payer may question or deny payment. Coding professionals must code correctly and then make whatever adjustment is required for reporting, or they run the risk of developing incorrect coding practices that will distort data used for other purposes.

Hospitals sometimes identify a need to code nonreportable diagnoses or procedures for internal use. This is acceptable if the facility has a system for maintaining this information outside the reporting system.

There are a variety of payment policies that may have an impact on coding. Those policies may contradict each other or may be inconsistent with ICD-10-CM/PCS rules and conventions. Therefore, it is not possible to write coding guidelines that are consistent with all existing payer guidelines.

The following advice is shared to help providers resolve coding disputes with payers:

- First, determine whether the problem is really a coding dispute and not a coverage issue. Always contact the payer for clarification if the reason for the denial is unclear.
-

## CHAPTER 4

# The Medical Record as a Source Document

### CHAPTER OVERVIEW

- The medical record is the source document for coding.
- Medical records contain a variety of reports. These include the following:
  - Reason the patient came to the hospital
  - Tests performed and their findings
  - Therapies provided
  - Descriptions of surgical procedures
  - Daily records of patient progress
- The discharge summary provides a synopsis of the patient's stay.

### LEARNING OUTCOMES

After studying this chapter, you should be able to:

- Explain what is present in a medical record.
- Understand when it is appropriate to query a physician about medical record documentation.

### TERMS TO KNOW

#### POA indicator

present on admission indicator; a data element that applies to diagnosis codes for claims involving inpatient care

#### Provider

a physician or any qualified health care practitioner (such as a nurse practitioner or physician assistant) who is legally accountable for establishing the patient's diagnosis

### REMEMBER ...

Coding professionals must make sure that the medical record documentation supports the principal diagnosis.

... Refer to [appendix B](#) of this handbook for more information on the POA indicator.

# INTRODUCTION

The source document for coding and reporting diagnoses and procedures is the medical record. Although discharge diagnoses are usually recorded on the problem list, a final progress note, or the discharge summary, further review of the medical record is needed to ensure complete and accurate coding. Operations and procedures are frequently not listed on the face sheet or are not described in sufficient detail, making a review of operative reports, pathology reports, and other special reports imperative. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

In some institutions, midlevel providers, such as nurse practitioners and physician assistants, are involved in the care of the patient and can document diagnoses in the medical record. It is appropriate to base code assignments on the documentation of midlevel providers if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility. The *ICD-10-CM Official Guidelines for Coding and Reporting* use the term “provider” to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. The term “provider” in the remaining text of this chapter is used in the same way.

Providers sometimes fail to list reportable conditions that developed during the stay but were resolved prior to discharge. Conditions such as urinary tract infection or dehydration, for example, are often not included in the diagnostic statement even though progress notes, providers’ orders, and laboratory reports make it clear that such conditions were treated. It is inappropriate to assign a diagnosis based solely on a provider’s orders for prescribed medications without the provider’s documentation of the diagnosis being treated. If enough information is present to strongly suggest that an additional diagnosis should be reported, the provider should be consulted; no diagnosis should be added without the approval of the provider. Because diagnostic statements sometimes include diagnoses that represent past history or existing diagnoses that do not meet the Uniform Hospital Discharge Data Set (UHDDS) guidelines for reportable diagnoses, the coding professional must review the medical record to determine whether these diagnoses should be coded for this encounter.

It is customary to list the principal diagnosis first in the diagnostic statement. However, many providers are unaware of coding and reporting guidelines, and, consequently, this custom is not consistently followed. Because the correct designation of the principal diagnosis is of critical importance in reporting diagnostic information, the coding professional must make sure that medical record documentation supports the designation of principal diagnosis. If it appears that another diagnosis should be designated as the principal diagnosis, or if it seems that conditions not listed should be reported, follow the health care facility’s procedures for obtaining a corrected diagnostic statement.

# INTRODUCTION

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## CHAPTER 5

# Basic ICD-10-CM Coding Steps

### CHAPTER OVERVIEW

- There are three basic steps for locating codes to be assigned.
  - Locate the main term in the Alphabetic Index. Search for subterms, notes, or cross-references.
  - Verify the alphanumeric code in the Tabular List.
  - Assign the verified code or codes.
- It is important to understand basic coding techniques before moving on to the harder, system-based chapters of this handbook.

### LEARNING OUTCOMES

After studying this chapter, you should be able to:

- Locate code entries in the Alphabetic Index.
- Determine the course of action when there are discrepancies between the Alphabetic Index and the Tabular List.
- Perform basic coding techniques.

### TERMS TO KNOW

#### Alphabetic Index of Diseases and Injuries and the Index to External Causes

include entries for main terms (diseases, conditions, or injuries) and subterms (site, type, or etiology), the Neoplasm Table, and the Table of Drugs and Chemicals

#### Tabular List

contains categories, subcategories, and valid codes

### REMEMBER ...

You cannot begin to code unless you have determined the principal diagnosis and other reportable diagnoses from the medical record.

# INTRODUCTION

Once the medical record has been reviewed to determine the principal/first-listed diagnosis and other reportable diagnoses, the following steps to locate the codes to be assigned should be undertaken:

1. Locate the main term in the Alphabetic Index.

- Review subterms and nonessential modifiers related to the main term.
- Follow any cross-reference instructions.
- Refer to any notes in the Alphabetic Index.
- A dash (-) at the end of an Index entry indicates that additional characters are required.

2. Verify the alphanumeric code in the Tabular List.

- Read the code title.
- Read and follow any instructional notes. Refer to other codes as instructed.
- Determine whether any additional characters must be added.
- Determine laterality (right, left, or bilateral) and any applicable extensions.

3. Assign the verified code or codes.

It is imperative that these steps be followed without exception; the condition to be coded must first be located in the Alphabetic Index and then verified in the Tabular List. Relying on memory or using only the Index or Tabular List may lead to incorrect code assignment.

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### Exercise 5.1

Without referring to the Alphabetic Index of Diseases and Injuries, underline the word that indicates the main term for each diagnosis.

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# CODING DEMONSTRATIONS

Follow the steps outlined above to determine the correct code for each of the diagnostic statements listed below:

- **Hirsutism**

Refer to the main term **Hirsutism** in the Alphabetic Index, which provides a code of L68.0. Note that there are no subterms. Verify this by referring to code L68.0 in the Tabular List. In this case, the Index entry and Tabular List title are identical and code L68.0 should be assigned.

- **Portal vein obstruction**

Refer to the main term **Obstruction** in the Alphabetic Index and the subterm for portal (circulation) (vein), which provides a code of I81. In the Tabular List, the title for code I81 is “Portal (vein) thrombosis” but an inclusion term is “portal (vein) obstruction.” If you are uncertain whether thrombosis and obstruction are the same condition for the purposes of coding, check the Index for the main term **Thrombosis**.

- **Abscess abdominal wall due to *Staphylococcus***

Look up the main term **Abscess** in the Alphabetic Index and then the subterm “abdomen, abdominal”; and then the subterm “wall.” The code entry is L02.211. Read the “use ‘additional code’ note” in the Tabular List that advises you to also assign a code to identify the organism involved (B95–B96). Hint: if you have trouble locating this note, check under the category title L02. Look up **Infection**, staphylococcal, and the subterm “as cause of disease classified elsewhere” in the Alphabetic Index and find code B95.8. In the Tabular List, the code title for B95.8 is “Unspecified staphylococcus as the cause of diseases classified elsewhere.” Review the medical record for any mention of the specific type of **Staphylococcus**. If one is mentioned, consider assigning the code B95.61, B95.62, or B95.7; if not, assign code B95.8 as an additional code.

- **Aplasia of pulmonary artery**

Refer to the main term **Aplasia** in the Alphabetic Index. Check the subterms, and note that there is no entry for pulmonary artery. However, there is a cross-reference note after **Aplasia** to “see also Agenesis.” Follow the cross-reference advice and refer to the main term **Agenesis**. You immediately see a more specific subterm for “artery, pulmonary,” with code entry Q25.79. The title for this code in the Tabular List is “Other congenital malformations of pulmonary artery,” and it is clearly the correct code for this condition. As additional confirmation that this is the correct code, “agenesis of pulmonary artery” is listed as an inclusion term.

- **Acute bronchopneumonia due to aspiration of oil**

Locate the main term **Bronchopneumonia** in the Alphabetic Index. Note the cross-reference instruction to “see **Pneumonia, broncho.**” Follow the cross-reference by turning to the main term **Pneumonia (acute) (double) (migratory)**.... Note that the term “acute” is a nonessential modifier enclosed in parentheses following the main term **Pneumonia**. This nonessential modifier applies also to the subterms, and so the term “acute” has now been accounted for but does not directly affect code assignment. Refer to the following subterms listed under the main term:

**Pneumonia (acute) (double) (migratory) ...**

-broncho-, bronchial (confluent) (croupous)  
(diffuse) (disseminated) (hemorrhagic) ...  
--aspiration—see **Pneumonia, aspiration**

Note the cross-reference to “see **Pneumonia, aspiration**.” Refer back to the subterm “aspiration” and locate the code J69.0. Search through the main term and subterms cited above and underline the component parts of the diagnostic statement that have been located so far. Note that all component parts of the diagnostic statement except “of oil” have been located. Refer back to “**Pneumonia, aspiration**,” and you will see that there are additional subterms here under the connecting words “due to,” with a subterm for “oils, essences” that takes you to code J69.1. Refer to code J69.1 in the Tabular List, and note that the title for this code is “Pneumonitis due to inhalation of oils and essences.” Although the title is not worded exactly the same as the diagnosis, there is such a close correlation that it is clear that this is the code that should be assigned. Assign code J69.1 because it covers all elements of the diagnosis and no instructional notes contradict its use.

## Review Exercise 5.2

Using the Alphabetic Index and the Tabular List, code the following diagnoses

## CHAPTER 6

# Basic ICD-10-CM Coding Guidelines

### CHAPTER OVERVIEW

- There are basic principles that all coding professionals must follow.
- It is important to use both the Alphabetic Index and the Tabular List during the coding process.
  - Follow all instructional notes.
  - Even if commonly used codes have been memorized, refer to the Alphabetic Index and Tabular List.
- Always assign codes to the highest level of detail.
  - All characters must be used.
  - None can be omitted or added.
- NEC and NOS codes should be assigned only when appropriate.
- Combination codes should be used if they are available.
  - Assign multiple codes as needed to fully describe a condition.
  - Avoid coding irrelevant information.

### LEARNING OUTCOMES

After studying this chapter, you should be able to:

- Determine what level of detail to assign to a code.
- Understand how to use combination codes.
- Explain how to assign multiple codes to fully describe a condition.
- Identify what qualifications determine whether an unconfirmed diagnosis is coded as though it were an established diagnosis.
- Explain the difference between "rule out" and "ruled out."
- Code "borderline" diagnoses.
- Code acute and chronic conditions.
- Code a condition labeled "impending," "threatened," or "late effect."

### TERMS TO KNOW

#### Combination code

a single code used to classify two diagnoses, a diagnosis with a secondary condition, or a diagnosis with an associated complication

**NEC**

not elsewhere classified

**NOS**

not otherwise specified

**"Rule out"**

indicates that a diagnosis is still possible

**"Ruled out"**

indicates that a diagnosis once considered likely is no longer possible

**REMEMBER ...**

For the current version of the *ICD-10-CM Official Guidelines for Coding and Reporting*, visit [www.cms.gov/Medicare/Coding/ICD10](http://www.cms.gov/Medicare/Coding/ICD10).

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The basic coding guidelines discussed in this chapter apply throughout the ICD-10-CM classification system. Following these principles is vital to accurate code selection and correct sequencing. Guidelines that apply to specific chapters of ICD-10-CM will be discussed in the relevant chapters of this handbook. To download a copy of the current version of the complete *ICD-10-CM Official Guidelines for Coding and Reporting*, please visit [www.cms.gov/Medicare/Coding/ICD10](http://www.cms.gov/Medicare/Coding/ICD10). This handbook has been prepared using the fiscal year 2026 version of the Official Coding Guidelines. Adherence to the guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act. The instructions and conventions of the classification take precedence over guidelines.

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The following examples demonstrate these basic coding principles:

- Refer to the Tabular List category J40, Bronchitis, not specified as acute or chronic. Code J40 has no fourth-character subdivisions; therefore, the three-character code is assigned.
- Refer to the Tabular List category K35, Acute appendicitis. This category includes fourth characters that indicate the presence of generalized or localized peritonitis. In addition, there are fifth characters and sixth characters that indicate whether there is an abscess, gangrene, rupture, or perforation of the appendix. Because fourth-character, fifth-character, and sixth-character subdivisions are provided, K35 cannot be assigned as a three-character code.
- Refer to the Tabular List category J45, Asthma. Category J45 has five fourth-character subdivisions (J45.2, J45.3, J45.4, J45.5, and J45.9). It also uses a final-character (fifth- or sixth-character) subclassification to specify whether the asthma is uncomplicated or if there is any mention of status asthmaticus or acute exacerbation. Any code assignment from category J45 must have five characters (for subcategories J45.2–J45.5) or six characters (for subcategory J45.9) to ensure coding accuracy.
- Refer to the Tabular List category T27, Burn and corrosion of respiratory tract. Category T27 has eight four-character subdivisions to specify whether the condition is burn or corrosion and to provide detail about the part of the respiratory tract affected. The general note at category T27 also indicates that the appropriate seventh character is to be added to each code from this category. Because the codes from category T27 are only four characters long, the placeholder character “x” is used as the fifth and sixth characters before the seventh character is added. For example, an initial encounter for burn of the larynx and trachea would be coded to T27.0xxA.

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## ASSIGN RESIDUAL CODES (NEC AND NOS) AS APPROPRIATE

The main term entry in the Alphabetic Index is usually followed by the code number for the unspecified condition. This code should never be assigned without a careful review of subterms to determine whether a more specific code can be located. When the review does not identify a more specific code entry in the Index, the titles and inclusion notes in the subdivisions under the three-character, four-character, or five-character code in the Tabular List should be reviewed. The residual NOS (not otherwise specified) code should never be assigned when a more specific code is available. The following examples demonstrate this basic coding principle:

- Refer to the Alphabetic Index for nontraumatic hematoma of breast, which is classified as N64.89. In the Tabular List, this code is listed as “other” specified disorders of the breast. Even though the diagnosis is very specific, no separate code is provided for it.
- Refer to the Alphabetic Index for phlebitis. Note that phlebitis, not otherwise specified, is assigned to code I80.9, Phlebitis and thrombophlebitis of unspecified site. Now, suppose that review of the medical record provides even further specificity, that the diagnosis is phlebitis of not only the lower extremity but the right popliteal vein. The more specific code I80.221, Phlebitis and thrombophlebitis of right popliteal vein, should be assigned.

