ICD-10-CM Coding Guidelines

Introduction

There are basic principles that all coders must follow. These guidelines assist in standardizing the assignment of ICD-10-CM codes for all users.

- Use both the Alphabetic Index and the Tabular List
- Assign Codes to the Highest Level of Detail
- Assign Residual Codes as Appropriate
- Assign Combination Codes when Available
- Assign Multiple Codes as Needed
- Code Unconfirmed Diagnoses as if Established
- Acute and Chronic Conditions
- Impending or Threatened Condition
- Reporting the Same Diagnosis Code More Than Once
- Late Effects

Use both the Alphabetic Index and the Tabular List

The first principle is that both the Alphabetic Index and the Tabular List must be used to locate and assign codes. The diagnosis should be first located in the Alphabetic Index and then verified using the Tabular List. All instructions and notes must be followed to ensure correct assignment of codes.
Assign Codes to the Highest Level of Detail

Codes must be assigned to the highest number of characters available. This can be accomplished by assigning:

- a three character code only if it is not further subdivided. For example, J40 for unspecified bronchitis.
- a four character code only when there are no five-character codes within that subcategory. For example, K35.X for acute appendicitis. As four character subdivisions are provided, K35 cannot be assigned this diagnosis.
- a five character code only when there are no six-character codes within that subcategory. For example, the diagnosis Asthma has five fourth-character subdivisions, as well as fifth or sixth character subclassification.
- A six character code only when there is a sixth-character subclassification.
- A seven character code when provided.

Assign Residual Codes as Appropriate (NEC and NOS)

When the coder’s review does not identify a more specific code entry in the Index or in the notes in the subdivisions in the Tabular List, an NOS code may be assigned.

- NEC (‘Not elsewhere classifiable’): This abbreviation in the Alphabetic Index represents “other specified”. When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.
- NOS (‘Not otherwise specified’): This abbreviation is the equivalent of unspecified.

Assign Combination Codes when Available

A combination code is a single code used to classify:

- two diagnoses,
- a diagnosis with an associated secondary process (manifestation), or
- a diagnosis with an associated complication.
Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

**Example**

Combination codes found in the Tabular List:

- **J11.2** Influenza with gastroenteritis
- **A02.21** Meningitis due to Salmonella infections

### Assign Multiple Codes as Needed

Multiple coding is the use of more than one code to identify the component elements of a complex diagnostic or procedural statement. Coders must report two codes to fully describe certain conditions. They should be guided by directions in the Tabular List for the use of an additional code/s. “Use additional code” notes are found in the Tabular List at codes when a secondary code is required to fully describe a condition. Report the “use additional code” as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.
Code Unconfirmed Diagnoses as if Established

NOTE: When a diagnosis for an inpatient admission is qualified as ‘probable’, ‘possible’, suspected’, ‘likely’, or ‘rule out’ at the time of discharge, the condition should be coded and reported as though the diagnosis were established. An exception to this guideline is the coding of HIV infection/illness and influenza due to certain identified influenza viruses.

This guideline does not apply to coding or reporting for outpatient services, including physician’s office coding.

Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Example

Alphabetic Index entry for bronchitis, with subterms (acute and chronic) at the same indentation level:

Bronchitis…

    acute or subacute J20.9
    chronic… J42

As both subterms appear at the same indentation level, both codes are assigned with code J20.9 (for acute) sequenced first.

When only one term is listed as a subterm, with the other in parenthesis as a nonessential modifier, assign only the code listed for the subterm.
Impending or Threatened Condition

Any condition described at the time of discharge as “impending” or “threatened” should be coded as follows:

- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
- If the subterms are listed, assign the given code.
- If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

Reporting the Same Diagnosis Code More Than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

Late Effects

A late effect is the residual condition after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. A late effect may be inferred when the diagnostic statement includes terms such as ‘late’, ‘old’, ‘due to previous injury or illness’, ‘following previous injury or illness’.

Alphabetic Index entry for a diagnosis of acute and chronic adenoiditis:

Adenoiditis (chronic) J35.02

acute J03.90

The only code assigned in this case is J03.90, Acute tonsillitis, unspecified.