ABBREVIATIONS

This manual uses its own abbreviations throughout that may not appear in the official *ICD-10-CM* manual. For ease of access, please find these terms defined below.

ALL	Acute lymphoblastic leukemia
AML	Acute myeloid leukemia
BMI	Body mass index
CKD	Chronic kidney disease
CMML	Chronic myelomonocytic leukemia
DM	Diabetes mellitus
E. coli	*Escherichia coli*
ESRD	End-stage renal disease
FB	Foreign body
H. influenzae	*Haemophilus influenzae*
H. pylori	*Helicobacter pylori*
HIV	Human immunodeficiency virus
K. pneumoniae	*Klebsiella pneumoniae*
LAC	Lupus anticoagulant
LBW	Low birth weight
LLQ	Left lower quadrant
LUQ	Left upper quadrant
M. pneumoniae	*Mycoplasma pneumoniae*
MPGN	Membranoproliferative glomerulonephritis
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-susceptible *Staphylococcus aureus*
NEC	Not elsewhere classified
NKHHC	Nonketotic hyperglycemic-hyperosmolar coma
NOS	Not otherwise specified
RLQ	Right lower quadrant
RUQ	Right upper quadrant
SARS	Severe acute respiratory syndrome
SCID	Severe combined immunodeficiency
SIRS	Systemic inflammatory response syndrome
SLE	Systemic lupus erythematosus
STEC	Shiga toxin-producing *Escherichia coli (E coli)*
TAR	Thrombocytopenia with absent radius
TIA	Transient ischemic attack

Pediatric ICD-10-CM 2022

A Manual for Provider-Based Coding

7th Edition

American Academy of Pediatrics

Cindy Hughes, CPC, CFPC, Consulting Editor

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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Disclaimer

Every effort has been made to include all pediatric-relevant *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) codes and their respective guidelines. It is the responsibility of the reader to use this manual as a companion to the official *ICD-10-CM* publication. Do not report new or revised *ICD-10-CM* codes until their published implementation date, at time of publication set for October 1, 2021. Further, it is the reader's responsibility to access the American Academy of Pediatrics (AAP) Coding at the AAP website (www.aap.org/coding) routinely to find any corrections due to errata in the published version.

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The American Academy of Pediatrics is committed to principles of equity, diversity, and inclusion in its publishing program. Editorial boards, author selections, and author transitions (publication succession plans) are designed to include diverse voices that reflect society as a whole. Editor and author teams are encouraged to actively seek out diverse authors and reviewers at all stages of the editorial process. Publishing staff are committed to promoting equity, diversity, and inclusion in all aspects of publication writing, review, and production. Likewise, it is the intent of the authors and publishing team to use visual representations of the diverse range of patients seen in medical settings where children are evaluated and treated.

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Tabular List

Foreword

The American Academy of Pediatrics (AAP) is pleased to publish this seventh edition of *Pediatric ICD-10-CM: A Manual for Provider-Based Coding,* a pediatric version of the *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) manual. The AAP believes it is vital to publish an *ICD-10-CM* manual that is more manageable for pediatric providers. The expansive nature of the code set from *International Classification of Diseases, Ninth Revision, Clinical Modification* to *ICD-10-CM* overwhelmed many physicians, providers, and coders, so we condensed the code set by only providing pediatric-relevant diagnoses and their corresponding codes. However, as we move forward, we want members to have access to more codes and those that are less common in pediatrics but still need to be included. We reduced the guidelines so that only those applicable to the physician or provider are included, while those only relevant to facilities are removed. When needed, those codes can be located in the larger *ICD-10-CM* manual. Lastly, guidelines that exist for topic-specific chapters or specific codes can now be found in their respective tabular chapter or right where the specific code is listed. This will aid the user in identifying any chapter- or code-specific guidelines where they are needed most. This should assist in reducing any coding errors caused by reporting services that go against the guidelines that were once solely kept in the front of the manual, away from applicable codes. In addition, tips are included throughout to aid in your coding. These are unique to this manual.

The AAP is committed to the clinical modification of the *ICD* code set and, for the past several years, has sent an AAP liaison to the *ICD* Coordination and Maintenance Committee Meeting. We are especially grateful to Edward A. Liechty, MD, FAAP, and Jeffrey F. Linzer Sr, MD, FAAP, our appointed liaisons. The *ICD* Coordination and Maintenance Meeting is the semiannual meeting where all new *ICD* codes are presented, as well as revisions to the tabular list, index, and guidelines. Having dedicated expert liaisons aids in presenting pediatric and perinatal issues at the meeting. The AAP is also very pleased to continue its work with the *ICD* Editorial Advisory Board for *Coding Clinic for ICD-10-CM and ICD-10-PCS*. *Coding Clinic* is responsible for publishing *ICD* coding guidance and clarifications to supplement the *ICD-10-CM* manual. Dr Linzer sits on the Editorial Advisory Board, and Dr Liechty is our alternate. They sit on the board to represent pediatric issues, and both are experts on all *ICD-10-CM* matters.

The AAP will continue to support its members on issues regarding coding, and the AAP Health Care Financing Strategy staff at the AAP headquarters stands ready to assist with problem areas not adequately covered in this manual. The AAP Coding Hotline can be accessed at https://form.jotform.com/Subspecialty/aapcodinghotline.

Acknowledgments

Pediatric ICD-10-CM: A Manual for Provider-Based Coding is the product of the efforts of many dedicated individuals. First and foremost, we must thank Cindy Hughes, CPC, CFPC, consulting editor, for her professional input and particularly for her ongoing work to make this manual more user friendly.

We would also like to thank members of the American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature, past and present, and the AAP Coding Publications Editorial Advisory Board. They support all coding efforts here at the AAP. These members contribute extensive time, reviewing and editing various coding content for the AAP.

We would also like to extend a very special thank-you to members of various subspecialty sections of the AAP who contributed their expertise and knowledge to the development of the original manual.

Lastly, we would like to acknowledge the tireless work of Jeffrey F. Linzer Sr, MD, FAAP, and Edward A. Liechty, MD, FAAP. Both Dr Liechty and Dr Linzer are advocates for pediatrics and neonatology and ensure that our issues are heard. They advocate for all pediatric patients in helping get codes established for conditions that need to be tracked for purposes of research and quality. They both keep the AAP and pediatric issues at the forefront of diagnostic coding, and we are very grateful for their time and expertise!

How to Use This Manual

Step 1. Locate the condition in the Alphabetic Index of diagnostic terms (ie, the front section). For example, for a *left ankle fracture of the medial malleolus,*

go to **Fracture**

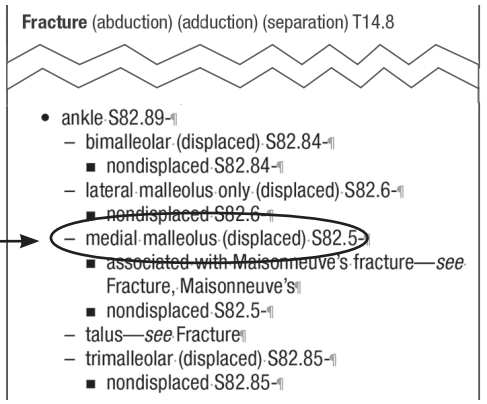
↓

ankle

↓

medial malleolus

The dash at **S82.5-** indicates further characters are needed.



Step 2. Next, find the code in the Tabular List (**never code from the index**). Check the Tabular List at the block, chapter, category, and code levels to see if the code has any special considerations. Read any code instructions, if applicable.

S82 4th **FRACTURE OF LOWER LEG, INCLUDING ANKLE**
Please see full *ICD-10-CM* manual for seventh characters applicable to open fracture types IIIA, IIIB, or IIIC.
Note: A fracture not indicated as displaced or nondisplaced should be coded to displaced
A fracture not indicated as open or closed should be coded to closed
The open fracture designations are based on the Gustilo open fracture classification
Includes: fracture of malleolus
Excludes1: traumatic amputation of lower leg (S88.-)
Excludes2: fracture of foot, except ankle (S92.-)
periprosthetic fracture around internal prosthetic implant of knee joint (M97.0-)

Step 3. The **5th** indicates that additional code characters are required for this diagnosis. Always code to the highest degree of specificity, including laterality.

S82.5 Fracture of medial malleolus
5th
Excludes1: pilon fracture of distal tibia (S82.87-)
Salter-Harris type III of lower end of tibia (S89.13-)
Salter-Harris type IV of lower end of tibia (S89.14-)
S82.51X Displaced fracture of medial malleolus of right tibia
7th
S82.52X Displaced fracture of medial malleolus of left tibia
7th
S82.54X Nondisplaced fracture of medial malleolus of right tibia
7th

Step 4. If the condition warrants further specificity, an additional character note will be added. For example, an injury code may require a seventh character. Refer to a box on that page or nearby to provide you with that additional information.

7th characters for category S82 except S82.16-, S82.31-, S82.81, & S81.82
A—initial encounter for closed fracture
B—initial encounter for open fracture type I or II
C—initial encounter for open fracture NOS
D—subsequent encounter for closed fracture with routine healing
E—subsequent encounter for open fracture type I or II with routine healing
G—subsequent encounter for closed fracture with delayed healing
H—subsequent encounter for open fracture type I or II with delayed healing
K—subsequent encounter for closed fracture with nonunion
M—subsequent encounter for open fracture type I or II with nonunion
P—subsequent encounter for closed fracture with malunion
Q—subsequent encounter for open fracture type I or II with malunion
S—sequela

Step 5. If more than one condition needs to be coded, check all notes, including *Excludes, Code also,* and *Code first.*

While attempting to stay true to the complete *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) manual, *Pediatric ICD-10-CM: A Manual for Provider-Based Coding* is meant specifically for pediatrics and only includes those conditions more commonly seen in pediatrics. We have attempted to remove all adult-only conditions, as well as those conditions not typically found in the United States. Because *ICD* classification is used worldwide, many conditions listed in the official manual are not found in this part of the world.

Some codes are included under *Excludes* notes in the Tabular List for reference purposes only and to be consistent with the coding guidance. However, not every code included under *Excludes* will be found in the Tabular List if the condition is not specific to US pediatric health care. In addition, some codes that can be found in the Alphabetic Index might not also appear in the Tabular List. Again, these conditions are not commonly found in US pediatric health care, and the codes are included in the Alphabetic Index for reference purposes only. These conditions can be found in the larger Tabular List on the National Center for Health Statistics website (https://www.cdc.gov/nchs/icd/icd10cm.htm).

Guidelines

Guidelines relevant to all pediatric codes are still included. Note that some chapter-specific guidelines will appear at the beginning of the related chapter when they are overarching to most of that chapter. However, chapter-specific guidelines that are relevant only at specific category or code levels will be found at those category or code levels. The beginning of each chapter will reference the category(ies) or code(s) where the guidelines can be found. Guidelines that are **bold** have been revised or added for 2022. Guideline updates for the current year in the front matter and chapter-specific guidelines are printed in **bold.**

Abbreviations

We use our own abbreviations throughout that may not appear in *ICD-10-CM;* however, all abbreviations are defined on the inside front cover for easy access as you navigate through the manual.

Unspecified Laterality

While unspecified codes can still be found throughout and in certain instances will be the most appropriate code, we have removed nearly every code that uses unspecified laterality. We feel it is important that laterality is documented in nearly all conditions. You will see a footnote in those chapters where we have specifically left out laterality in nearly all conditions. If you need to report unspecified laterality for a condition and it is not listed in the chapter, refer to the full *ICD-10-CM* manual. Those codes will typically have a final character of 0 (zero) or 9.

Three-Character Codes

Three-character codes still exist in *ICD-10-CM.* Those will be noted specifically throughout the chapters as well.

E15 NONDIABETIC HYPOGLYCEMIC COMA

✔ ***Includes:*** drug-induced insulin coma in nondiabetic
hyperinsulinism with hypoglycemic coma
hypoglycemic coma NOS

Abbreviated Code Descriptors

To help keep the size of the manual manageable, some codes are only written out fully at the category or subcategory level. The category or subcategory will be notated with a semicolon (;) and the code will begin with a lowercase letter. For example,

A37.0 Whooping cough due to Bordetella pertussis;
A37.00 without pneumonia
A37.01 with pneumonia

At the subcategory level (**A37.0**) you see the semicolon (;), and at the code levels (**A37.00** and **A37.01**), the codes begin with a lowercase letter. Therefore, code **A37.00** reads, "Whooping cough due to Bordetella pertussis without pneumonia."

Symbols

The following symbols are used throughout the text:

- • Identifies new codes
- ▲ Identifies revised codes
- ◘ Identifies codes linked to social determinants of health

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Reminder: New guidelines have been bolded.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. federal government's Department of Health and Human Services (DHHS), provide the following guidelines for coding and reporting by using the International Classification of Diseases, 10th Revision, Clinical Modification (*ICD-10-CM*). These guidelines should be used as a companion document to the official version of the *ICD-10-CM* as published on the NCHS website. The *ICD-10-CM* is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The *ICD-10-CM* is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the *ICD-10-CM*: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the *ICD-10-CM* itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of *ICD-10-CM*, but they provide additional instruction. Adherence to these guidelines when assigning *ICD-10-CM* diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all the rules and instructions needed to code properly.

Note: Updates have been bolded.

Section I. Conventions, general coding guidelines, and chapter-specific guidelines

The conventions, general guidelines, and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the *ICD-10-CM*

The conventions for the *ICD-10-CM* are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the *ICD-10-CM* as instructional notes.

1. The Alphabetic Index and Tabular List

The *ICD-10-CM* is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms, and the Table of Drugs and Chemicals.

See Section I.C2. General guidelines

See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects

2. Format and Structure

The *ICD-10-CM* Tabular List contains categories, subcategories, and codes. Characters for categories, subcategories, and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6, or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The *ICD-10-CM* uses an indented format for ease in reference.

3. Use of codes for reporting purposes

For reporting purposes, only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The *ICD-10-CM* utilizes a placeholder character "X." The "X" is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect, and underdosing codes, categories T36-T50. Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters

Certain *ICD-10-CM* categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

6. Abbreviations

a. Alphabetic Index abbreviations

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.

b. Tabular List abbreviations

NEC "Not elsewhere classifiable"—This abbreviation in the Tabular List represents "other specified." When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.

NOS "Not otherwise specified —This abbreviation is the equivalent of unspecified.

7. Punctuation

[ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording, or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as *nonessential modifiers.* The nonessential modifiers in the Alphabetic 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 the *ICD-10-CM* 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."

: Colons are used in the Tabular List after an incomplete term, which needs one or more of the modifiers following the colon to make it assignable to a given category.

8. Use of "and"

Refer to Section I.A.14 (page XV). Use of the term "And"

9. Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

See Use of Sign/Symptom/Unspecified Codes, page XVII

10. Includes Notes

This note appears immediately under a three-character code title to further define, or give examples of, the content of the category.

11. Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

12. Excludes Notes

The *ICD-10-CM* has two types of excludes notes. Each type of note has a different definition for use, but they are all similar in that they indicate that codes excluded from each other are independent of each other.

a. Excludes1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

b. Excludes2

A type 2 Excludes note represents "Not included here." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, 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, when appropriate.

13. **Etiology/manifestation convention ("code first," "use additional code," and "in diseases classified elsewhere" 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. Wherever 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. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code, and the rules for sequencing apply.

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index, both conditions are listed together with the etiology code first, followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

See Section I.B.7. Multiple coding for a single condition.

14. **"And"**

The word "and" should be interpreted to mean either "and" or "or" when it appears in a 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.

15. **"With"**

The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears 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 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 when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis"). For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.

The word "with" in the Alphabetic Index is sequenced immediately following the main term or subterm, not in alphabetical order.

16. **"See" and "See Also"**

The "see" instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

17. **"Code also note"**

A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.

18. **Default codes**

A code listed next to a main term in the *ICD-10-CM* Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the

unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

B. General Coding Guidelines

1. Locating a code in the *ICD-10-CM*

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character, can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

2. Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available **and to the highest level of specificity documented in the medical record.**

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in *ICD-10-CM* as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

3. Code or codes from A00.0 through T88.9, Z00–Z99.8

The appropriate code or codes from A00.0 through T88.9, Z00–Z99.8 **and U00–U85** must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of *ICD-10-CM*, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 – R99), contains many but not all codes for symptoms.

See Use of Sign/Symptom/Unspecified Codes, page XVII

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

7. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. "Use additional code" notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair; "use additional code" indicates that a secondary code should be added, if known.

For example, for bacterial infections that are not included in Chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A "use additional code" note will normally be found at the infectious disease code, indicating a need for the organism code to be added 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, if known.

"Code, if applicable, any causal condition first" notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for sequela, complication codes, and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

8. 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.

9. Combination Code

A combination code is a single code used to classify:

Two diagnoses, or

A diagnosis with an associated secondary process (manifestation)

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.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. 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.

10. Sequela (Late Effects)

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. 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. Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never
used with a code for the late effect.

Application of 7th characters refer to Chapter 19

11. Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" 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.

12. Reporting 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.

13. Laterality

Some *ICD-10-CM* codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition 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). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

When laterality is not documented by the patient's provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient's attending provider should be queried for clarification. Codes for "unspecified" side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

14. Documentation by *Clinicians Other Than the Patient's Provider*

Code assignment is based on the documentation by **the** patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, **when** code assignment may be based on medical record documentation from clinicians who are not the patient's provider (ie, physician or other qualified healthcare practitioner legally

accountable for establishing the patient's diagnosis). **In this context, "clinicians" other than the patient's provider refer to healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record.**

These exceptions include codes for:

- **Body Mass Index (BMI)**
- **Depth of non-pressure chronic ulcers**
- **Pressure ulcer stage**
- **Coma scale**
- **NIH stroke scale (NIHSS)**
- **Social determinants of health (SDOH)**
- **Laterality**
- **Blood alcohol level**

This information is typically, or may be, documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, or a condition classifiable to category F10, Alcohol related disorders) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI, coma scale, NIHSS, blood alcohol level codes and codes for social determinants of health should only be reported as secondary diagnoses.

See Section I.C.21.c.17 for additional information regarding coding social determinants of health.

15. **Syndromes**
Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

16. **Documentation of Complications of Care**
Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

17. **Borderline Diagnosis**
If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (eg, borderline diabetes). If a borderline condition has a specific index entry in *ICD-10-CM*, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

18. **Use of Sign/Symptom/Unspecified Codes**
Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each health care encounter should be coded to the level of certainty known for that encounter.

As stated in the introductory section of these official coding guidelines, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (eg, a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

19. Coding for Healthcare Encounters in Hurricane Aftermath

a. Use of External Cause of Morbidity Codes

An external cause of morbidity code should be assigned to identify the cause of the injury(ies) incurred as a result of the hurricane. The use of external cause of morbidity codes is supplemental to the application of *ICD-10-CM* codes. External cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes. The external cause of morbidity codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military). They should not be assigned for encounters to treat hurricane victims' medical conditions when no injury, adverse effect or poisoning is involved. External cause of morbidity codes should be assigned for each encounter for care and treatment of the injury. External cause of morbidity codes may be assigned in all health care settings. For the purpose of capturing complete and accurate *ICD-10-CM* data in the aftermath of the hurricane, a healthcare setting should be considered as any location where medical care is provided by licensed healthcare professionals.

b. Sequencing of External Causes of Morbidity Codes

Codes for cataclysmic events, such as a hurricane, take priority over all other external cause codes except child and adult abuse and terrorism and should be sequenced before other external cause of injury codes. Assign as many external cause of morbidity codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapse during the hurricane, external cause codes for both the hurricane and the building collapse should be assigned, with the external causes code for hurricane being sequenced as the first external cause code. For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by the code X37.0-, Hurricane (with the appropriate 7th character), and any other applicable external cause of injury codes. Code X37.0- also should be assigned when an injury is incurred as a result of flooding caused by a levee breaking related to the hurricane. Code X38.-, Flood (with the appropriate 7th character), should be assigned when an injury is from flooding resulting directly from the storm. Code X36.0.-, Collapse of dam or man-made structure, should not be assigned when the cause of the collapse is due to the hurricane. Use of code X36.0- is limited to collapses of man-made structures due to earth surface movements, not due to storm surges directly from a hurricane.

c. Other External Causes of Morbidity Code Issues

For injuries that are not a direct result of the hurricane, such as an evacuee that has incurred an injury as a result of a motor vehicle accident, assign the appropriate external cause of morbidity code(s) to describe the cause of the injury, but do not assign code X37.0-, Hurricane. If it is not clear whether the injury was a direct result of the hurricane, assume the injury is due to the hurricane and assign code X37.0-, Hurricane, as well as any other applicable external cause of morbidity codes. In addition to code X37.0-, Hurricane, other possible applicable external cause of morbidity codes include:

W54.0-, Bitten by dog
X30-, Exposure to excessive natural heat
X31-, Exposure to excessive natural cold
X38-, Flood

d. Use of Z codes

Z codes (other reasons for healthcare encounters) may be assigned as appropriate to further explain the reasons for presenting for healthcare services, including transfers between healthcare facilities **or provide additional information relevant to a patient encounter.** The *ICD-10-CM Official Guidelines for Coding and Reporting* identify which codes maybe assigned as principal or first-listed diagnosis only, secondary diagnosis only, or principal/first-listed or secondary (depending on the circumstances). Possible applicable Z codes include:

Z59.0, Homelessness
Z59.1, Inadequate housing
Z59.5, Extreme poverty
Z75.1, Person awaiting admission to adequate facility elsewhere
Z75.3, Unavailability and inaccessibility of health-care facilities
Z75.4, Unavailability and inaccessibility of other helping agencies
Z76.2, Encounter for health supervision and care of other healthy infant and child
Z99.12, Encounter for respirator [ventilator] dependence during power failure

The external cause of morbidity codes and the Z codes listed above are not an all-inclusive list. Other codes may be applicable to the encounter based

upon the documentation. Assign as many codes as necessary to fully explain each healthcare encounter. Since patient history information may be very limited, use any available documentation to assign the appropriate external cause of morbidity and Z codes.

C. Chapter-Specific Coding Guidelines

Please refer to each chapter for information on specific guidelines.

Section II. Selection of Principle Diagnosis

Excluded as not relevant to provider-based coding. Refer to the full *ICD-10-CM* manual if needed.

Section III. Reporting Additional Diagnoses

Excluded as not relevant to provider-based coding. Refer to the full *ICD-10-CM* manual if needed.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the *ICD-10-CM* Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Information about the correct sequence to use in finding a code is also described in Section I.

The terms "encounter" and "visit" are often used interchangeably when describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

A. Selection of first-listed condition

In the outpatient setting, the term "first-listed diagnosis" is used in lieu of "principal diagnosis."

In determining the first-listed diagnosis, the coding conventions of *ICD-10-CM*, as well as the general and disease specific guidelines, take precedence over the outpatient guidelines.

Diagnoses are often not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule is to begin the search for the correct code assignment through the Alphabetic Index. Never search initially in the Tabular List, as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from A00.0 through T88.9, Z00–Z99

The appropriate code(s) from A00.0 through T88.9, Z00–Z99 **and U00–U85** must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of *ICD-10-CM* diagnosis codes

For accurate reporting of *ICD-10-CM* diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses, as well as symptoms, problems, or reasons for the encounter. There are *ICD-10-CM* codes to describe all of these.

D. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of *ICD-10-CM*, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00 – R99) contains many, but not all codes for symptoms.

E. Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00 – Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

See Chapter 21*, Factors influencing health status and contact with health services.*

F. Level of Detail in Coding

1. *ICD-10-CM* codes with 3, 4, 5, 6, or 7 characters

ICD-10-CM is composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in *ICD-10-CM* as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth, or seventh characters to provide greater specificity.

2. **Use of full number of characters required for a code**
   A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
3. **Highest level of specificity**
   Code to the highest level of specificity when supported by the medical record documentation.

G. *ICD-10-CM* code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the *ICD-10-CM* code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the **provider**.

H. Uncertain diagnosis

Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80–Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (eg, chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (eg, chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy. In this case, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed is listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

See Chapter 15*, Pregnancy, childbirth and the puerperium.*

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

See Chapter 21*, Factors influencing health status and contact with health services, Screening*