Conventions and Guidelines

A quick reference guide to assist with accurate, complete documentation and coding that reflects the true nature of a patient's current health status at the highest level of specificity. Per ICD-10 official guidelines reporting and coding.
The importance of consistent, complete documentation in the medical record cannot be over-emphasized. Without such documentation, accurate coding cannot be achieved.

Documentation & Coding Tips

Conventions for the ICD-10-CM

Etiology/manifestation convention ("code first", "use additional code")

- 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, if applicable, 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.

"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.

"With"

- The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, 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.

"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.

"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.

General Coding Guidelines

Level of Detail in Coding

- 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.

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.
- Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

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.

Combination Code

- A combination code is a single code used to classify: Two diagnoses, or a diagnosis with an associated secondary process (manifestation), or a diagnosis with an associated complication
  Combination codes are identified by referring to sub term entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List. **EXAMPLES BELOW**

Sequela

- 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 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. **EXCEPTION WHEN CODING SEQUELA OF STROKE, SEE BELOW**

Laterality

- Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or 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. 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.

Outpatient Coding Guidelines

Uncertain Diagnoses

- 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.

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)

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.

Chapter Specific Guidelines

CHAPTER 9: DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Combination Code examples

- **HYPERTENSION WITH HEART DISEASE:** Hypertension with heart conditions classified to I50.- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure. The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.
- **HYPERTENSIVE CHRONIC KIDNEY DISEASE:** Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the physician has specifically documented a different cause. The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.
- **HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE:** Assign codes from combination category I13. The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.
- **HYPERTENSIVE CEREBROVASCULAR DISEASE:** For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

Sequelae of Cerebrovascular Disease CATEGORY I69

- Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.
- Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:
    - For ambidextrous patients, the default should be dominant.
    - If the left side is affected, the default is non-dominant.
    - If the right side is affected, the default is dominant.

Acute vs. History of CVA

ICD-10 Code	Description	Coding Guidance	Examples
I63.x	Acute Cerebral Infarction	Acute Current CVA is happening now.	Member transported to ED via EMS, admitted to hospital where stroke was diagnosed after complete workup.
G45.9	Transient ischemic attack (TIA)	Acute Current TIA is happening now.	Member seen in ER for complaints of left sided weakness. Diagnosed with TIA.
I69.x	Sequela of Cerebrovascular Disease	Code the neuro deficits that persist after initial onset of CVA (i.e., hemiplegia/paresis, monoplegia etc.)	Member seen for follow-up visit, had CVA in 2016 which resulted in persistent right dominant side hemiparesis. I69.351
Z86.73	History of TIA or CVA with **NO** residual deficits		Member seen in clinic. Previous CVA, doing well and doesn't have any residual, persisting deficits.

Acute vs. History MI

ICD-10 Code	Description	Coding Guidance	Examples
I21.x	STEMI and NSTEMI	MI specified as acute or within 28 days (about 4 weeks) or less from onset	Member hospitalized on 05/02/21 for acute NSTEMI. Seen by PCP for f/u on 05/20/2021
I22.x	Subsequent MI	Acute MI occurring within 28 days of a previous acute MI	Member experienced a subsequent NSTEMI less than 3 weeks after the onset of a previous STEMI or NSTEMI
I25.2	Old MI	Healed or past MI diagnosed by ECG or other investigation currently presenting no symptoms.	Member had MI at least 28 days ago or later.

References:

https://icdlist.com/icd-10/guidelines/section-iv-diagnostic-coding-reporting-guidelines-for-outpatient-services
https://www.encoderprofp.com/epro4payers/index.jsp