

## ICD-10 Documentation and Diagnosis Coding Tips

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). The change to ICD-10 does not affect CPT coding for outpatient procedure and physician services.

### ICD-10-CM Format and Structure – Diagnosis Codes

- Contain from 3 to 7 characters (seventh character extension)
- Character 1 is alpha
- Character 2 is numeric
- Characters 3 through 7 are alpha or numeric (alpha digits are not case sensitive)
- Decimal appears after the third digit
- The first three characters make up the **ICD-10 category**
- Characters 4 through 7 are driven by **clinical concepts in documentation**



### Understanding ICD-10-CM Coding

- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.
- ICD-10-CM/PCS will not affect physician, outpatient facility, and hospital outpatient department use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition.
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific codes to be assigned.

### ICD-10-CM Official Coding Guidelines for Outpatient Services

The outpatient coding guidelines for ICD-10-CM are similar to those found in ICD-9-CM. Listed below are some of the ICD-10-CM guidelines relevant to outpatient and office visit encounters. Visit the CDC [website](#) for a pdf version of the guidelines.

- ICD-10-CM Section IV.C - Accurate reporting of ICD-10-CM diagnosis codes. For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems or reasons for the encounter. It is acceptable to report the appropriate unspecified code if sufficient clinical information about a particular health condition is not known or is unavailable for assigning a more specific code.
- ICD-10-CM Section IV.F. 1-2, Level of detail in coding - ICD-10-CM uses 3, 4, 5, 6 or 7 characters. Three character codes represent category headings and may be further subdivided by using the fourth, fifth, sixth or seventh character to provide greater specificity. ICD-10-CM diagnosis codes must be

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reported to the highest number of characters available. Incomplete or invalid diagnoses codes are not acceptable for reporting.

- ICD-10-CM Section IV.H, Uncertain diagnosis - Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “ruled out,” “working,” “consistent with” or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- ICD-10-CM Section IV.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 conditions. Typically, chronic conditions always impact care provided. They should be assessed and reported at each visit.
- ICD-10-CM Section IV.J, Code all documented conditions that co-exist - Code all documented conditions that coexist at the time of the encounter/visit that require or affect patient treatment or management. Do not code conditions that were previously treated and that no longer exist.

### Clinical Concepts in Documentation

Certain clinical concepts appear in ICD-10 coding, which may or may not be present in ICD-9. Providers should become familiar with these concepts to ensure that documentation includes all known pertinent details for accurate code assignment in ICD-10. Examples of clinical concepts include:

- Cause and effect
- Laterality
- Timing
- Associated conditions
- Contributing factors
- Remission status
- Severity
- Episode of care
- Trimester of pregnancy
- Complications/manifestations
- Agent and/or organism
- Anatomical location
- Comorbidities
- Depth/stage for wounds and ulcer
- Late effects

### New Coding Conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set:

- **Seventh Character Extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **placeholder “X”** may be used in the fifth or sixth character field to ensure that a seventh character is added correctly. Example: T15.12XS - Foreign body in conjunctival sac, left eye, sequel (late effect)



### Locating the Correct Diagnosis Code in the ICD-10 Code Book

- Locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the [Official ICD-10-CM Coding Guidelines](#) and follow all instructions for the chapter and category related to specific codes, including “Excludes1” and “Excludes2” notes.
  - Excludes1 - Not coded here. The codes should never be used at the same time.

- Excludes2 - Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, EHR systems, and cheat sheets alone can lead to coding errors.

**Locating Official Coding Advice**

- The *American Hospital Association (AHA) Coding Clinic™* is the CMS-approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new or updated information about the use of ICD-10-CM, as well as clarification of previously published coding advice.
- Additional advice on ICD-10-CM can be located on [CMS website](#).

**Documenting Specificity for Accurate ICD-10 Coding**

Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member’s health status. Health care providers should begin incorporating additional documentation into patient encounters. The table below shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

| Chronic condition: | Provider documentation required for correct coding:   | ICD-10 Code      |
|--------------------|---|------------------|
| Asthma             | <ul style="list-style-type: none"> <li>● <b>Severity</b> – document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent.</li> <li>● <b>Type</b> – exercise induced or cough variant are other types of asthma; documentation should specify type.</li> <li>● <b>Acute exacerbation</b> – documentation should state if the asthma is in acute exacerbation.</li> <li>● <b>Status asthmaticus</b> – is defined as an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators.</li> <li>● <b>Infection</b> – a superimposed infection may be present; this should clearly be documented by the provider.</li> </ul>  | J45.20 – J45.998 |
| Hypertension       | <ul style="list-style-type: none"> <li>● <b>Primary or secondary</b> – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension, one to identify the underlying etiology and one from category <i>I15 Secondary hypertension</i>.</li> <li>● <b>Transient</b> – A temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code <i>R03.0 elevated blood pressure reading without a diagnosis of hypertension</i>.</li> <li>● <b>Controlled/uncontrolled</b> – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is <i>I10 Essential (primary) hypertension</i>.</li> <li>● <b>Complications</b> – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive, caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following</li> </ul> | I10 – I15.9      |

|                               |  |                  |
|-------------------------------|--|------------------|
|                               | <p>coding guidance applies to hypertensive complications:</p> <ul style="list-style-type: none"> <li>○ <b>I11 Hypertensive heart disease</b>, use additional code from category <i>I50 Heart failure</i> if present.</li> <li>○ <b>I12 Hypertensive chronic kidney disease</b>, use additional code from category <i>N18 chronic kidney disease</i> to identify the stage.</li> <li>○ <b>I13 Hypertensive heart and chronic kidney disease</b>, requires use of additional code from category <i>I50 Heart failure</i> if present and use additional code from category <i>N18 Chronic kidney disease</i> to identify the stage.</li> <li>○ <b>I60 – I69 Hypertensive cerebrovascular disease</b>, code also <i>I10 Essential (primary) hypertension</i>.</li> <li>○ <b>H35.0 Hypertensive retinopathy</b>, code also <i>I10 Essential (primary) hypertension</i>.</li> </ul>  |                  |
| <p>Diabetes mellitus (DM)</p> | <ul style="list-style-type: none"> <li>● <b>Type</b> – Providers must document the type of diabetes in ICD-10-CM:           <ul style="list-style-type: none"> <li>○ <b>E08 Diabetes mellitus</b> due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc.</li> <li>○ <b>E09 Drug or chemical induced diabetes mellitus</b>, code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect, if applicable, to identify drug.</li> <li>○ <b>E10 Type 1 diabetes mellitus</b>, that due to pancreatic islet B cell destruction. Also known as “juvenile diabetes”.</li> <li>○ <b>E11 Type 2 diabetes mellitus</b>, use for diabetes not otherwise specified.</li> <li>○ <b>E13 Other specified diabetes mellitus</b>, includes that due to genetic defects and secondary diabetes not classified elsewhere.</li> </ul> </li> <li>● <b>Body system affected</b> – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented.</li> <li>● <b>Complications affecting that body system</b> – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include: diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes.</li> <li>● <b>Insulin use</b> – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term, then apply code Z79.4 (long term, current use of insulin).</li> </ul> | <p>E08 – E13</p> |