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.

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 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.
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.

   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.

   “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 late effects, 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. **Late Effects (Sequela)**
A late effect 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 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. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect 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 late effect is never used with a code for the late effect.

*See Section I.C.9. Sequelae of cerebrovascular disease*
*See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium*
*See Section I.C.19. Code extensions*

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**

For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

14. **Documentation for BMI and Pressure Ulcer Stages**

For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) 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 codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

**C. Chapter-Specific Coding Guidelines**

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.