Blue Medicare Advantage

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Medicare risk adjustment provider documentation and coding guide

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Part 1: Medicare risk adjustment (MRA) basics

1.1 Introduction to MRA

Medicare risk adjustment (MRA) is a CMS payment model — calculated at the patient level — designed to deliver the appropriate resources to support quality patient care and improved patient outcomes. Specifically, the model aims to ensure those with more complex medical needs receive appropriate care by allocating appropriate funding. Proper payment from CMS to Medicare Advantage (MA) organizations (MAOs), and by extension providers, depends on the comprehensive assessment of each Medicare Advantage beneficiary at least once annually coupled with accurate and complete documentation and coding of each active condition impacting patient health, care, and/or treatment.

1.2 How do providers support the MRA process?

The MRA process kicks off with a face-to-face (whether in-person or via real-time, simultaneous audio-visual, interactive telehealth) encounter between a patient and an acceptable provider type (MD, DO, NP, or PA) during which the provider assesses the patient and documents all active conditions impacting the patient's health, care, and/or treatment at the time of the encounter. Providers can take several steps to support complete and accurate coding for MRA, such as:

- Comprehensive documentation via a thorough assessment, like an annual wellness visit.
- Diagnosis code assignment at the highest level of specificity, accurately representing the patient's health status, avoiding unspecified or generic codes when the documentation allows for a more specific one.
- Regular training in documentation and coding best practices.
- Periodic review of patients' medical record documentation to identify inaccuracies in diagnosis code reporting.

1.3 How can providers improve the comprehensiveness of submission to CMS of active patient conditions?

- **Patient assessment:** Conduct an annual comprehensive wellness exam for each attributed MA beneficiary.
- **Medical record documentation:** Ensure the patient's medical record, including clinical notes and test results, contains accurate, complete, and current information.
- **Diagnosis coding:** Use accurate ICD-10-CM codes to reflect a patient's diagnosis with the highest level of specificity.
- **Billing:** Ensure the documented diagnosis codes are integrated into the billing process, so the codes are included in the claims forms that are submitted to the MAO.
- **MAO coordination:** Work with the MAO to improve claims processing (for example, claim rejection) and/or EHR (such as truncated codes) functionality.
- **Risk adjustment supplemental data:** Submit a supplemental data file to account for any additional diagnosis code(s) supported by medical record documentation but not submitted on a previous claim/encounter (for example, clearing house modification) and/or correct diagnostic information reported on an already submitted claim/encounter.

1.4 International classification of diseases (ICD), tenth revision (ICD-10), clinical modification (ICD-10-CM) | Hierarchical condition categories (HCCs) | MA enrollee risk scores

A subset of the more than 70,000 ICD-10-CM codes map to HCCs and risk adjust. HCCs are groupings of clinically related diagnoses with similar expected medical costs. CMS assigns a risk factor value to

each HCC. HCC diagnosis code mapping is subject to change. Some disease states, such as kidney disease, are grouped into disease families that are subject to hierarchy. Per CMS, if a patient has two active conditions that map to two separate HCCs within the same disease family (for example, kidney disease), only the risk factor associated with the relatively more severe HCC will impact the risk score.

CMS uses the HCC risk factor values, along with demographic factors,[1] to annually calculate MA enrollee risk scores, which ultimately determines not only the premium paid to MAOs but also payment to providers. The risk score across the Medicare population resets to 1.0 every year; 1.0 is a benchmark. Diagnoses submitted in one year do not carry over into the following year, even if those diagnoses are chronic and thought to persist year over year. Therefore, because of the way CMS calculates premiums, patients should be comprehensively assessed at least annually for any active condition impacting their care, including chronic conditions.

1.5 MRA regulatory framework and provider obligations

CMS has strict requirements regarding what data is eligible for risk adjustment purposes. Specifically, diagnosis data submitted for payment must be:

- Documented in a medical record based on an allowable service delivered via a face-to-face encounter between a patient and acceptable provider type (such as MD, DO, NP, or PA) and physician specialty (such as general practice or hospitalist). Diagnosis codes appearing on certain types of medical records, such as radiology and lab reports, are not allowable for risk adjustment purposes; in such situations, the provider-patient face-to-face element is missing:
  - The face-to-face requirement may be satisfied by care delivered in person or via telehealth. In terms of telehealth, face-to-face eligibility requires that the encounter be facilitated via an interactive, simultaneous audio and video telecommunications system that permits real-time communication between the patient and provider.
- Coded per standard guidelines (for example, ICD-10-CM), as the risk adjustment factor is based, in part.
- Submitted to CMS within the predetermined CMS data collection period *(open period)*:
  - Of note, diagnosis code data corrections (for example, diagnosis code errors), however, must be submitted to CMS regardless of whether the CMS data submission deadline has passed *and* within 60 days of identification.

1.6 Key reminders

- Diagnoses submitted in one year do not carry over into the following year, even if those diagnoses are chronic and thought to persist year-over-year.
- Each provider-patient encounter should center on providing quality clinical care and accurately and completely documenting, as applicable based on the provider's evaluation and independent clinical judgment, conditions that exist at the time of the encounter and require or affect patient care, treatment, and/or management.
- Risk scores that reflect the true health status of MA enrollees coupled with payments that allow for proper patient care, depend heavily on not only the comprehensive annual assessment of MA enrollees by providers but also the annual reporting of active conditions based on such assessments.
- Risk scores — without consideration of other information — are neither an indicator of the quality of care delivered by a provider nor of a provider's practices relative to accurate and complete documentation and coding. The composition and health status of a provider's patient panel changes constantly. Risk score information should not be used to set performance targets for or by provider organizations or individual care providers.

[1] The demographic risk factor accounts for the following: (i) age, sex; (ii) eligibility status (e.g., dual eligible, original Medicare eligibility, and current Medicare eligibility); and (iii) model (e.g., ESRD, new enrollee, etc.).

Part 2: documentation guidance

The intent of all our Medicare Advantage risk adjustment programs is to report annually to the CMS all current health conditions that are supported by medical record documentation and addressed in the patient's medical record during an allowable service from a face-to-face encounter with an approved risk adjustment provider specialty type.

2.1 ICD-10-CM: Impact on documentation and coding

ICD-10-CM classification brought about increased specificity in the coding system with a more logical structure and clinical accuracy. ICD-10-CM introduced to its code set the concepts of laterality and anatomical site and location. Documenting the episode of care such as initial, active care, subsequent episodes of care, and sequelae from injuries or disease is also an ICD-10-CM documentation and coding concept. The assignment of a diagnosis code is based on the provider's clinical expertise and diagnostic statement.

When a conclusive diagnosis has not been established by the end of the visit, it is appropriate to report codes for sign(s) and/or symptom(s) as a substitute for a definitive diagnosis. If the clinical information is insufficient, unknown, or unavailable when assigning a specific code for a disorder, it is acceptable to report the proper unspecified code. It is inappropriate to select a more specific code that is not supported by the medical record documentation.

2.2 Documentation best practices

To ensure that accurate and complete diagnosis data is being reported, provider documentation must be thorough and specific. Coders can only assign a diagnosis code based on the information documented within the medical record.

To code to the highest level of specificity, in compliance with ICD-10-CM guidelines, the documentation must be all of the following:

- Clear
- Concise
- Consistent
- Complete
- Comprehensive

The ICD-10-CM guidelines state, "Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment."[1] When documenting, providers should consider the following:

- Each encounter in the medical record should contain:
  - Date of service for the face-to-face encounter on each page.
  - Patient's complete name plus a second identifier, such as date of birth or medical record number on each page.
  - Provider's name, signature, credentials, and date signed.
  - Handwriting that is legible (to someone else).
  - Only industry standard abbreviations.
  - All conditions impacting the patient's care/health, including coexisting conditions, capturing the patient's true health status.
  - Details based on the provider's independent clinical judgment to code to the highest degree of specificity.
- Each medical condition addressed during the encounter should include a statement indicating the impact on patient care, treatment, and/or management:
  - At a minimum, include a brief statement that updates the status of each diagnosis.
- Medications may suggest the presence of a condition, but a diagnosis cannot be assumed based on medications:

  - Make sure that for every medication prescribed, a diagnosis is listed and addressed in the medical record, specifying for which condition the medication is being prescribed.
- Document at least once a year:
  - Chronic conditions (such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus) that require ongoing treatment and monitoring.
  - Active status conditions (such as amputations and ostomies).
  - Historic conditions that may no longer exist yet have the potential for reoccurrence requiring continued monitoring.
  - All conditions that impact patient care, treatment, and/or management.
- Be specific, for example:
  - Include the recurrence and severity of major depression.
  - Include whether bronchitis is acute or chronic.
  - Specify cardiac arrhythmia such as atrial fibrillation or atrial flutter.
  - When clinical criteria are present to support it, document *malnutrition* instead of *loss of weight*.
  - Use words to describe the status of conditions:
    - For example, *Hypertensive heart disease is stable*.
- Only assign *other* or *other specified* diagnosis codes for diagnostic statements for which a specific ICD-10-CM code does not already exist. Use linking language to establish a causal relationship between two conditions:
  - For example, Diabetic neuropathy, neuropathy *due to* DM, or neuropathy *caused by* DM.
- Use descriptive words and phrases to add specificity, such as acute, chronic, in remission, exacerbation, stable, or compensated.
- Only use the words *history of* or *resolved* to describe conditions that no longer exist. Be mindful of the timing, especially of acute conditions, for example:
  - Document *history of MI* instead of *MI* after four weeks or 28 days post-onset.
  - Document *history of malignant neoplasm* after all treatment is complete.
  - Document *history of transient ischemic attack (TIA)* or *history of cerebral infarction*, and whether the patient has any residual deficits instead of *CVA* after the patient leaves the hospital and is seen in follow-up.
- Do not use the words *history of* to describe active, chronic conditions:
  - For example, document *chronic, stable COPD* instead of *history of COPD*.
  - Document *controlled type 2 diabetes mellitus* instead of *history of type 2 diabetes mellitus*.
- Avoid entering conflicting information in the medical record:
  - For example, documenting a final diagnosis of *hemiplegia* in the assessment with a physical exam finding of *5/5 strength in all four extremities*.
- Acute conditions can rarely be appropriately treated in the outpatient setting. If an acute condition is treated in the outpatient setting, there must be clear documentation by the treating provider as to why and how the condition was treated.
- Conditions *in diseases classified elsewhere* require two conditions to be documented and linked to appropriately report:[2]
  - For example, G63 – Polyneuropathy in diseases classified elsewhere requires the underlying etiology to be documented and linked to polyneuropathy to appropriately report. G63 - Polyneuropathy in diseases classified elsewhere cannot be reported by itself.
- Telehealth services:
  - MAOs may submit diagnoses for risk adjustment payment from telehealth encounters only when those encounters meet all criteria for risk adjustment eligibility.
  - For telehealth services, face-to-face eligibility requires facilitating the encounter by way of an interactive, simultaneous audio and video telecommunications system that permits real-time communication between the patient and provider.
  - Providers must use applicable E/M CPT© code, CPT Telehealth modifier *95,* and applicable place of service (POS) code (for example, POS 10, patient's home; and POS 02, locations other than patient's home) to indicate an audio/video telehealth visit.
  - Audio-only encounters do not satisfy the criteria for risk adjustment data eligibility.

  - Use CPT modifier *93* to represent a synchronous telemedicine service rendered by way of real-time audio-only telecommunications system, for example, telephone.
  - Additionally, and as a best practice, providers are encouraged to include a statement in the medical record regarding the telecommunications medium used for the visit, for example, real-time audio and video or telephone.

2.3 Provider signature requirements in the medical record

All provider documentation, including progress notes, must be signed by the provider rendering the services. The provider must sign all progress notes with their name and credentials as part of their signature. Best practice is also to include the provider's printed name and credentials on any pre-printed note or stationery. Stamped signatures are not acceptable, effective since April 28, 2008.

Electronic signatures are an acceptable form of medical record authentication so long as the system requires the provider to authenticate the signature at the end of each note. Examples of acceptable signatures include: *electronically signed, authenticated by, signed by, validated by, approved by,* or *sealed by*. The signed EMR record must be dated within 180 calendar days of the encounter and closed to all changes.[3]

1 National Center for Health Statistics. (2023, September 22). ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.4.J cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
2 National Center for Health Statistics. (2023, September 22). ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.13. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
3 Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance. In effect as of 01/10/2020, Version 2.0. Retrieved November 29, 2023: cms.gov/files/document/medical-record-reviewer-guidance-january-2020.pdf

Part 3: disease-specific documentation for common conditions

In addition to general documentation best practices, there are disease-specific documentation and coding best practices for common conditions.

This section will cover some of the more common conditions, such as:

- Human immunodeficiency virus infection
- Neoplasms
- Diabetes mellitus
- Body mass index
- Dementia
- Substance use disorder
- Major depressive disorder
- Schizophrenia
- Atherosclerotic heart disease
- Myocardial infarction
- Cardiac arrhythmias
- Congestive heart failure
- Stroke
- Vascular disease
- Chronic obstructive pulmonary disease
- Pressure ulcers
- Rheumatoid arthritis
- Fractures
- Chronic kidney disease

3.1 Human immunodeficiency virus infection

Documentation guidelines

When documenting human immunodeficiency virus (HIV) infection, include:

- Status, such as positive HIV status, asymptomatic, and exposure.
- Symptoms or diseases related to the HIV infection, such as opportunistic infections and malignancies:
  - Document the link between HIV and HIV-related illness.
- Any current treatment.

Document positive HIV status if the patient tests positive for HIV but has no symptoms. This should be documented on any future visits despite the persistent absence of symptoms.

When the patient meets the clinical definition of acquired immunodeficiency syndrome (AIDS), either based on a low CD4 count or an AIDS-defining condition (such as opportunistic infection or Kaposi sarcoma), *AIDS* or *HIV disease* should be documented. The provider must expressly document the link between HIV and any condition deemed to be an HIV-related illness.

Once a patient is diagnosed with AIDS (HIV disease), this should be documented in all subsequent encounters. They are no longer considered to have *asymptomatic HIV status* even if they become asymptomatic in the future as a result of treatment.

In addition, all AIDS-defining conditions present at the time of the evaluation must be addressed and documented separately. Include in the documentation whether the patient is under the care of an infectious disease specialist.

In patients without a prior diagnosis of HIV or AIDS, document any confirmed or suspected exposure to HIV when testing results are pending or not available.

Coding guidelines

Coders are instructed to only code confirmed cases of HIV. Per ICD-10-CM guidelines, confirmation does not require documentation of positive serology or culture for HIV. Instead, the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient to assign a confirmed diagnosis of HIV. If the patient is HIV positive without any documentation of symptoms or HIV-related illness, then use Z21, Asymptomatic human immunodeficiency virus [HIV] infection status. Patients with inconclusive HIV serology and no definitive diagnosis or manifestation should be coded with R75, Inconclusive laboratory evidence of human immunodeficiency virus HIV.[1]

According to the ICD-10-CM coding guidelines, patients with any known prior diagnosis of an HIV-related illness should be coded to B20, Human immunodeficiency virus HIV disease. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. The ICD-10-CM classification includes acquired immune deficiency syndrome (AIDS) with code B20 (HIV disease).[1]

HIV infection	
ICD-10-CM code	**Diagnosis code description**
B20	Human immunodeficiency virus HIV disease
R75	Inconclusive laboratory evidence of human immunodeficiency virus HIV
Z11.4	Encounter for screening for human immunodeficiency virus HIV

HIV infection	
ICD-10-CM code	**Diagnosis code description**
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus HIV
Z21	Asymptomatic human immunodeficiency virus HIV infection status
Z71.7	Human immunodeficiency virus HIV counseling

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: HIV-positive patient with known history of HIV-related pneumocystis pneumonia comes in for a follow up visit. They have been asymptomatic in response to highly active antiretroviral therapy (HAART). Viral load and CD4 count were ordered.

Coding scenario 1: Human immunodeficiency virus HIV disease **B20**, other long-term (current) drug therapy **Z79.899**

Documentation scenario 2: Patient recently had a positive HIV test and came in for a follow-up visit. They remain asymptomatic at this time. They were counseled on HIV infection and preventive measures for their HIV-negative partner.

Coding scenario 2: Asymptomatic human immunodeficiency virus HIV infection status **Z21**, human immunodeficiency virus HIV counseling **Z71.7**

[1] National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.1.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.2 Neoplasms

Documentation guidelines

When documenting neoplasms, include:

- Primary site, including organ and location within the organ, for example, lower-outer quadrant of breast.
- Laterality, if applicable, for example, right bronchus or lung.
- Histology, for example, squamous cell, large cell, adenocarcinoma, sarcoma.
- Behavior, such as malignant or benign.
- Stage and grade of the malignancy, if known.
- Current treatment or treatment plan.
- Secondary malignancies, specifying the primary source:
  - Indicate whether the secondary malignancy was the result of local invasion, lymphatic spread, or hematologic metastasis.

Malignant neoplasms should only be documented as active when:

- The diagnosis has been confirmed and the treatment has not yet started.
- The patient and provider agreed not to treat the malignancy, for example, watchful waiting in the case of a low-grade malignancy or patient opts for hospice.
- The patient is on a break (drug holiday) from current ongoing treatment.
- Treatment is current and ongoing, including, but not limited to surgery, chemotherapy, radiation, immunotherapy, stem cell transplant, adjuvant therapy, and hormonal therapy:
  - Adjuvant and/or hormonal therapy can span multiple years. Malignant neoplasms are considered active throughout the entire duration of therapy. Common examples include tamoxifen for breast cancer and leuprorelin for prostate cancer.

When all forms of treatment have been completed and the malignancy is no longer considered active, it should be documented as *history of*.

Coding guidelines

According to the ICD-10-CM coding guidelines, "When a primary malignancy has been excised or eradicated from its site and there is no further treatment directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."[1]

In patients with multiple myeloma and leukemia, once treatment is completed and the patient is considered *in remission,* the documentation should reflect that. Patients with lymphoma that are documented as *in remission* are still considered to have active lymphoma per *American Hospital Association (AHA) Coding Clinic* and should be coded as having active lymphoma.[2] Patients documented as having a *history of* lymphoma are coded to personal history of lymphoma.[2]

If a patient is seen in the outpatient setting with a mass that is suspicious for malignancy, only code the mass until the malignancy is confirmed. Unconfirmed diagnoses are not to be coded in the outpatient setting. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.[3]

Neoplasms (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM category	**Diagnosis code description**
C00.- through C96.-	Malignant neoplasms, primary or secondary by site
D00.- through D09.-	In situ neoplasms
D10.- through D36.-	Benign neoplasm, except benign neuroendocrine tumors
D3A.-	Benign neuroendocrine tumors
D37.- through D48.-	Neoplasms of uncertain behavior, polycythemia vera, and myelodysplastic syndromes
D49.-	Neoplasms of unspecified behavior
Z85.-	Personal history of malignant neoplasm

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: Female patient is seen for recheck of wound site following excision of right

[2] For further insights on lymphoma guidelines, please refer to the AHA Coding Clinic for ICD-10-CM in the third quarter of 2022, on page 28.

breast cancer from the upper-outer quadrant. Pathology showed metastatic breast cancer in two of the patient's right axillary lymph nodes. She is following up with oncology to initiate chemotherapy and radiation.

Coding for scenario 1: Malignant neoplasm of upper-outer quadrant of right female breast **C50.411**, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes **C77.3**

Documentation scenario 2: Patient following up for history of prostate cancer two years ago. He completed radiation one year ago. Patient is doing well. Prostate-specific antigen (PSA) level is normal.

Coding for scenario 2: Encounter for follow-up examination after completed treatment for malignant neoplasm **Z08**, Personal history of malignant neoplasm of prostate **Z85.46**

Documentation scenario 3: Patient seen for recheck of lymphoma. Patient was diagnosed three years ago with lymphoma involving the abdominal lymph nodes. He completed chemotherapy and is following up with oncology. Recent CT of abdomen was within normal limits. Patient is in remission.

Coding for scenario 3: Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes **C85.93**

1 National Center for Health Statistics. (2023, September 22). ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.2.d. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
2 American Hospital Association (AHA) Coding Clinic, 2Q 1992, page 3
National Center for Health Statistics. (2023, September 22). ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.H cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.3 Diabetes mellitus

Documentation guidelines

When documenting diabetes mellitus (DM), include:

- Type of diabetes, for example, type 1, type 2, or secondary.
- Associated complications:
  - Indicate whether the complication is acute or chronic.
  - Body system(s) affected.
  - Laterality, if applicable, for example, right diabetic foot ulcer, or diabetic retinopathy of the left eye.
  - Severity, if applicable.
- Use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic drugs.
- Status of diabetic control, such as controlled, with hyperglycemia, or with hypoglycemia.

Acute complications, for example, diabetic ketoacidosis and hyperosmolar coma are typically managed in the inpatient setting.

It is a documentation best practice to clearly identify diabetic complications and causal relationships with linking verbiage such as *due to, secondary to,* or *caused by*. Some complications of DM require added specificity in the documentation to describe the complication in more detail. For example, the stage of CKD caused by DM, the presence of proliferative vs. nonproliferative diabetic retinopathy and associated laterality, or the presence of gangrene associated with diabetic peripheral angiopathy. If a condition commonly associated with diabetes (such as neuropathy) is unrelated to the DM, the best practice is to expressly document the two conditions are unrelated.

Documentation of the term *uncontrolled* for DM is insufficient. Uncontrolled DM must be further defined as *with hyperglycemia* or *with hypoglycemia* to capture the most appropriate diagnosis code. Other acceptable phrases to describe uncontrolled DM with hyperglycemia are *poorly controlled, out of control,* and *inadequately controlled*.

When utilizing the diagnosis Diabetes Mellitus with other specified complications, two things must be considered: 1) The provider must clearly document the complication associated with the diabetes. 2) The provider must ensure it is truly a complication of Diabetes Mellitus, and not a comorbid condition.

Coding guidelines

There are combination codes in ICD-10-CM that describe the type of DM and the associated complication(s). When a combination code exists for a particular complication, it should be assigned rather than assigning DM and the complication as independent codes, if the documentation supports the cause-and-effect relationship.[1] The words *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 sub-term), 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*.[2] Diabetic codes containing the word *with* represent conditions caused by diabetes, not comorbidities of diabetes.

When multiple complications of DM are addressed and documented during the same encounter, multiple combination codes corresponding to the diabetic complications should be assigned. According to the *American Hospital Association (AHA) Coding Clinic*, "Any combination of the diabetes codes can be assigned together, unless one diabetic condition is inherent in another."[3] For example, diabetic retinopathy documented with hyperglycemia would be reported with two ICD-10-CM codes: E11.319, Type 2 DM with unspecified diabetic retinopathy without macular edema, and E11.65, Type 2 DM with hyperglycemia.

In ICD-10-CM, DM uncontrolled is indexed as diabetes, uncontrolled, meaning hyperglycemia or *hypoglycemia.* Medical record documentation must clearly indicate the presence of hyperglycemia or hypoglycemia to ensure accurate diagnosis code assignment. Since the documentation of *uncontrolled DM* does not allow coders to assign a specific code as explained above, clinicians may use alternate phrases that will correspond to diabetes with hyperglycemia. These phrases are *poorly controlled, out of control,* and *inadequately controlled* DM.

Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic, as follows:

- Long-term Insulin Use (Z79.4) — Should only be coded as secondary to diabetes. If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.
- If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.
- If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

Code category E13.- Other specified diabetes mellitus, should be used when a patient is documented as having diabetes type 1.5 or other terms such as combined diabetes type 1 and 2, latent autoimmune diabetes of adults (LADA), or double diabetes, per *AHA Coding Clinic*.[4]

Diabetes mellitus (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
E08.-	Diabetes mellitus due to underlying condition

Diabetes mellitus (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
E09.-	Drug or chemical induced diabetes mellitus
E10.-	Type 1 diabetes mellitus
E11.-	Type 2 diabetes mellitus
E13.-	Other specified diabetes mellitus
Z79.4	Long term (current) use of insulin
Z79.84	Long term (current) use of oral hypoglycemic drugs
Z79.85	Long-term (current) use of injectable non-insulin antidiabetic drugs
Z79.899	Other long term (current) drug therapy

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient has severe nonproliferative diabetic retinopathy with macular edema of both eyes caused by type 2 DM. Patient currently on insulin, following with endocrinology and ophthalmology.

Coding for scenario 1: Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral **E11.3413**, Long-term (current) use of insulin **Z79.4**

Documentation scenario 2: Patient has chronic kidney disease stage 3a due to type 2 DM. GFR is stable on most recent labs and patient is on oral hypoglycemic drug.

Coding for scenario 2: Type 2 diabetes mellitus with diabetic chronic kidney disease **E11.22**, Chronic kidney disease, stage 3a **N18.31**, Long-term (current) use of oral hypoglycemic drugs **Z79.84**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.4.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
2 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.15.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
3 American Hospital Association (AHA) Coding Clinic, 3Q 2013, page 20
4 American Hospital Association (AHA) Coding Clinic, 3Q 2018, page 4

3.4 Body mass index and nutrition-related conditions

Documentation guidelines

When documenting body mass index (BMI) and nutrition-related conditions, include:

- Specific clinical diagnosis of nutrition-related conditions, such as overweight, obesity, protein-calorie malnutrition, cachexia, or other related condition.
- Severity, for example, mild, moderate, severe.
- Causative factors, for example, excessive calories, terminal illness, drug-induced, malabsorption.
- Associated conditions, such as anorexia, bulimia, Cushing's syndrome.
- Complications such as alveolar hypoventilation, obstructive sleep apnea, degenerative disease of the joints and spine, delayed healing.

The medical definition of Morbid obesity is, "a serious health condition that results from an abnormally high body mass that is diagnosed by having a body mass index (BMI) greater than 40 kg/m^2, a BMI of greater than 35 kg/m^2 with at least one serious obesity-related condition or being

more than 100 pounds over ideal body weight (IBW)."[1] Ultimately, it is based on the provider's clinical judgment and documentation of whether or not a patient meets the definition of morbid obesity.

Establishing a diagnosis of malnutrition or cachexia is also dependent on the provider's clinical assessment based on the findings in each individual case as there are no widely agreed-upon diagnostic criteria. Supportive clinical findings should always be documented in the record such as weight loss, low BMI, or loss of muscle mass. In addition, document any underlying causes of malnutrition such as celiac disease, multiple sclerosis, AIDS, or malignancy, if known.

Coding guidelines

To assign a diagnosis code for morbid obesity, the provider must expressly document obesity as *morbid, severe,* or *class 3* in the medical record. Per the *American Hospital Association (AHA) Coding Clinic*, BMI codes should be reported as a secondary code when the provider also documents a clinical diagnosis such as underweight, obesity, or morbid obesity that corresponds to the BMI value.[2]

Codes for BMI may be assigned based on medical record documentation from clinicians who are not the patient's provider but instead are involved in the care of the patient, such as a nurse or dietician. The BMI must be clearly documented as coders are not permitted to calculate BMI based on the documented height and weight of the patient.[3]

Obesity, morbid obesity, and nutrition-related conditions (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
E43	Unspecified severe protein-calorie malnutrition
E44.-	Mild or moderate protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition
E66.-	Overweight, obese, and morbidly obese
R63.6	Underweight
R64	Cachexia
Code also BMI Z68.-	

Documentation and coding scenarios (*for illustrative purposes only)*

Documentation scenario 1: Patient comes in complaining of unintentional weight loss, and states their appetite and food intake has not changed. Patient is noted to be underweight with a BMI of 18.3. Nutritional supplement was prescribed and work-up to uncover cause of weight loss was initiated.

Coding scenario 1: Underweight **R63.6**, Body mass index 19.9 or less, adult **Z68.1**

Documentation scenario 2: Patient comes in for follow up visit. They are morbidly obese with a BMI of 42.4. Counseled on weight loss, including diet and exercise.

Coding scenario 2: Morbid (severe) obesity due to excess calories **E66.01**, Body mass index 40.0–44.9 **Z68.41**

1 Obesity Medicine Association. (2023, November 6). Shifting from "Morbid Obesity" to "Class III Obesity." Obesity Medicine Association. https://obesitymedicine.org/blog/shifting-from-morbid-obesity-to-class-iii-obesity/
2 American Hospital Association (AHA) *Coding Clinic*, 4Q 2018, page 77
3 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.21.c.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.5 Dementia and seizure disorder

Documentation guidelines

When documenting dementia, include:

- Type, such as vascular (for example, hypertensive cerebral vascular disease and multi-infarct) and dementia in Diseases Classified Elsewhere (for example, Alzheimer's, Lewy Body, HIV, Parkinsonism, Pick's Disease)
- The presence of behavioral disturbance, such as agitation, combativeness, wandering

When documenting seizure disorder (epilepsy), include:

- Single seizure versus seizure disorder
- Type of seizures, for example, generalized, petit mal, partial complex
- Convulsive (tonic-clonic) vs. other symptoms, for example, absence seizure, myoclonus
- Controlled vs. intractable
- Presence of status epilepticus
- Idiopathic vs. secondary
- Underlying cause or pathology, if any, for example, anoxic brain injury, brain tumor, previous CVA
- Diagnostic testing or ongoing treatment with medications

Coding guidelines

Diagnosis code assignment for dementia depends on the type of dementia, underlying conditions, associated conditions, and whether or not the patient has behavioral disturbances. When dementia is the result of another condition, the underlying condition is reported first with code F02.8-, Dementia in other diseases classified elsewhere with or without behavioral disturbance, is reported as a secondary code. ICD-10-CM contains guidance for the use of an additional code, Z91.83, to identify wandering in dementia, if applicable.[1]

Diagnosis codes for convulsions that are not classified as epileptic in nature code to the signs and symptoms chapter of ICD-10-CM. Epilepsy and seizure disorders code to category G40.- and require the type of epilepsy or recurrent seizures, whether intractable or not intractable, and with or without status epilepticus, to assign codes to the highest level of specificity.

Dementia and seizure disorder (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F01.-	Vascular dementia
F02.-	Dementia in diseases classified elsewhere

Dementia and seizure disorder (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F03.-	Unspecified dementia
G40.-	Epilepsy and recurrent seizures
R56.-	Convulsions, not elsewhere classified

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient with Parkinson's disease was brought in by family following episodes of agitation and combativeness. They were recently evaluated by neurology and diagnosed with Parkinson's dementia. At this visit, the patient's work-up did not reveal an organic cause of the agitation such as an infection. Based on a phone consultation with neurology the patient was started on a low dose antipsychotic at bedtime with plans for follow-up.

Coding for scenario 1: Parkinson's disease **G20**, Dementia with behavioral disturbance **F02.81**

Documentation scenario 2: Patient presents for refills on anti-epileptic medications. They have had generalized idiopathic epilepsy for many years with only a few breakthrough seizures related to medication adjustment. The patient has not experienced any seizures in the past six months and has been stable on the same medication. Their medication was refilled.

Coding for scenario 2: Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus **G40.309**

1 ICD-10-CM Expert for Physicians: The Complete Official Code Set (FY 2024)

3.6 Substance use disorder

Substance use disorders are a cluster of cognitive, behavioral, and physiological symptoms due to the use of a substance. A *Use disorder* is characterized by a defined set of clinical criteria originally published in the *Diagnostic and Statistical Manual of Mental Health Disorders Fifth Edition (DSM-5),* and continued in the text revision *(DSM-5-TR)*. The criteria evaluate for impaired control, social impairment, risky use, tolerance, and withdrawal. Based on clinical evaluation and the number of symptom criteria endorsed, a use disorder can be diagnosed, and the severity of the use disorder can then be prescribed.[1]

Documentation tips

- Name of substance
- Current severity/remission: mild, moderate, severe, early remission, sustained remission
- Specify if present: withdrawal, intoxication, associated mental disorders

Diagnostic criteria of substance use disorder

A problematic pattern of the use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within 12 months:[1]

1. The substance is often taken in larger amounts or over a longer period than was intended
2. There is a persistent desire or unsuccessful efforts to cut back on substance use
3. An excessive amount of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. Craving, or a strong desire or urge to use the substance

5. Recurrent substance use results in a failure to fulfill major role obligations at work, school, or home
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Loss of important social, occupational, or recreational activities due to substance use
8. Recurrent substance use in situations in which it is physically hazardous
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance
10. Tolerance, as defined by either of the following:
    a. A need to markedly increase amounts of substance to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of the substance
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the substance
    b. Substance is taken to relieve or avoid withdrawal symptoms

Note: Criterion 10 and 11 are not considered to be met for those individuals taking the substance solely under appropriate medical supervision[1]

Severity of use disorder is based on the amount of symptom criteria present:[1]

- Mild: Presence of two to three symptom criteria
- Moderate: Presence of four to five symptom criteria
- Severe: Presence of six or more symptom criteria

Coding guidelines

Per ICD-10-CM guidelines only one code should be assigned according to the following hierarchy when use, abuse, or dependence are documented for the same substance:

- Code abuse, when use and abuse are documented
- Code dependence if use and/or abuse is documented with dependence
- Code abuse when mild substance use disorder is documented
- Code dependence when moderate or severe substance use disorder is documented

Coding guidelines also state that codes for psychoactive substance use are to be used only when the psychoactive substance use is associated with a physical, mental, or behavioral disorder, and such a relationship is documented.[2]

There are no codes for history of alcohol and drug dependence. A patient with a personal history of drug or alcohol dependence is coded as *in remission*.

Substance use, abuse, and dependence (Note: A dash (-) indicates that additional character(s) required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F10.- through F19.-	Alcohol, opioid, cannabis, sedative, cocaine, stimulant, hallucinogen, nicotine, inhalant, and other psychoactive substance related disorders
Z72.0	Tobacco use
Z87.891	Personal history of nicotine dependence

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient was recently started on an anti-anxiety medication after being evaluated by a psychiatrist. The patient was diagnosed with anxiety disorder related to their

cocaine abuse. The patient was counseled on cessation and referred to rehab.

Coding for scenario 1: Cocaine abuse with cocaine-induced anxiety disorder **F14.180**

Documentation scenario 2: Patient comes to the office seeking help with smoking cessation. They have a 30-pack-year history of smoking cigarettes. They suffer from COPD which is managed with inhalers. Despite their COPD diagnosis, they have failed to quit smoking multiple times. They also have a history of alcohol dependence but managed to quit drinking and have been sober for seven years.

Coding for scenario 2: Nicotine dependence, cigarettes, uncomplicated **F17.210**, Alcohol dependence, in remission **F10.21**, Chronic obstructive pulmonary disease, unspecified **J44.9**

1 American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2022
2 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.5.b.2*. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.7 Major depressive and bipolar disorders

Documentation guidelines

When documenting major depressive disorder (MDD), include:

- Recurrence, such as single episode or recurrent
- Severity, such as mild, moderate, or severe
- Presence of psychotic features
- Remission status, if applicable, such as partial or full

Utilize available tools, such as the patient health questionnaire-9 (PHQ-9) and the geriatric depression scale (GDS), to detect and determine the severity of depression symptoms. The clinical interpretation of the results of the screening tool must be documented by the provider in the medical record. A coder cannot assign a diagnosis code based on the score from the screening test.

In patients with MDD, *in remission* denotes the absence of depression symptoms as a result of ongoing treatment.

When documenting bipolar disorder, include:

- Type, such as type I or type II
- Current episodes, such as hypomanic, manic, depressed, or mixed
- Severity, such as mild, moderate, or severe
- Presence of psychotic features
- Remission status, such as partial or full

Always document ongoing treatment for major depressive and bipolar disorders including antidepressant and antipsychotic medications, psychotherapy, and electroconvulsive therapy (ECT). Document any recent hospitalization for inpatient treatment of these disorders.

Coding guidelines

Per *American Hospital Association (AHA) Coding Clinic, chronic depression* should be coded as F32.9, *Major depressive disorder, single episode, unspecified*. Per ICD-10-CM, code **F32.9** is also used to indicate depression NOS (not otherwise specified), depressive disorder NOS, or MDD NOS as inclusion terms under this code.[1]

Since the publication of the *Coding Clinic* cited above, ICD-10-CM has introduced a new code for Depression NOS and Depressive disorder NOS. Per Optum360, "Code F32.A is reserved for depression or depressive disorders not otherwise specified. It is the default code assigned when a clinician documents depression or depressive disorder but has not specified the episode, severity, or clinical status of the depression."[2]

When MDD and bipolar disorder are documented concurrently within an encounter, ICD-10-CM requires the assignment of bipolar disorder alone. The ICD-10-CM code set contains an Excludes 1 note at F31.-, Bipolar disorder, indicating that bipolar disorder and major depressive disorder cannot be reported together.

Major depressive and bipolar disorders (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F22	Delusional disorders
F24	Shared psychotic disorder
F30.-	Manic episode
F31.-	Bipolar disorder
F32.-	Major depressive disorder, single episode
F33.-	Major depressive disorder, recurrent
F34.-	Persistent mood [affective] disorders
F39	Unspecified mood [affective] disorder

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient with recurrent major depressive disorder comes in for a follow-up visit. Patient reports a persistent depressed mood and scored 12 on the PHQ-9. Based on the reported symptoms and associated PHQ-9 score, a moderate level of depression is indicated. The patient will be referred to psychiatry for medication adjustment.

Coding for scenario 1: Major depressive disorder, recurrent, moderate **F33.1**

Documentation scenario 2: Patient recently discharged from the inpatient psychiatric unit comes in for a follow-up visit. They have bipolar I disorder and were hospitalized for five days for a manic episode. They are now in full remission and report no manic or depressive symptoms. They were instructed to continue their current antipsychotic medication regimen.

Coding for scenario 2: Bipolar disorder, in full remission, most recent episode manic **F31.74**

1 American Hospital Association (AHA) *Coding Clinic*, 4Q 2013, page 107
2 Optum360 Encoder Pro is an online software platform that offers key coding sets such as ICD-10-CM, ICD-9, CPT®, and HCPCS Level II, in addition to crosswalk capabilities. It organizes medical terminology in a hierarchical, tree-like system ranging from broad categories to more specific ones, thereby aiding users in selecting medical codes accurately.

3.8 Schizophrenia, personality, and eating disorders

Documentation guidelines

When documenting schizophrenia, include the type, if known:

- Paranoid, disorganized, catatonic, residual, or undifferentiated schizophrenia
- Schizophreniform disorder

When documenting personality disorders, include the type, if known:

- Paranoid, schizoid, antisocial, borderline, histrionic, obsessive-compulsive, and narcissistic personality disorder

When documenting eating disorders, include the type, if known:

- Anorexia nervosa, restricting type, binge eating/purging type, Bulimia nervosa, and other specified eating disorders such as pica

In addition, document body mass index (BMI) and any complications related to poor nutrition due to an eating disorder such as malnutrition or vitamin deficiency. Complications resulting from purging, such as tooth erosion and electrolyte imbalance, should be documented using linking language to establish a relationship between the complication and the underlying disorder.

Document any ongoing treatment of mental and behavioral disorders including antipsychotic medications, psychotherapy, and cognitive behavioral therapy. Document any recent hospitalization for inpatient treatment of mental and behavioral disorders.

Coding guidelines

American Hospital Association (AHA) Coding Clinic states that there are currently no ICD-10-CM codes that differentiate between severity or acute exacerbation of schizophrenia. Therefore, if the patient has an acute exacerbation of schizophrenia, assign code F20.9, Schizophrenia unspecified.[1]

Per the *AHA Coding Clinic,* BMI codes should be reported as a secondary code when the provider also documents a clinical diagnosis such as underweight, obesity, or morbid obesity that corresponds to the BMI value.[2] Codes for BMI may be assigned based on medical record documentation from clinicians who are not the patient's provider but instead are involved in the care of the patient, such as a nurse or dietician. The BMI must be clearly documented as coders are not permitted to calculate BMI based on the documented height and weight of the patient.[3]

Schizophrenia, personality, and eating disorders (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F20.-	Schizophrenia
F21	Schizotypal disorder
F22	Delusional disorder
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25.-	Schizoaffective disorders
F50.-	Eating disorders

Schizophrenia, personality, and eating disorders (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
F60.-	Specific personality disorders

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient was brought in by their spouse because they are convinced that the elderly couple living next door are plotting to kidnap him. The patient also reported hearing voices that his spouse could not hear. The patient is known to have paranoid schizophrenia, and they decided to cut their medication dose in half because of side effects. The spouse was instructed to resume the medication at the prescribed dose and to follow up with the patient's psychiatrist.

Coding for scenario 1: Paranoid schizophrenia **F20.0**, Underdosing **T43.596A**, Patient's noncompliance with medication regimen for other reason **Z91.148**

Documentation scenario 2: Patient with anorexia nervosa, binge eating/purging type comes in complaining of generalized weakness and fatigue. Physician exam showed a BMI of 18, erosion of the incisors, and lab tests confirmed hypokalemia. The patient was referred to an eating disorder treatment program.

Coding for scenario 2: Anorexia nervosa, binge eating/purging type **F50.02**, Erosion of teeth **K03.2**, Hypokalemia **E87.6**, Body mass index (BMI) 19.9 or less, adult **Z68.1**

1 American Hospital Association (AHA) *Coding Clinic*, 2Q 2019, page 32
2 American Hospital Association (AHA) *Coding Clinic*, 4Q 2018, page 77
3 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.21.c*. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.9 Atherosclerotic heart disease and angina pectoris

Documentation guidelines

When documenting atherosclerotic heart disease (ASHD)/coronary artery disease (CAD), include:

- Native coronary artery or bypass graft:
  - If present, indicate whether the graft(s) is arterial, venous, or synthetic and whether autologous or non-autologous
- Affected coronary artery(ies)
- Native or transplanted heart
- Presence or absence of angina pectoris:
  - If present, indicate the type of angina pectoris, such as:
    - Unstable:
      - Note: Unstable angina is an emergent condition and as such, documentation must demonstrate a clinically appropriate treatment plan
    - With documented spasm if present (Prinzmetal angina)
    - Other, for example, stable angina of effort, angina equivalent

If a patient has angina as a result of ASHD, the relationship between the two conditions should be documented.

Coding guidelines

ICD-10-CM combination codes from subcategories I25.11 and I25.7 (ASHD with angina pectoris) should be assigned if the patient has angina as a result of ASHD. A causal relationship between the two conditions can be assumed unless documented as being unrelated or angina is documented as being due to a condition other than atherosclerosis. When one of these combination codes is used, it is not necessary to use an additional code for angina pectoris.[1]

If the documentation states that the patient is exhibiting angina symptoms but has no known ASHD, there are ICD-10-CM codes for reporting angina alone.

Documentation must specifically state the type of angina as unstable in order for it to be coded as such. Unstable angina is a medical emergency and will, in most cases, be treated in the inpatient setting.

ASHD/CAD (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I20.0	Unstable angina
I20.1	Angina pectoris with documented spasm (for example, Prinzmetal angina)
I20.8-	Angina pectoris with coronary microvascular dysfunction and other forms of angina pectoris (for example, exertional angina, angina of effort, stable angina)
I20.9	Angina pectoris, unspecified
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.11-	Atherosclerotic heart disease of native coronary artery with angina pectoris
I25.7-	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
I25.81-	Atherosclerosis of other coronary vessels without angina pectoris

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient with atherosclerotic heart disease, status post stent placement in right coronary artery two weeks ago, comes in for follow-up visit. They report no chest pain or other angina symptoms. Patient takes an aspirin daily.

Coding for scenario 1: Atherosclerotic heart disease of native coronary artery without angina pectoris **I25.10**, Presence of coronary angioplasty implant and graft **Z95.5**

Documentation scenario 2: Patient with coronary artery disease status post coronary artery bypass grafting (CABG) five years ago, presents with exertional angina for which they take sublingual nitroglycerin with subsequent relief of symptoms. Recent coronary angiogram showed atherosclerosis and narrowing in two of the patient's saphenous vein grafts.

Coding for scenario 2: Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris **I25.718**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.9.b.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.10 Myocardial infarction

Documentation guidelines

When documenting myocardial infarction (MI), include:

- Type, such as ST-elevation myocardial infarction (STEMI), non-ST elevation myocardial infarction (NSTEMI), or other type
- Affected artery
- Site of infarction, for example, anterolateral wall, inferior wall
- Timing, for example, initial episode of care, subsequent episode of care (follow-up for an MI occurring within four weeks or 28 days of an initial MI), or old healed MI requiring no further care
- Date of onset
- Any current complications, such as hemopericardium or rupture of the cardiac wall

Acute coronary syndrome (ACS) is considered to be a broad category of acute myocardial events falling into three main categories: STEMI, NSTEMI, and unstable angina. These conditions are medical emergencies, typically diagnosed in the emergency department and treated in an inpatient setting. They are unlikely to be seen or documented in the outpatient setting due to the acute nature of these conditions.

Coding guidelines

An MI may be reported with a code from category I21, Acute myocardial infarction, up to four weeks (28 days) from the date of onset. Encounters for care related to the MI after the four-week time frame should be reported with the appropriate aftercare code. An old or healed MI, not requiring further care, should be documented and coded as I25.2, Old myocardial infarction.[1] Default to old MI if the age of the infarct is unknown.

Myocardial infarction (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I21.0-	ST elevation (STEMI) myocardial infarction of anterior wall
I21.1-	ST elevation (STEMI) myocardial infarction of inferior wall
I21.2-	ST elevation (STEMI) myocardial infarction of other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I21.9	Acute myocardial infarction, unspecified
I21.A1	Myocardial infarction type 2
I21.A9	Other myocardial infarction type
I22.-	Subsequent ST elevation (STEMI) myocardial infarction and non-ST elevation (NSTEMI) myocardial infarction
I23-	Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28-day period)
I25.2	Old myocardial infarction

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient presents for a routine check-up following MI of the left main coronary artery three months ago. They are asymptomatic and require no continued care for the MI.

Coding for scenario 1: Old myocardial infarction **I25.2**

Documentation scenario 2: Patient suffered an acute MI of the right coronary artery three weeks ago. They are in the office for their two-week follow-up from the hospital. The patient reported no chest pain since they were discharged, and they were given refill prescriptions for beta blocker and anti-platelet agent today.

Coding for scenario 2: ST elevation (STEMI) myocardial infarction involving the right coronary artery **I21.11**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.9.e.2.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.11 Cardiac arrhythmias

Documentation guidelines

When documenting cardiac arrhythmias, include:

- Type of arrhythmia, for example, atrial fibrillation, atrial flutter, supraventricular tachycardia
- Chronicity, if known, for example, paroxysmal, persistent, permanent, chronic
- Presence of a pacemaker or an automatic implantable cardiac defibrillator (AICD) and the underlying condition necessitating the device
- Ongoing treatment, such as rate control, antiarrhythmics, anticoagulants
- Previous procedures, such as radio-frequency ablation, watchman device

Ventricular arrhythmias (ventricular tachycardia and ventricular fibrillation) are acute diagnoses and typically result in cardiac arrest. They should only be documented when the arrhythmia occurs. Patients who have an AICD placed after the initial episode of arrhythmia may have recurrent episodes, at which time the AICD will attempt to shock them back into a normal rhythm.

Conduction disorders should also be documented to the highest specificity when present, such as second-degree atrioventricular (AV) block, and sick sinus Syndrome (SSS). Conduction disorders are typically treated with the placement of a permanent pacemaker. However, the pacemaker does not cure the underlying conduction disorder. Therefore, it is appropriate to continue to document the conduction disorder even after a pacemaker has been placed.

Some arrhythmias, including atrial fibrillation, can be treated with radiofrequency or cryoablation which destroys the source or pathway of the abnormal rhythm. An ablation is considered a curative procedure. An arrhythmia should be documented as historic or resolved following an ablation, unless unsuccessful or the patient has a recurrent episode.

Coding guidelines

Per the *American Hospital Association (AHA) Coding Clinic,* notes that although sick sinus syndrome may be controlled with a pacemaker, the condition itself is still considered to be present and reportable as a chronic condition. It would be appropriate to assign a code for sick sinus syndrome and the presence of a cardiac pacemaker when both are documented and supported in the medical record.[1]

Cardiac arrhythmias (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I44.-	Atrioventricular and left bundle-branch block
I47.-	Paroxysmal tachycardia

Cardiac arrhythmias (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I48.-	Atrial fibrillation and flutter
I49.-	Other cardiac arrhythmias
R00.-	Abnormalities of heartbeat
Z95.0	Presence of cardiac pacemaker
Z95.810	Presence of automatic (implantable) cardiac defibrillator

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: Patient came in for follow-up visit with cardiologist. Had a pacemaker placed three months ago for second-degree AV block, Mobitz II. Patient denies chest pain or palpitations. EKG shows paced rhythm with a rate of 70 beats per minute.

Coding for scenario 1: Atrioventricular block, second degree **I44.1**, presence of cardiac pacemaker **Z95.0**

Documentation scenario 2: Patient seen in the office for atrial fibrillation. They had failed multiple attempts at cardioversion and their atrial fibrillation is now permanent. They are on anticoagulation and their INR was checked this visit and is within the therapeutic range.

Coding for scenario 2: Permanent atrial fibrillation **I48.21**, Long-term (current) use of anticoagulants **Z79.01**

1 *American Hospital Association (AHA) Coding Clinic*, 1Q 2019, page 33

3.12 Congestive heart failure

Documentation guidelines

When documenting congestive heart failure (CHF), include:

- Type of heart failure, such as systolic (heart failure with reduced ejection fraction HFrEF), diastolic (Heart failure with preserved ejection fraction HFpEF), or combined systolic and diastolic
- Acuity, such as acute, chronic, or acute on chronic
- Underlying causes, for example, hypertension (with or without chronic kidney disease), cardiomyopathy (specify type such as ischemic, dilated, restrictive, and the like), rheumatic, or non-rheumatic valvular disease.

In the outpatient setting, chronic CHF will be the appropriate diagnosis most of the time as acute CHF is a medical emergency typically treated in the inpatient setting. Treatment for acute congestive heart failure may include intravenous diuretics and nitroglycerin as well as supplemental oxygen.

Coding guidelines

The *American Hospital Association (AHA) Coding Clinic* states, "These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used and can be further described as acute or chronic. Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as *diastolic heart failure* or *systolic heart failure*, respectively, or a combination of both indicated, and assign the appropriate ICD-10-CM codes."[1]

The heart failure code range has a *code first* guideline for heart failure due to hypertension (I11.0),

heart failure due to hypertension with chronic kidney disease (I13.-), heart failure following surgery (I97.13-), and rheumatic heart failure (I09.81).

Assign combination codes for hypertension with heart failure or hypertensive heart and chronic kidney disease with heart failure when both conditions coexist in the same patient. Use an additional code(s) from category I50 to identify the type(s) of heart failure.[2]

Congestive heart failure (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I50.2-	Systolic (congestive) heart failure
I50.3-	Diastolic (congestive) heart failure
I50.4-	Combined systolic (congestive) and diastolic (congestive) heart failure
I50.81-	Right heart failure
I50.9	Heart failure, unspecified

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: Patient with hypertension, chronic kidney disease stage 3a, and chronic diastolic heart failure comes in for a follow-up visit. They complain of persistent swelling of the lower extremities. Otherwise their blood pressure is well controlled, and they deny shortness of breath or other symptoms. Their dose of diuretics was increased, and blood was drawn to recheck the patient's GFR.

Coding scenario 1: Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease **I13.0**, Chronic kidney disease, stage 3a **N18.31**, Chronic diastolic (congestive) heart failure **I50.32**

Documentation scenario 2: Patient presents to the emergency department complaining of gradually worsening shortness of breath, fatigue, and cough productive of frothy sputum. They are known to have chronic systolic congestive heart failure due to ischemic cardiomyopathy. Exam findings and chest x-ray confirm acute congestive heart failure. The patient is given a dose of intravenous diuretics and a cardiology consultation is requested.

Coding scenario 2: Acute on chronic systolic (congestive) heart failure **I50.23**, Ischemic cardiomyopathy **I25.5**

1 American Hospital Association (AHA) *Coding Clinic*, 1Q 2016, page 10
2 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.9.a.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.13 Stroke or cerebrovascular accident

Documentation guidelines

When documenting stroke or cerebrovascular accident (CVA) in the acute setting, include:

- Type of stroke, such as ischemic or hemorrhagic
- Affected vessel, if known, for example, right middle cerebral artery
- Mechanism, if known, for example, thrombosis or embolism
- Risk factors, for example, atrial fibrillation, uncontrolled hypertension

Documentation of *stroke* or *CVA* without further specificity will default to an acute stroke, which rarely occurs in an office visit setting. A stroke is a medical emergency that is typically managed in the acute inpatient setting.

On follow-up visits after the stroke, document *history of stroke* along with any current residual neurological or cognitive deficits and link them to the stroke.

When documenting residual neurological deficits of a stroke, include:

- Type of CVA, for example, nontraumatic subarachnoid hemorrhage, nontraumatic intracerebral hemorrhage, other nontraumatic intracranial hemorrhage, or cerebral infarction
- Type of deficits, for example, motor, sensory, cognitive, speech
- Limb(s) if involved, including laterality, for example, left hemiplegia, monoplegia of the right upper limb
- Specify if dominant or nondominant side is affected, that is, whether the patient is right-handed or left-handed
- Linking verbiage, such as, *due to* or *caused by*

Coding guidelines

Documentation of *stroke* or *CVA* results in the assignment of an acute CVA code, which would be inappropriate to report except for the initial episode of care when the acute CVA was diagnosed and treated (typically in an emergency department or inpatient setting).

In ICD-10-CM, code category I63 should be utilized when the medical documentation indicates that a cerebral infarction or stroke has occurred. There are specific codes that indicate the cause of the cerebral infarction, such as embolism or thrombosis, as well as the specific affected arteries. The sixth digit provides additional information that designates the affected side when applicable.

In the outpatient setting, after the patient's initial episode of acute CVA care, CVA coding will concentrate on properly assigning codes for sequelae or late effects of CVAs, if applicable. History of CVA with no current associated residual deficits should be reported using a personal history code.

Stroke or CVA (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I60.-	Nontraumatic subarachnoid hemorrhage
I61.-	Nontraumatic intracerebral hemorrhage
I62.-	Other and unspecified nontraumatic intracranial hemorrhage
I63.-	Cerebral infarction
I69.-	Sequelae of cerebrovascular disease*
Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
*4th character specifies the type of CVA *5th character specifies particular deficits *6th character specifies laterality and whether the dominant side is affected	

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient is in the office for a follow-up visit. They were discharged from the

hospital three weeks ago after a right parietal cerebral infarction. This was thought to be embolic due to paroxysmal atrial fibrillation. The patient is right-handed, and they have moderate residual left hemiparesis. The patient is now on anticoagulants and their coagulation profile was within the therapeutic range today. They are showing slow improvement with physical therapy.

Coding for scenario 1: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side **I69.354**, Paroxysmal atrial fibrillation **I48.0**, Long-term (current) use of anticoagulants **Z79.01**

3.14 Vascular disease

Documentation guidelines

When documenting vascular disease, include:

- Acuity, such as acute or chronic
- Specify vessels involved, including laterality, for example, stricture of left renal artery, thoracic aortic aneurysm, atherosclerosis of right femoral artery
- Complications from vascular diseases like dissection and aneurysms of blood vessels, skin ulcers, and gangrene
- Link manifestations to the underlying cause, for example, intermittent claudication due to peripheral vascular (arterial) disease (PVD/PAD), rest pain due to atherosclerosis of arteries of the left lower extremity, arterial foot ulcer on the right great toe
- Long-term use of anticoagulants

Link PVD/PAD to diabetes if it is considered an underlying cause.

Document the initial size of the aneurysm, if known, and plans for ongoing monitoring. If an aneurysm is resected and replaced with a graft, it is considered resolved and should be documented as *history of aneurysm*. On the other hand, if an aneurysm is treated with an endograft or a stent, it should still be documented as active since the aneurysm is still present.

Documenting *deep venous thrombosis* (DVT) or *pulmonary embolis*m (PE) without specifying the chronicity of the condition results in the default assignment of the acute DVT/ PE code. Acute DVT/PE codes are only appropriate to assign when the DVT/PE is first diagnosed, and initial treatment is started.

Once treatment is completed, whether a six- or nine-month course of anticoagulants or insertion of an inferior vena cava filter, *history of* DVT or PE should be documented.

Since there is no ICD-10-CM code for *recurrent DVT* or *recurrent PE*, such documentation again results in the default assignment of the corresponding acute codes. Therefore, when a patient is on long-term (or life-long) treatment with anticoagulants because of a chronic DVT or chronic PE, these should be documented as such.

When documenting varicose veins (lower extremity), include:

- Location or site, including laterality
- Ulcer and/or inflammation, including site, laterality, and severity
- Other complications, such as pain, swelling, edema

Coding guidelines

Stasis (venous) ulcers without varicose veins index to I87.2, Venous insufficiency. Stasis (venous) ulcers with varicose veins index to Varix, leg, with, ulcer, I83.-, Varicose veins of lower extremities. Both I87.2 and I83.- require the use of an additional code to identify the severity of the ulcer using code category, L97.-, non-pressure chronic ulcer of lower limb, not elsewhere classified.

Vascular disease (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
I26-	Pulmonary embolism
I27.82	Chronic pulmonary embolism
I71-	Aortic aneurysm and dissection
I73.89	Other specified peripheral vascular diseases
I73.9	Peripheral vascular disease, unspecified
I74.-	Arterial embolism and thrombosis
I82.5-	Chronic embolism and thrombosis of deep veins of lower extremity
I83.-	Varicose veins of lower extremities
I87.2	Venous insufficiency (chronic) (peripheral)
Z86.711	Personal history of pulmonary embolism
Z86.718	Personal history of venous embolism and thrombosis

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: Patient came in complaining of pain in the left leg with walking that subsides with rest. They are diagnosed with intermittent claudication and an arterial Doppler study confirms stenosis in the left femoral artery due to atherosclerosis. The patient also has history of abdominal aortic aneurysm resected two years ago and replaced with a graft. They are referred to vascular surgery for management.

Coding for scenario 1: Atherosclerosis of native arteries of extremities with intermittent claudication, left leg **I70.212**, Personal history of other diseases of the circulatory system **Z86.79**

Documentation scenario 2: Patient is in the office for a follow-up visit. They have chronic DVT of the right popliteal vein and are on life-long anticoagulation. The patient's coagulation profile was checked and was within therapeutic range. Their anticoagulant prescription was refilled during the visit.

Coding for scenario 2: Chronic embolism and thrombosis of right popliteal vein **I82.531**, Long-term (current) use of anticoagulants **Z79.01**

3.15 COPD and other respiratory diseases

Documentation guidelines

When documenting COPD and other respiratory diseases, include:

- Subtype of COPD, if known, for example, emphysema, chronic bronchitis, chronic obstructive asthma
- Associated conditions, for example, bronchiectasis, pulmonary fibrosis, alpha-1 antitrypsin deficiency
- Tobacco use, dependence, or a history of tobacco use or exposure to second-hand tobacco smoke
- Complications, for example, lower respiratory tract infection, acute or chronic respiratory failure, spontaneous pneumothorax
- Dependence on supplemental oxygen or mechanical ventilation

Acute exacerbations of COPD are treated in the inpatient setting most of the time. "An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection."[1] An acute exacerbation must be documented as such, and if caused by an infection, the type of infection and the causal organism should be documented, in addition to the management and treatment.

Accurate documentation of asthma should include the severity of asthma and describe the frequency, such as mild intermittent, or severe persistent.

Cystic fibrosis, interstitial lung disease, and pulmonary fibrosis are irreversible, life-long conditions that should be evaluated and documented yearly. Documentation should include whether the patient is under the care of a pulmonologist.

Patients with pneumonia may need inpatient care. When documenting pneumonia, specify the causative organism, if known, based on respiratory and blood cultures, such as streptococcus, pseudomonas, and anaerobes. Also include the underlying cause, if any, such as aspiration.

Coding guidelines

In ICD-10-CM, category J44 includes combination codes to indicate COPD with acute lower respiratory infection, COPD with (acute) exacerbation, and COPD unspecified. If there is an acute lower respiratory infection, the provider will need to document the type of infection, for example, pneumonia or acute bronchitis for appropriate secondary code assignment. ICD-10-CM coding guidelines state that, "An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection."[1] ICD-10-CM also has a *Use additional code* instruction for coders to identify tobacco smoke exposure, tobacco use, or dependence.[2]

When COPD and emphysema are documented concurrently within an encounter, ICD-10-CM directs to report only the emphysema as the more specific, obstructive process. When chronic bronchitis and emphysema are documented concurrently within an encounter, ICD-10-CM requires the assignment of COPD. Chronic Bronchitis with emphysema is an inclusion term under the J44 code set.

COPD and other respiratory diseases (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
J41.-	Simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.-	Emphysema
J44.-	Other chronic obstructive pulmonary disease
J45.-	Mild intermittent, mild persistent, moderate persistent, and severe persistent asthma
J47.-	Bronchiectasis
J96.-	Respiratory failure, not elsewhere classified
Z99.81	Dependence on supplemental oxygen

Documentation and coding scenario examples *(for illustrative purposes only)*

Documentation scenario 1: Patient with known COPD due to heavy tobacco use in the past presents complaining of a dry cough and low-grade fever for the past three days. Denies shortness of breath beyond the baseline. Chest X-ray does not show evidence of pneumonia. Patient is diagnosed with acute bronchitis and is sent home with a course of oral antibiotics.

Coding scenario 1: COPD with acute lower respiratory infection **J44.0**, acute bronchitis **J20.9**, Personal history of nicotine dependence **Z87.891**

Documentation scenario 2: Patient is in the office for re-evaluation of their COPD. They had a chest CT and pulmonary function test the week prior which confirmed the presence of emphysema. They have been dependent on home oxygen since they were placed on it six months ago and today reported no shortness of breath. Their pulse oximetry in the office showed a concentration of 97%.

Coding Scenario 2: Emphysema, unspecified **J43.9**, Dependence on supplemental oxygen **Z99.81**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.10.a.1*. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-

CM-Guidelines-October%201%20FY2024FINALv.2.pdf
2 *ICD-10-CM Expert for Physicians: The Complete Official Code Set* (FY 2024)

3.16 Pressure and non-pressure ulcers

Documentation guidelines

When documenting pressure ulcers, include:

- Location or site, specifying laterality, if applicable
- Depth/severity by stages 1-4, unspecified stage, unstageable:
  - Stage 1-pressure pre-ulcer skin changes limited to persistent focal edema
  - Stage 2-pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
  - Stage 3-pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue
  - Stage 4-pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
- Deep tissue pressure injury
- Risk factors, for example, bed-ridden status, paralysis, malnutrition, severe cognitive impairment
- Complications, such as infection involving skin, soft tissue, or bone

When documenting non-pressure chronic ulcers, include:

- Location or site, specifying laterality, if applicable
- Depth/severity:
  - Breakdown of skin
  - Fat layer exposed
  - Muscle involvement, with or without necrosis
  - Bone involvement, with or without necrosis
  - Other specified severity
  - Unspecified severity
- Etiology/underlying conditions, such as:
  - Atherosclerosis of the arteries of the lower extremities
  - Gangrene
  - Diabetes mellitus
  - Chronic venous hypertension
  - Varicose veins

Coding guidelines

Codes in category L89-, pressure ulcer, are combination codes based on the site and stage of the pressure ulcer. Additional characters are added based on site and laterality, for example, L89.021, Pressure ulcer of left elbow, stage 1. An unstageable ulcer means a stage cannot be clinically determined. An unspecified stage means that there is no documentation regarding the stage.

For pressure-induced deep tissue damage or injury not due to trauma are assigned codes L89.—6.

When coding for non-pressure ulcers, code first any underlying condition and then the depth of the ulcer as stated above. No code is assigned if the documentation states that the non-pressure ulcer is completely healed.

ICD-10-CM classifies an unspecified wound as traumatic by default. Wounds such as skin tears, burns, abrasions, or surgical complications are not coded to pressure or non-pressure ulcers.[1]

Pressure and non-pressure ulcers (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)

ICD-10-CM code	Diagnosis code description
L89.-*	Pressure ulcer
L97.-*	Non-pressure chronic ulcer of lower limb, not elsewhere classified
L98.4-	Non-pressure ulcer of skin, not elsewhere classified
*4th character specifies site *5th character specifies laterality *6th character specifies stage	

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient who is bed-bound due to advanced multiple sclerosis is brought in by family for evaluation of a bed sore. They have a stage 2 pressure ulcer on the right buttock which looks clean without evidence of infection or necrosis. The family was counseled on frequent turning and the patient was set up with home care for dressing changes.

Coding for scenario 1: Pressure ulcer of right buttock, stage 2 **L89.312**, Multiple sclerosis **G35**, Bed confinement status **Z74.01**

Documentation scenario 2: Patient presents for a follow-up visit. They have a chronic ulcer on the left heel due to atherosclerosis of the arteries of the left leg. The ulcer involves the bone associated with chronic osteomyelitis but no evidence of necrosis. The patient has a peripherally inserted central venous catheter (PICC) and is receiving IV antibiotics under the supervision of an infectious disease specialist. They also see an orthopedic surgeon for debridement and wound care.

Coding for scenario 2: Atherosclerosis of native arteries of the left leg with ulceration of heel and midfoot **I70.244**, Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis **L97.426**, Other chronic osteomyelitis, left ankle and foot **M86.672**, Presence of other vascular implants and grafts **Z95.828**, Long term (current) use of antibiotics **Z79.2**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.12.a*. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.17 Rheumatoid arthritis

Documentation guidelines

When documenting rheumatoid arthritis, include:

- Limb(s) and joint(s) involved, including laterality
- Positive (seropositive) or negative (seronegative) rheumatoid factor
- Type, such as juvenile or adult-onset
- Complications, for example, joint destruction and deformities
- Organ or system involvement (extra-articular), for example, lung, skin
- Severity, such as mild, moderate, or severe
- Current status, for example, active or in remission

Document whether the patient is being treated with a disease-modifying anti-rheumatic drug (DMARD). If not on a DMARD, document the reason and list other long-term medications being used such as NSAIDs, opioids, steroids, and immunosuppressants.

Referrals to rheumatology and other specialists should be documented, including physical and occupational therapists and orthopedic surgeons.

Rheumatoid arthritis that is in remission should be documented as *in remission* and not as *history of*.

History of is interpreted as the patient no longer has the condition.

Coding guidelines

Rheumatoid arthritis classifies to the categories listed below and is further indexed to juvenile, seronegative, seropositive, and unspecified. Seronegative means the patient does not test positive for rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) antibodies. Seronegative ICD-10-CM codes index to category M06.-. Seropositive means the patient does test positive for rheumatoid factor or other antibodies (anti-CCP).

Seropositive ICD-10-CM codes index to M05.9. Extra-articular involvement of RA can include organs such as the heart, skin, and lungs. In the ICD-10-CM Index under arthritis, rheumatoid, is the linking term *with* for carditis, lung involvement, vasculitis, and the like. This directs users to extra-articular conditions; for example, rheumatoid carditis indexes to M05.30.

Since there is not an ICD-10-CM code for long-term current use of immunosuppressants, code Z79.899, Other long-term (current) drug therapy, should be assigned to capture the long-term use of immunosuppressants.

Severe joint pain should not be coded separately as this is a characteristic of rheumatoid arthritis. Also, do not assign codes for an immunocompromised state as immunosuppressants are used for this condition.

Per ICD-10-CM guidelines, most codes within *Chapter 13, Diseases of the Musculoskeletal System and Connective Tissue,* have site and laterality designations. For conditions where one bone, joint, or muscle is involved, such as osteoarthritis, there is a *multiple sites* code available. Any time a condition affects more than one anatomic site, for example, hand and ankle, and a *multiple sites* option is available within the category, assign the designated *multiple sites* code.[1]

When a condition affects a single site, bilaterally, for example, right and left hands, assign each code independently rather than assigning a code for *multiple sites*. A code for multiple sites should be reserved for instances where the condition affects more than one anatomic location.

Rheumatoid arthritis (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
M05.-	Rheumatoid arthritis with rheumatoid factor
M06.0-	Rheumatoid arthritis without rheumatoid factor
M06.8-	Other specified rheumatoid arthritis
M08.-	Juvenile arthritis
Z79.899	Other long term (current) drug therapy

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient recently diagnosed with rheumatoid arthritis came in for a follow-up visit. Patient has joint involvement in both hands, and they tested positive for rheumatoid factor. No other organs are involved. They are tolerating treatment with methotrexate well and were given a refill today.

Coding for scenario 1: Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement **M05.741**, Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement **M05.742**, Other long-term (current) drug therapy **Z79.899**

Documentation scenario 2: Patient with rheumatoid lung disease comes in complaining of pain in the right shoulder. Examination and imaging findings confirm rheumatoid arthritis involving the right shoulder. The lung disease had been well controlled on DMARD therapy. The patient is referred to rheumatology for possible medication regimen adjustment.

Coding for scenario 2: Rheumatoid lung disease with rheumatoid arthritis of right shoulder [M05.111], Other long-term (current) drug therapy **Z79.899**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.13.a*. cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.18 Traumatic and pathological fractures

Documentation guidelines

When documenting fractures-disorders and injuries of the musculoskeletal system, include:

- Site (bone, muscle, or joint). If multiple sites are involved, they should all be listed.
- Laterality, such as right, left, or bilateral.
- Underlying systemic disease, if any, such as systemic lupus erythematosus (SLE) or rheumatoid arthritis (RA).
- With fractures, specify:
  - Traumatic or pathological:
    - If pathological, document etiology, for example, malignant neoplasm, osteoporosis
  - Open or closed
  - Displacement of bone fragments
  - Episode of care, such as initial, subsequent, or sequelae (late effects)
  - Complications, for example, delayed healing, nonunion, malunion

Episodes of care for fractures and injuries should be documented as *initial* as long as the patient is receiving active treatment which may include surgical intervention and/or stabilization. While the patient may be seen by a new or different provider throughout treatment for an injury or a fracture, documentation of an *initial encounter* is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time. An initial encounter could also be documented if the patient delayed seeking treatment. Pain management alone is not considered *active* treatment.

Any later follow-up encounters should be documented as *subsequent encounters*, including those for nonunion and malunion. Document *sequelae* for long-term complications of the fracture or injury that requires ongoing care or treatment.

Pathological fractures can result from neoplasms involving the bone (primary or secondary), osteoporosis, Paget's disease, hyperparathyroidism, and nutritional or congenital disorders.

Coding guidelines

ICD-10-CM uses seventh characters to characterize different stages of injury, poisoning, and other external causes. Character *A* denotes the initial encounter, character *D* denotes a subsequent

encounter or recovery phase, and character *S* denotes sequela and is used when there are complications or conditions that arise as a direct result of a condition.[1]

Osteoporosis is a systemic condition that does not have a site component for coding purposes. A code from category M81 should be used for patients with osteoporosis, without a current pathological fracture at the time of the encounter. For patients with osteoporosis and a current pathological fracture, a code from category M80 should be reported. The site codes under category M80 identifying the site of the pathological fracture, not the osteoporosis. A traumatic fracture code should not be used when a patient with known osteoporosis suffers a fracture from a minor fall or trauma that would not usually break a normal, healthy bone, a pathological fracture code should be used instead.[2]

For conditions where one bone, joint, or muscle is involved, such as osteoarthritis, there is a *multiple sites* code available. Any time a condition affects more than one anatomic site, for example, hand and ankle, and a *multiple sites* option is available within the category, assign the designated *multiple sites* code.

When a condition affects a single site, bilaterally, for example, right and left hands, assign each code independently rather than assigning a code for *multiple sites*. A code for multiple sites should be reserved for instances where the condition affects more than one anatomic location.

Traumatic and pathological fractures (Note: A dash (-) indicates that additional character(s) are required for a valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
M80.-	Osteoporosis with current pathological fracture
M81.-	Osteoporosis without current pathological fracture
M84.5-	Pathological fracture in neoplastic disease
S00.- through S39.-	Injuries to the head and neck, thorax, abdomen, lower back, lumbar spine, pelvis, and external genitals
S40.- through S69.-	Injuries to the upper extremity (shoulder and upper arm, elbow and forearm, wrist, hand, and fingers)
S70.- through S79.-	Injuries to the lower extremity (hip and thigh, knee and lower leg, ankle, and foot)

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient on chemotherapy for right breast cancer with bone metastasis came in complaining of severe pain and inability to bear weight on the right lower extremity. Imaging studies revealed a pathological fracture in the right femur at the site of a metastatic lesion. She was given analgesics for pain control. Her oncologist was notified, and an orthopedic surgery consultation was requested.

Coding for scenario 1: Pathological fracture in neoplastic disease, right femur, initial encounter for fracture **M84.551A**, Malignant neoplasm of unspecified site of right female breast **C50.911**, Secondary malignant neoplasm of bone **C79.51**

Documentation scenario 2: Patient is in the office for a follow-up on a non-healing fracture. They sustained a closed traumatic fracture of the left tibial shaft six months ago and the most recent imaging studies confirmed non-union of the fracture. The patient indicated their pain is well controlled with medications and they have an upcoming appointment with orthopedic surgery to

explore surgical treatment options.

Coding for scenario 2: Unspecified fracture of shaft of left tibia, subsequent encounter for closed fracture with nonunion **S82.202K**

1 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.19.a.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
2 National Center for Health Statistics. (2023, September 22). *ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.13.c.* cdc.gov. Retrieved November 29, 2023, from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf

3.19 Chronic kidney disease (CKD)

Documentation guidelines

When documenting CKD, include:

- Stage of CKD based on estimated glomerular filtration rate (eGFR)
- Underlying cause, if known, such as diabetes mellitus (DM) or hypertension
- Presence of arterio-venous (AV) shunt or other form of intravenous access for dialysis
- Whether the patient is on dialysis and is non-compliant with dialysis
- History of kidney transplant, if applicable

Although kidney function can improve or worsen over time, providers should avoid documenting multiple stages of CKD in the same encounter. The stage of CKD documented should reflect the patient's kidney function at the time of that encounter to the best of the provider's knowledge.

Once a patient receives a kidney transplant, their end-stage renal disease (ESRD) is considered cured and should no longer be documented. Status-post kidney transplant should be documented. If the patient has any residual CKD after the transplant, this should be documented with the current stage.

Coding guidelines

ICD-10-CM classifies the severity of CKD into stages 1 through 5, and (ESRD) based on estimated glomerular filtration rate (eGFR) values and dialysis treatment. The stage of CKD must be explicitly stated in the record to ensure accurate code selection. Code selection cannot be assigned based on documented eGFR.

Stage	Loss of kidney function	eGFR	ICD-10-CM code
1	Normal to slightly decreased	≥ 90	N18.1
2	Mild	60-89	N18.2
3a	Mild to moderate	44-59	N18.31
3b	Moderate to Severe	30-44	N18.32
4	Severe	15-29	N18.4
5	Kidney failure not requiring dialysis	< 15	N18.5
6	End stage renal disease requiring dialysis	< 15	N18.6

ICD-10-CM assumes a cause-and-effect relationship between CKD and DM and between CKD and hypertension. Assign the appropriate combination code when these diagnoses coexist unless the documentation states one or the other as the underlying cause, or a different underlying cause is documented.

Per the *American Hospital Association (AHA) Coding Clinic,* if a patient has diabetes, hypertension, and CKD, and the provider documents CKD due to diabetes, assign a code for the diabetic CKD. Do not assign a code for hypertensive CKD, the hypertension would be coded separately.[1]

Patients who have had a kidney transplant may still have some degree of CKD, therefore having CKD post-transplant may not constitute a complication of the transplant. Per ICD-10-CM guidelines, assign the appropriate N18 code for the patient's CKD stage and code Z94.0, Kidney transplant status. If a complication of the transplant such as failure or rejection occurs, assign a code from category T86.1- Chronic kidney disease is a common diabetic complication. For patients who are status post kidney transplant with diabetes and CKD, assign the appropriate N18 code for the patient's CKD stage, E08-E13.22 Diabetes with diabetic kidney disease, and code Z94.0, Kidney transplant status.

Code Z99.2, Dependence on renal dialysis, contains the inclusion phrase of the presence of an AV shunt for dialysis. Therefore, Z99.2 should be reported when the AV fistula is being used for active dialysis per *AHA Coding Clinic*.[2]

Chronic kidney disease (Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)	
ICD-10-CM code	**Diagnosis code description**
E08.22, E09.22, E10.22, E11.22, E13.22	DM with diabetic chronic kidney disease
I12.-	Hypertensive chronic kidney disease
I13.-	Hypertensive heart and chronic kidney disease
T86.1-	Complications of kidney transplant
Z91.15-	Patient's noncompliance with renal dialysis
Z94.0	Kidney transplant status
Z99.2	Dependence on renal dialysis

Documentation and coding scenarios *(for illustrative purposes only)*

Documentation scenario 1: Patient with type II diabetes and CKD stage 3b due to hypertension came in for a follow-up visit. Blood pressure is controlled and eGFR is stable at 41 mL/min based on most recent labs.

Coding for scenario 1: Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease **I12.9**, Chronic kidney disease, stage 3b **N18.32**

Documentation scenario 2: Patient with ESRD, on regular hemodialysis three times a week, came into the office complaining of generalized weakness. Their lab results showed a low hemoglobin confirming anemia due to ESRD. They were referred to be evaluated for treatment with erythropoietin injections.

Coding for scenario 2: End stage renal disease **N18.6**, Anemia in chronic kidney disease **D63.1**, Dependence on renal dialysis **Z99.2**

1 American Hospital Association (AHA) *Coding Clinic*, 3Q 2019 page 3
2 American Hospital Association (AHA) *Coding Clinic*, 2Q 2013 page 6