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Code Description	Code	# of ICD-10 code characters	Use This Code When…	Do NOT Use This Code When…
Abdominal Aortic Aneurysm w/o rupture (AAA)	**I71.4**	**4**	Condition is initially established in visit documentation and refers to radiology results, during active monitoring (e.g., serial US)	Surgically repaired
Atrioventricular block, complete	**I44.2**	**4**	Patient is symptomatic, new condition or pacemaker malfunction	Pacemaker
Atrial Fibrillation, unspec. **Chronic Atrial Fibrillation** **Paroxysmal Atrial Fibrillation** **Persistent Atrial Fibrillation**	**I48.91** **I48.20** **I48.0** **I48.11**	**4-5**	You are monitoring or treating AFib. Document treatment (e.g., anticoagulation, pacemaker). For pacemaker patients: continue to report the rhythm issue after pacemaker and document presence of cardiac pacemaker (Z95.0). This applies to SSS	Atrial fib has resolved
Coagulation				
Deep Vein Thrombosis, Chronic (see D68.8 Other specified coagulation defect, below)	**I82.50-**	**6**	Patient has recurring DVTs	DVT is acute (3-6 months of treatment); not for patients treated prophylactically following surgery or if Z86.718 History of DVT
Hemorrhagic disorder due to extrinsic circulating anticoagulants	**D68.32**	**5**	Applies if patient develops a hemorrhagic disorder **related to warfarin, heparin or other anticoagulant use**. Document/code using 3 conditions: 1.The bleeding by site,such as hemoptysis, hematuria, hematemesis, hematochezia 2.**D68.32 Hemorrhagic disorder due to extrinsic circulating anticoagulants,** and 3. T45.515 Adverse effect of anticoagulant	Hemorrhagic condition is not due to an adverse effect of anticoagulant
Acquired coagulation factor deficiency	**D68.4**	4	Deficiency of coagulation factor due to liver disease or vitamin K deficiency. Code the underlying condition	Coagulation issue is related to taking an anticoagulant
Coagulation defect, other specified (use in addition to chronic PE, DVT)	**D68.8**	4	Document/code using 3 conditions: 1. **I27.82 Chronic PE** or **I82.50- Chronic DVT** 2. **D68.8 Coagulation defect, other specified**, and 3. Z79.01 Long-term use of anticoagulants	Anticoagulation is related to atrial fibrillation treatment
Pulmonary Embolism **Chronic Pulmonary Embolism** (Chronic: see **D68.8**, above)	**I26.99** **I27.82**	**5**	Acute and current PE, actively being treated. Also code: Coagulation defect D65-D68 (e.g., **D68.2 Hereditary deficiency of clotting factor, Factor V**)	Resolved, then code Z86.711 History of PE
Cachexia	**R64**	3	Document: underlying condition if known (e.g., cancer, COPD, HF, dementia, etc.) and assessments related to signs of cachexia like loss of overall wt. (usually 5% or > loss), loss of muscle and/or fat	Patient weight loss is not attributed to underlying disease or condition
Malnutrition, Protein Calorie Moderate & Mild	**see table below**	**4**	Patient meets guidelines re: serum albumin, BMI, etc. (see table below). Document patient counseling	Guidelines are not met

Protein-Calorie Malnutrition Clinical Classifications

Measurement	Normal	E44.1 Mild Malnutrition	E44.0 Moderate Malnutrition	E43 Unspec. Severe Malnutrition
% Normal Weight	90-100	85-90	75-85	<75
BMI	19-24*	18-18.9	16-17.9	<16
Serum Albumin	3.5-5.0	3.1-3.4	2.4-3.0	<2.4
Serum Transferrin	220-400	201-219	150-200	<150
Total lymphocyte count	2000-3500	1501-1999	800-1500	<800

*In the elderly, BMI < 21 is associated with increased mortality risk *(Berrington de Gonzales NEJ.Med 2010)*

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Cancer, Active	**C00-D49-**	**varies by site**	Patient in active treatment or active surveillance following treatment. For seed implant: considered active cancer dx for 5 years after implant. External radiation: use active cancer dx for 1 year after treatment. Code as active when patient is receiving hormonal treatment to prevent recurrence (e.g., Tamoxifen, Lupron). Beware of stating "history of cancer" unless considered cured	Patient considered to be cured or no current evidence of disease - may be communicated by oncologist. Do not use if patient has completed all appropriate treatment or is being given prophylactic meds due to family history
Cancer, History of	**Z85.-** **Z86.-**	**5-6**	Patient does not meet definition of Active Cancer (see above)	Patient has Active Cancer or cancer not considered curable such as **C91.91 Chronic Lymphocytic Leukemia (CLL), unspec, in remission**
Cancer, Metastatic or Secondary	**C77-C79**	**varies by site**	Always code once diagnosed; use additional code for primary site (**C80.1 primary site unknown**)	No evidence of disease
Chronic Kidney Disease (CKD)	N18.-	**4**	Signs of renal damage (persistent microalbuminuria) or abnormal GFR	There are no labs to support condition or staging
CVA, Cerebral Infarct	**I63.-**	**5-6**	Code describes acute event and is an acute/inpatient code. In office only with evidence on MRI/CT	After acute care of CVA/TIA, then use Z86.73 History of CVA/TIA; for residual deficits see I69.3-
CVA, Sequelae Mono/hemi -plegia, -paresis, paralytic syndrome	**I69.031** through **I69.969**	**6**	Patient has current residual effects in any limb s/p CVA. Codes specify limb or side effected	Any residual deficits have resolved
Dependence, Alcohol	**F10.-**	**5-6**	Patient has abuse or dependence issues related to alcohol such as **F10.180 Alcohol abuse w/related anxiety disorder**.History of alcohol dependence is **F10.21 Alcohol dependence w/remission.** Include associated conditions such as **K70.30 Alcoholic cirrhosis w/out ascites** -or- **K70.31 Cirrhosis w/ ascites**	
Dependence, Drug		**5-6**	Patient meets DSM-5R Substance Dependence Criteria. Patient may require referral to specialist for medication mgmt as they are displaying drug seeking behavior plus other symptoms added to equal Dependence as described by DSM-5R. Use remission codes once resolved	Symptoms of tolerance and withdrawal are occurring when pt. is appropriately medicating and/or drug is being titrated down
Opioid	**F11.-**			
Sedative	**F13.-**			
Depressive Disorder, Major F32.9 does not risk adjust	**F32.- F33.-**	**5**	Patient is being treated for depressive episode > 2 weeks. Specify severity and episode (see table below). Use remission codes once resolved	Symptoms last less than 2 weeks

Major Depressive Disorder (all codes below risk adjust at the same value)

Single Episode					
Mild	Moderate	Severe w/out Psychotic	Severe w/ Psychotic	Partial Remission	Full Remission
F32.0	F32.1	F32.2	F32.3	F32.4	F32.5

Recurrent Episode (interval of at least two consecutive months between separate episodes)								
Mild	Moderate	Severe w/out Psychotic feature	Severe w/Psychotic feature	In Remission unspec	Partial Remission	Full Remission	Other depressive disorder	MDD unspec
F33.0	F33.1	F33.2	F33.3	F33.40	F33.41	F33.42	F33.8	F33.9

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DM II w/ unspecified complications	**E11.8**	**4**	*Avoid using this code*	
DM II w/hyperglycemia (documented as poorly or uncontrolled)	**E11.65**	**5**	HgA1C > 9 or glucose level abnormally high	HgA1C and glucose within normal range
Diabetes II w/o complications	**E11.9**	**4**	Patient does not have DM complications upon exam	Patient has DM complications (HTN, hyperlipidemia, atherosclerosis, CAD, renal, eye, neuro, etc.)
DM II with peripheral arterial angiopathy without gangrene	**E11.51**	**5**	Patient has Type 2 DM and PVD	PVD is caused by condition other than DM
DM II below REQUIRES 2 Condition Codes				
Diabetes II with CKD	**E11.22 + CKD code**	**5**	CKD Code & Stage / GFR N18.1 Stage 1 > 90 N18.2 Stage 2 60-89 **N18.3 Stage 3** 30-59 **N18.4 Stage 4** 15-29 **N18.5 Stage 5** < 15 **N18.6 ESRD** < 15 N18.9 Unspecified	No documented evidence of renal damage or disease. There are no labs to support condition or staging. CKD is due to anything other than diabetes
DM II with other circulatory complications	**E11.59 +** complication code	**5**	Patient has circulatory complication (not PVD E11.51, above) such as: Atherosclerosis (I70.20-I99), CAD (I25.10), ED (N52.1), HTN (I10). Causal relationship to DM is clearly documented using causation terms such as "due to" or "complicated by." Bill both codes	Documentation does not support relationship to DM
Diabetes II with foot ulcer	**E11.621 + ulcer code**	**6**	Patient has current foot ulcer. Code specific site (e.g., **L97.4- Non-pressure ulcer of heel and midfoot**)	Ulcer has healed or if documented as a wound
Diabetes II with other skin ulcer	**E11.622 + skin ulcer code**	**6**	Patient has current ulcer other than foot. Other lower limb sites: **L97.101 - L98.499**	Ulcer has healed or if documented as a wound
Diabetes II with other specified complications	**E11.69 +** other specified code	**5**	Patient has DM complication and relationship to DM is clearly documented using causation terms such as "due to" or "complicated by." Bill both codes. Additional code e.g.: B37.- Thrush/candidiasis (B37.0 oral, B37.3 vaginal) or M90.5- **Osteonecrosis in diseases classified elsewhere**	Complication(s) specified in other DM codes or DM with no complications
Diabetes II with other ophthalmic complications	**E11.39 +** eye code	**5**	Patient has H40 Glaucoma or H42 Glaucoma in diseases classified elsewhere	No ophthalmic complications or patient's eye condition is specified under **E11.3-** (retinopathy, etc.)

Co-morbid Condition Examples for Morbid Obesity when BMI 35-40	
Heart disease	**Depression**
Type II diabetes	**Sleep apnea & respiratory conditions**
Cancer (endometrial, breast, colon)	**Osteoarthritis**
Hypertension	**Gynecological problems**
Dyslipidemia	**Stroke**
Liver and gallbladder disease	

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Disorder involving the immune mechanism, unspecified	**D89.9**	**4-6**	The immunocompromised state is described in labs and symptom but there is not a definitive diagnosis	Immunocompromised state is due to a specific disease process or due to a drug
Fracture, Current Pathological, with Age-related Osteoporosis	M80.0- Not all M80.- codes risk adjust	**7**	Treating symptomatic pathological fracture. Code fracture site and encounter type such as **M80.08XA Age-Related Osteoporosis with Path Fx, Vertebra(e), Initial Encounter.** 7th character "A" indicates "initial encounter." Once healed use M81.0 (see below)	No longer being treated and/or subsequent visit with routine healing. Z87.31- Hx of pathologic fracture
Age-related Osteoporosis Without Current Pathological Fracture	M81.0	4	Patient has Age-related osteoporosis; any pathological fracture is healing or healed	Z87.31- Hx of pathologic fracture
Fracture, Traumatic	use fracture code + external cause code	7	Treating patient's high-impact injury fracture. Document location and any complications. Fractures that risk adjust include head, spine, pelvis, hip, femur. Use external cause codes (V, W, X, Y) upon diagnosis	The traumatic fracture is resolved or healed, there are no symptoms or treatment
Heart Failure	**I50.-**	**5**	Patient has clinical syndrome of heart failure, including compensated and/or no current signs/symptoms w/ treatment	There is only evidence of diastolic dysfunction or an enlarged heart on chest x-ray or echo. (Heart failure is a clinical syndrome.)
Myocardial Infarction, Old	I25.2	4	MI ≤ 4 weeks old, use **I21.3 STEMI or I21.4 non-STEMI**	MI ≥ 4 weeks old, code I25.2 Old MI
Obesity, Morbid (Severe) due to excess calories	**E66.01**	5	BMI ≥ 40 OR BMI 35-39.9 with comorbidities (see table bottom of previous page). Document high risk co-morbid condition and note causation: "pt. is morbidly obese causing major depressive disorder" or "pt. has DM due to severe obesity." Bill both codes. Code all Z68.- BMI values annually	BMI < 35 OR 35-39.9 w/o comorbidities
Obesity, Morbid with Alveolar Hypoventilation	**E66.2**	**4**	Condition has been established in an acute care setting using ABG results	Patient has obesity with sleep apnea or BMI <35
Peripheral Vascular Disease, unspecified	**I73.9**	**4**	PVD is not related to diabetes. Use I70.2- codes for atherosclerotic vascular disease	PVD is related to Diabetes. See **E11.51 DM II w/PVD**
Polyneuropathy, unspecified	G62.9	4	Neuropathy not related to Diabetes. Consider: **G62.0 Drug induced polyneuropathy, G62.1 Alcoholic polyneuropathy, G62.2 Polyneuropathy due to other toxic agents**	Neuropathy is related to diabetes. See **E11.4- DM II w/neuro complications**
Respiratory Failure, Chronic **Unspec.: hypoxia or hypercapnia** **with hypoxia** **with hypercapnia**	 **J96.10** **J96.11** **J96.12**	**5**	Oxygen ordered and documented 24/7 > 28 days. Document underlying disease (COPD, HF, etc.). Must state "Chronic Respiratory Failure"	Patient using nocturnal O2 or CPAP only
Sinoatrial Node Dysfunction **Sick Sinus Syndrome (SSS)**	**I49.5**	**4**	Continue to use diagnosis when patient is receiving treatment for condition (drugs or pacemaker)	Documentation states history of or resolved
Essential (hemorrhagic) thrombocythemia	**D47.3**	**4**	Persistent platelets > 450,000 typically diagnosed by hematologist or via bone marrow study	Short-term or expected high value
Thrombocytopenia, unspecified	**D69.6**	**4**	Persistent platelets < 150,000	Short-term or expected low value

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