Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-10-CM

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.

1. The Alphabetic Index and Tabular List

The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals. See Section I.C2. General guidelines See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character. The ICD-10-CM uses an indented format for ease in reference.

The ICD-9-CM uses an indented format for ease in reference
3. Use of codes for reporting purposes
For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character
The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50. Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters
Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

6. Abbreviations
   a. Alphabetic Index abbreviations
      NEC “Not elsewhere classifiable” This abbreviation in the Alphabetic Index represents “other specified”. When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

      Index abbreviations
      NEC “Not elsewhere classifiable” This abbreviation in the index represents “other specified” when a specific code is not available for a condition the index directs the coder to the “other specified” code in the tabular.

      NOS “Not otherwise specified” This abbreviation is the equivalent of unspecified.

   b. Tabular List abbreviations
      NEC “Not elsewhere classifiable” This abbreviation in the Tabular List represents “other specified”. When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

      Tabular abbreviations
      NEC “Not elsewhere classifiable” This abbreviation in the tabular represents “other specified”. When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the “other specified” code. (See Section I.A.5.a. “Other” codes).

      NOS “Not otherwise specified” This abbreviation is the equivalent of unspecified. (See Section I.A.5.b., “Unspecified” codes)
7. Punctuation

[] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

() Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic”.

: Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

8. Use of “and”.

See Section I.A.14. Use of the term “And”

9. Other and Unspecified codes

a. “Other” codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate “other” codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.

Codes titled “other” or “other specified” (usually a code with a 4th digit 8 or fifth-digit 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate “other” codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.
b. **“Unspecified” codes** Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

*See Section 1.B.18 Use of Signs/Symptom/Unspecified Codes*

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code.

**10. Includes Notes** This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

**11. Inclusion terms** List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

List of terms is included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

**12. Excludes Notes** The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

**a. Excludes1** A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
b. Excludes2 A type 2 Excludes note represents “Not included here”. An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes) Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. “In diseases classified elsewhere” codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention. There are manifestation codes that do not have “in diseases classified elsewhere” in the title. For such codes, there is a “use additional code” note at the etiology code and a “code first” note at the manifestation code and the rules for sequencing apply. In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second. An example of the etiology/manifestation convention is dementia in Parkinson’s disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance. “Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination. See Section I.B.7. Multiple coding for a single condition.
There are manifestation codes that do not have “in diseases classified elsewhere” in the title. For such codes a “use additional code” note will still be present and the rules for sequencing apply.

In addition to the notes in the tabular, these conditions also have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

The most commonly used etiology/manifestation combinations are the codes for Diabetes mellitus, category 250. For each code under category 250 there is a use additional code note for the manifestation that is specific for that particular diabetic manifestation. Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient’s complete diabetic condition. The category 250 diabetes codes should be sequenced first, followed by the manifestation codes.

“Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

See - Section I.B.9. “Multiple coding for a single condition”.

14. “And” The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

For example, cases of “tuberculosis of bones”, “tuberculosis of joints” and “tuberculosis of bones and joints” are classified to subcategory A18.0, Tuberculosis of bones and joints.

15. “With” The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

16. “See” and “See Also” The “see” instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the “see” note to locate the correct code. A “see also” instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the “see also” note when the original main term provides the necessary code.
It is not necessary to follow the “see also” note when the original main term provides the necessary code.

17. “Code also note” A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

18. Default codes A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

B. General Coding Guidelines

1. Locating a code in the ICD-10-CM
To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List. It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (−) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

Use of Both Alphabetic Index and Tabular List
Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.
Locate each term in the Alphabetic Index
Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

2. Level of Detail in Coding
Diagnosis codes are to be used and reported at their highest number of characters available. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail. A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
Level of Detail in Coding

Diagnosis and procedure codes are to be used at their highest number of digits available. ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail. A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. For example, Acute myocardial infarction, code 410, has fourth digits that describe the location of the infarction (e.g., 410.2, Of inferolateral wall), and fifth digits that identify the episode of care. It would be incorrect to report a code in category 410 without a fourth and fifth digit. ICD-9-CM Volume 3 procedure codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of third and/or fourth digits, which provide greater detail.

3. Code or codes from A00.0 through T88.9, Z00-Z99.8

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

Code or codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the admission/encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.
5. **Conditions that are an integral part of a disease process**
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. **Conditions that are not an integral part of a disease process**
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

7. **Multiple coding for a single condition**
In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

“Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.
a condition. The sequencing rule is the same as the etiology/manifestation pair - “use additional code” indicates that a secondary code should be added. For example, for infections that are not included in chapter 1, a secondary code from category 041, Bacterial infection in conditions classified elsewhere and of unspecified site, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code. “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a “code first” note is present and an underlying condition is present the underlying condition should be sequenced first. “Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis. Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

8. Acute and Chronic Conditions
If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

9. Combination Code
A combination code is a single code used to classify:
Two diagnoses, or
A diagnosis with an associated secondary process (manifestation)
A diagnosis with an associated complication
Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.
Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.
A diagnosis with an associated complication
Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List. Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

10. Sequela (Late Effects)
A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second. An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.
See Section I.C.9. Sequelae of cerebrovascular disease
See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium
See Section I.C.19. Application of 7th characters for Chapter 19

Late Effects
A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second. Exceptions to the above guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) or the classification instructs otherwise. The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

11. Impending or Threatened Condition
Code any condition described at the time of discharge as “impending” or “threatened” as follows:
If it did occur, code as confirmed diagnosis.
If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”

If the subterms are listed, assign the given code.
If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

**Impending or Threatened Condition**
Code any condition described at the time of discharge as “impending” or “threatened” as follows:
If it did occur, code as confirmed diagnosis.
If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
If the subterms are listed, assign the given code.
If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

**12. Reporting Same Diagnosis Code More than Once**
Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

**13. Laterality**
Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

**Admissions/Encounters for Rehabilitation**
When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.
Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.
14. Documentation for BMI, Non-pressure ulcers and Pressure Ulcer Stages

For the Body Mass Index (BMI), depth of non-pressure chronic ulcers and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

The BMI codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

15. Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

16. Documentation of Complications of Care

Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an
indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

**Documentation of Complications of care**

Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

### 17. Borderline Diagnosis

If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

### 18. Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.