BCA's Diagnosis Coding Booklet

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BCA's Diagnosis Coding Booklets are designed as practical tools to assist with diagnosis code selection. These resources are intended to be used in conjunction with the HIPAA-mandated, current, and published ICD-10-CM coding guidelines for appropriate application and reporting.

From the American Medical Association ICD-10-CM 2026 The Complete Official Codebook:

"These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Guidelines in Section I—Conventions, general coding guidelines, and chapter-specific guidelines—should also be applied for outpatient services and office visits."

"These guidelines are a set of rules developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over the guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. **Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).**"

Note from BCA: We have done our best to indicate in this guide if a code risk adjusts by indicating "Yes" in the Risk? column. If there is an asterisk (*) in this column, it indicates that this is a new code, and we do not yet have risk adjustment information. This is based on our experience and research of HCC and CDPS value-based care models we have worked with and should not be construed as the authority on whether a code risk adjusts. It is provided simply as an indication that you may want to review the code more closely for risk adjustment purposes.

Please refer to your **payer policy** for their official guidance on risk adjustment coding.

For additional BCA resources, including BCA's most current guidance on COVID-19 coding, visit www.bcarev.com/revu.

DIABETES TYPE 2 (T2DM) *(not an all inclusive list, see ICD-10)*

Type 2 Diabetes without complications	Code
Controlled and without complications	E11.9
without complications **In Remission**	E11.A
Uncontrolled w/ hyperglycemia	E11.65
Uncontrolled w/ hypoglycemia, w/o coma	E11.649
Hypoglycemia Level 1	+E16.A1
Hypoglycemia Level 2	+E16.A2
Hypoglycemia Level 3	+E16.A3
Always code when patient on insulin	+Z79.4
Long-term use oral hypoglycemic drug	+Z79.84
LT use of injectable non-insulin antidiabetic drug	+Z79.85
T2DM with diabetic nephropathy	E11.21
T2DM w/ complication of CKD *code also stage*	E11.22
CKD stage 1 GFR >90 (Glomerular Filtration Rate)	+N18.1
CKD stage 2 GFR 60-89 (Mild)	+N18.2
CKD stage 3 Unspecified (Moderate)	+N18.30
CKD stage 3a GFR 45-59 (Moderate)	+N18.31
CKD stage 3b GFR 30-44 (Moderate)	+N18.32
CKD stage 4 GFR 15-29 (Severe)	+N18.4
CKD stage 5 GFR <15	+N18.5
End Stage Renal Disease (ESRD)	+N18.6
If the DM is not controlled, assign also	+E11.65
T2DM w/ proteinuria	E11.29
T2DM w/ microalbuminuria	R80.9
DM with complication of neurological system, specifically;	
polyneuropathy	E11.42
mononeuropathy	E11.41
gastroparesis (autonomic polyneuropathy)	E11.43
DM with unspecified neuropathy	E11.40
DM with neuropathic arthropathy	E11.610
If the DM is not in control assign *also*	+E11.65
Diabetes w/complication of circulatory system, specifically;	
DM with peripheral angiopathy, no gangrene	E11.51
DM w/peripheral angiopathy, w/ gangrene	E11.52
DM with other circulatory complication	E11.59
If the DM is not in control assign *also*	+E11.65
DM with complication of eyes, specifically:	
DM w/nonproliferative retinopathy w/o edema	E11.329-
with macular edema	E11.321-
DM w/proliferative retinopathy *see choices*	E11.351- thru E11.359-
Dash indicates must have 7th character	
DM with diabetic cataract	E11.36
DM with eye complication not listed above	E11.39
If the DM is not in control assign *also*	+E11.65
Diabetes - varied complications	
DM with; arthropathy	E11.618
dermatitis	E11.620
foot ulcer *(Code also site L97.4-, L97.5-)*	E11.621
skin ulcer *(Code also site L97.1-L98.49)*	E11.622
other skin complication	E11.628
DM with hyperosmolarity, without coma	E11.00
hyperosmolarity, with coma	E11.01
If DM is not in control assign *also*	+E11.65

Also Assign Overweight/Obesity & BMI (adult)	Code
Obesity, Class 1	**E66.811**
Overweight	**E66.3**
Code also ADULT BMI from below or PED BMI from peds sheet	
BMI 25.0 - 25.9	+Z68.25
BMI 26.0 - 26.9	+Z68.26
BMI 27.0 - 27.9	+Z68.27
BMI 28.0 - 28.9	+Z68.28
BMI 29.0 - 29.9	+Z68.29
Obesity, Class 2	**E66.812**
Obesity due to excess calories	**E66.09**
Other Obesity	E66.8
Code also ADULT BMI from below or PED BMI from peds sheet	
BMI 30.0 - 30.9	+Z68.30
BMI 31.0 - 31.9	+Z68.31
BMI 32.0 - 32.9	+Z68.32
BMI 33.0 - 33.9	+Z68.33
BMI 34.0 - 34.9	+Z68.34
BMI 35.0 - 35.9	+Z68.35
BMI 36.0 - 36.9	+Z68.36
BMI 37.0 - 37.9	+Z68.37
BMI 38.0 - 38.9	+Z68.38
BMI 39.0 - 39.9	+Z68.39
Obesity, Class 3	**E66.813**
Morbid Obesity due to excess calories	**E66.01**
Code also ADULT morbid obesity BMI from below	
BMI 40.0 - 44.9	+Z68.41
BMI 45.0 - 49.9	+Z68.42
BMI 50.0 - 59.9	+Z68.43
BMI 60.0 - 69.9	+Z68.44
BMI 70 or greater	+Z68.45
Genetic susceptibility to obesity	Z15.2
Status and History Codes	
Amputation, Below Knee, Left	Z89.512
Amputation, Below Knee, Right	Z89.511
Family history of diabetes	Z83.3
Family history of familial hypercholesterolemia	Z83.42
Diabetes in pregnancy not here - see ICD10 Category O24	

Miscellaneous Diagnoses	Code
Lab Dx: Impaired fasting glucose	R73.01
Abnormal glucose, prediabetic	R73.09
Elevated blood sugar	R73.9
Screening for diabetes mellitus	Z13.1
Metabolic syndrome	E88.81
Pre-diabetes *(borderline DM, latent DM)*	R73.03
Lipoid Disorders: Hypercholesterolemia, pure	E78.00
Homozygous familial hypercholesterolemia [HoFH]	E78.010
Heterozygous familial hypercholesterolemia [HeFH]	E78.011
Familial hypercholesterolemia, **unspecified**	E78..019
Hyperglyceridemia (very low density lipoid type)	E78.1
Mixed hyperlipidemia (combo of E78.0 & E78.1)	E78.2
Dyslipidemia/hyperlipidemia, unspecified	E78.5
Noncompliance w/treatment	Z91.19
Noncompliance w/renal dialysis	Z91.15
Underdosing of insulin and/or oral antidiabetic medication: 7th character, replace "X" with: A = Initial (active treatment phase), D = Subsequent (healing phase), S = Sequela.	T38.3X6X X= A, D, or S
Also code reason for underdosing:	
Intentional underdosing due to financial hardship	Z91.120
Intentional underdosing for other reason	Z91.128
Unintentional underdosing due to age-related debility	Z91.130
Unintentional underdosing for other reason	Z91.138

DIABETES TYPE 1 (T1DM)

Diabetes without complications	Type 1
DM controlled and without complications	E10.9
DM uncontrolled	E10.65
Diabetes with complications	**Type 1**
DM with diabetic nephropathy	E10.21
DM with complication of CKD *code also stage*	E10.22
CKD stage 1 GFR >90 (Glomerular Filtration Rate)	+N18.1
CKD stage 2 GFR 60-89 (Mild)	+N18.2
CKD stage 3 unpsecified (Moderate)	+N18.30
CKD stage 3a GFR 45-59 (Moderate)	+N18.31
CKD stage 3b GFR 30-44 (Moderate)	+N18.32
CKD stage 4 GFR 15-29 (Severe)	+N18.4
CKD stage 5 GFR <15	+N18.5
End Stage Renal Disease (ESRD)	+N18.6
If the DM is not in control assign *also*	**+E10.65**
DM with complication of neurological system, specifically;	
polyneuropathy	E10.42
mononeuropathy	E10.41
gastroparesis (autonomic polyneuropathy)	E10.43
DM with neuropathic arthropathy	E10.610
DM with any other neuro comp. not listed above	E10.40
Diabetes with complication of circulatory system, specifically;	
DM with peripheral angiopathy, no gangrene	E10.51
DM with peripheral angiopathy, with gangrene	E10.52
DM with other circulatory complication	E10.59
If the DM is not in control assign *also*	**+E10.65**
DM with complication of eyes, specifically;	
DM w/nonproliferative retinopathy w/o mac. edema	E10.329
with macular edema	E10.321
DM w/proliferative retinopathy *see choices (must have 6th & 7th characters)*	E11.351X-E11.359X
DM with diabetic cataract	E10.36
DM with eye complication not listed above	E10.39
If the DM is not in control assign *also*	**+E10.65**
Other complications	
DM with; arthropathy	E10.618
dermatitis	E10.620
foot ulcer *(Code also site L97.4-, L97.5-)*	E10.621
skin ulcer *(Code also site L97.1-L98.49)*	E10.622
other skin complication	E10.628
DM with hypoglycemia, without coma	E10.649
hypoglycemia, with coma	E10.641
DM with ketoacidosis, without coma	E10.10
ketoacidosis, with coma	E10.11
If DM is not in control assign *also*	**+E10.65**
Nicotine Dependence, Use, Exposure	
Cigarette, uncomplicated *(no related illness)*	F17.210
in remission	F17.211
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of tobacco dependence	Z87.891
Tobacco use, [no dependence] *avoid*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	

Miscellaneous Diagnoses	Type 1
Lab Dx: Impaired fasting glucose	R73.01
Abnormal glucose, not currently diabetic	R73.09
Prediabetes	R73.03
Elevated blood sugar	R73.9
Screening for diabetes mellitus	Z13.1
Lipoid Disorders: Pure hypercholesterolemia	E78.00
Homozygous familial hypercholesterolemia [HoFH]	E78.010
Heterozygous familial hypercholesterolemia [HeFH]	E78.011
Familial hypercholesterolemia, **unspecified**	E78..019
Hyperglyceridemia (very low density lipoid type)	E78.1
Mixed hyperlipidemia (combo of E78.0 & E78.1)	E78.2
Dislipidemia/hyperlipidemia, unspecified	E78.5
Noncompliance w/treatment	Z91.19
Noncompliance w/renal dialysis	Z91.15
Assign Overweight/Obesity & BMI (Adult)	
Obesity, Class 1	**E66.811**
Overweight	**E66.3**
BMI between 25.0 - 25.9 *(See pediatric BMIs on Peds sheet)*	+Z68.25
BMI between 26.0 - 26.9	+Z68.26
BMI between 27.0 - 27.9	+Z68.27
BMI between 28.0 - 28.9	+Z68.28
BMI between 29.0 - 29.9	+Z68.29
Obesity, Class 2	**E66.812**
Obesity due to excess calories	**E66.09**
BMI between 30.0-30.9 Z68.30 BMI between 35.0-35.9	Z68.35
BMI between 31.0-31.9 Z68.31 BMI between 36.0-36.9	Z68.36
BMI between 32.0-32.9 Z68.32 BMI between 37.0-37.9	Z68.37
BMI between 33.0-33.9 Z68.33 BMI between 38.9-38.9	Z68.38
BMI between 34.0-34.9 Z68.34 BMI between 39.0-39.9	Z68.39
Obesity, Class 3	**E66.813**
Morbid Obesity due to excess calories	**E66.01**
BMI between 40.0 - 44.9	+Z68.41
BMI between 45.0 - 49.9	+Z68.42
BMI between 50.0 - 59.9	+Z68.43
BMI between 60.0 - 69.9	+Z68.44
BMI 70 or greater	+Z68.45
Diabetes in pregnancy not here - see ICD10 Category O24	
Some Signs/Symptom Codes	
Blurry vision	H53.8
Excessive thirst	R63.1
Excessive eating/appetite	R63.2
Frequent urination	R35.0
Numbness in hands/feet	R20.0
Tingling in hands/feet	R20.2
Status and History Codes	
Amputation, Below Knee, Left	Z89.512
Amputation, Below Knee, Right	Z89.511
Family history of diabetes	Z83.3
Family history of familial hypercholesterolemia	Z83.42
Underdosing of insulin and/or oral antidiabetic medication: 7th character, replace "X" with: A = Initial (active treatment phase), D = Subsequent (healing phase), S = Sequela.	T38.3X6X X= A, D, or S
Also code reason for underdosing:	
Intentional underdosing due to financial hardship	Z91.120
Intentional underdosing for other reason	Z91.128
Unintentional underdosing due to age-related debility	Z91.130

Cardiovascular Conditions

Abnormal Findings	Code
Blood pressure reading low (not hypotension - see I95.X)	R03.1
Blood pressure, elevated but not HTN	R03.0
Cardiovascular function study, (e.g., ABN stress test)	R94.39
Chest x-ray/lung imaging	R91.8
Chest sounds	R09.89
Abnormal lipid finding	E75.6
Echocardiogram	R93.1
EKG (long QT syndrome I45.81)	R94.31
Abnormal Labs: Serum enzymes	R74.8
Coagulation profile	R79.1
Abnormal blood gas	R79.81
Angina	
Unspecified angina or ischemic chest pain	I20.9
Prinzmetal angina (w/documented spasm)	I20.1
Stable angina	I20.8
Unstable angina/Intermediate coronary syndrome	I20.0
Cardiac/Circulatory Signs and Symptoms	
Bradycardia	R00.1
Chest discomfort/chest pain *(See book)*	R07.89
Intercostal pain	R07.82
painful respiration	R07.1
Cough	R05
Debility, age related physical (debility)	R54
Dizziness	R42
Dyspnea, unspecified	R06.00
Periodic breathing	R06.3
Snoring	R06.83
Other forms of dyspnea	R06.09
Edema, unspecified	R60.9
Generalized edema	R60.1
Localized edema	R60.0
Falls, repeated	R29.6
Fluid overload	E87.70
Heart murmur, unspecified	R01.1
Benign and innocent cardiac murmurs	R01.0
Weakness	R53.1
Other fatigue	R53.83
Other malaise	R53.81
Nausea	R11.0
Nausea w/vomiting	R11.2
Vomiting alone	R11.11
Palpitations	R00.2
Shortness of breath	R06.02
Sleep apnea	G47.30
Syncope	R55
Tachycardia	R00.0
Family History of	
Family history of ischemic heart disease	Z82.49
Sudden cardiac death	Z82.41
Other cardiovascular conditions	Z82.49

Conduction/Rhythm Disorders	Code
Atrial fibrillation, longstanding persistent	I48.11
Atrial fibrillation, other persistent	I48.19
Atrial fibrillation, chronic, unspecified	I48.20
Atrial fibrillation, permanent	I48.21
Atrial fibrillation, paroxysmal	I48.0
Atrial flutter, typical	I48.3
Atrial flutter, atypical	I48.4
Atrial flutter, unspecified	I48.92
Anticoagulation Medication Management	
Therapeutic drug monitoring	Z51.81
Long term (current) use of anticoagulants	Z79.01
Coronary Atherosclerosis (CAD)	
of native coronary artery, without angina pectoris	I25.10
with unstable angina pectoris	I25.110
with other forms of angina pectoris	I25.118
with unspecified angina pectoris	I25.119
of coronary artery bypass graft (NOS) w/o angina	I25.810
autologous artery coronary artery bypass graft(s)	
with unstable angina pectoris	I25.720
with other forms of angina pectoris	I25.728
Chronic total occlusion of coronary artery	I25.82
Other documented forms of chronic ischemic HD	I25.89
Lipoid Disorders	
Dyslipidemia / Hyperlipidemia NOS	E78.5
Pure Hypercholesterolemia	E78.00
Homozygous familial hypercholesterolemia [HoFH]	E78.010
Heterozygous familial hypercholesterolemia [HeFH]	E78.011
Familial hypercholesterolemia, **unspecified**	E78..019
Pure hyperglyceridemia	E78.1
Mixed hyperlipidemia (combo of E78.0- & E78.1)	E78.2
Myocardial Infarction - *The most basic codes*	
MI, acute, STEMI *(acute ≤ 28 days from episode)*	I21.3
MI, acute, NSTEMI	I21.4
MI, acute, STEMI *(subsequent ≤ 28 days from initial MI)*	I22.9
MI old, by EKG/Hx, no problem now	I25.2
Cardiomyopathy	
Cardiomyopathy, ischemic	I25.5
Cardiomyopathy, Dilated	I42.0
Cardiomyopathy, unspecified *(See other I42 choices)*	I42.9
Cardiac/Circ. Status Codes, Hx & Screening	
Cardiac defibrillator in situ	Z95.810
Cardiac pacemaker in situ	Z95.0
Heart valve replacement (mechanical)	Z95.2
Heart valve replacement (tissue)	Z95.3
Screening for	
Lipids	Z13.220
Anemia	Z13.0
Cardiovascular disorder *Including Hypertension*	Z13.6
Ischemic heart condition	
Malformation, congenital	Z13.89

Cardiovascular Conditions

Nicotine Dependence and Exposure	Code
Cigarette, uncomplicated *(no related illness)*	F17.210
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of tobacco dependence	Z87.891
Tobacco use, *[no dependence]* *avoid*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	

Personal History of	Code
CABG	Z95.1
PCI (angioplasty w/ implant)	Z95.5
Coronary angioplasty (only) status	Z98.61
CVA/TIA	Z86.73
DVT	Z86.718
Corrected congenital mal. heart/circ system	Z87.74
Pulmonary embolism	Z86.711
Smoking	Z87.891
Sudden cardiac arrest	Z86.74
Surgery to heart and great vessels	Z98.890

HYPERTENSION, HEART DISEASE, AND RENAL DISEASE

I10 Hypertension without HD or CKD	**Code**	**Elevated blood pressure** *(not hypertension)*	**Code**
I10 Hypertension (HTN), essential hypertension	I10	Elevated blood pressure	R03.0
I11 Hypertensive Heart Disease (HHD) ***When HTN & HD exist together, use HHD codes below & I50 code if heart failure exists***			
Hypertensive Heart Disease incudes: *Heart Failure (I50.-), Myocarditis (I51.4), Myocardial degeneration (I51.5), Cardiomegaly (I51.7), Other ill-defined heart disease, e.g. Carditis, Pancarditis (I51.89) or Unspecified heart disease (I51.9).*			
HHD **with** heart failure (HF) *Code also HF from [I50]*	I11.0	HHD **without** heart failure (HF)	I11.9
Heart Failure (I50) Specificity Options			
Left heart failure, CHF and Other heart failure		***Right heart failure***	
Left heart failure	I50.1	Right heart failure, unspecified	I50.810
End stage heart failure *(Code also heart failure, I50.2-I50.43*	I50.84	Acute right heart failure	I50.811
Other heart failure	I50.89	Chronic right heart failure	I50.812
Biventricular heart failure	I50.82	Acute on chronic right heart failure	I50.813
High output heart failure	I50.83	Right heart failure due to left heart failure	I50.814
Congestive heart failure *(CHF, unspecified)* *Avoid*	I50.9		
Diastolic heart failure		***Systolic heart failure***	
Chronic diastolic heart failure	I50.32	Chronic systolic heart failure	I50.22
Acute diastolic heart failure	I50.31	Acute systolic heart failure	I50.21
Acute on chronic diastolic heart failure	I50.33	Acute on chronic systolic heart failure	I50.23
Combined systolic and diastolic heart failure			
Chronic systolic and diastolic heart failure	I50.42		
Acute systolic and diastolic heart failure	I50.41		
Acute on chronic systolic and diastolic heart failure	I50.43		
I12 Hypertensive Chronic Kidney Disease (HCKD) ***When HTN & CKD exist together, use HCKD codes below & N18 code***			
HCKD w/stage 1-4 CKD or stage unspecified	I12.9	HCKD with stage 5 CKD or end stage (ESRD)	I12.0
N18 Chronic Kidney Disease-*Report stage w/HCKD above. Note: GFRs per National Kidney Foundation, 2017.*			
CKD stage 1 *GFR 90 or higher* (Glomerular Filtration Rat	N18.1	CKD stage 4 *GFR 15-29*	N18.4
CKD stage 2 *GFR 60-89*	N18.2	CKD stage 5 *GFR <15*	N18.5
CKD stage 3 unpsecified	N18.30	End stage renal disease (ESRD)	N18.6
CKD stage 3a GFR 45-59	N18.31	CKD w/o stage documented in medical record	N18.9
CKD stage 3b GFR 30-44	N18.32	Dependence on renal dialysis	Z99.2
I13 Hypertensive Heart Disease (HHD) and Chronic Kidney Disease (HCKD) ***(1) When HTN, HD & CKD exist together, use appropriate code I13 below (2) Report also the stage of CKD from above. (3) If heart failure exists, report the type of failure from I50 above.***			
HHD w/CKD, stage 1-4 or undoc., code I13, If HF add I50 code.		***HHD with CKD, stage 5 or ESRD, code I13, if HF add I50 code.***	
with heart failure *(code also the failure from I50)*	I13.0	with heart failure *(code also the failure from I50)*	I13.2
without heart failure	I13.10	without heart failure	I13.11
I16 Hypertensive Crisis. ***Code also any identified hypertensive disease (I10-I15)***			
According to the American Heart Association: **Hypertensive urgency (I16.0)** occurs when systolic blood pressure exceeds 180, or diastolic exceeding 110, without progressive organ dysfunction. **Hypertensive emergency (I16.1)** occurs when levels exceed 180 systolic or 120 diastolic, with impending or progressive organ damage. Also document any consequences of the uncontrolled pressure.			
Hypertensive urgency	I16.0	Hypertensive emergency	I16.1
Underdosing of Antihypertensive Drugs *(common drugs listed below, check a current code book for other choices)*			
In ICD10CM, Underdosing refers to taking less of a medication than is prescribed by a provider or manufacturer's instruction. Discontinuing the use of a RX on the patient's own initiative...is also classified as underdosing.			
ACE Inhibitors (e.g. Lisinopril, Lotensin, Zesteril)	T46.4x6**X**	Beta Blockers (e.g. Lopressor, Atenolol, Metoprolol)	T44.7x6**X**
Diuretics/thiazides (e.g. HCTZ)	T50.2x6**X**	Calcium Channel Blocker (e.g. Cardizem, Procardia)	T46.1x6**X**
7th character code, replace "X" with A, D or S: A = initial (active treatment phase) or D = Subsequent (healing phase) or S = Sequela			
Also code reason for underdosing:			
Intentional underdosing due to financial hardship	Z91.120	Intentional underdosing for other reason	Z91.128
Unintentional underdosing due to age-related debility	Z91.130	Unintentional underdosing for other reason	Z91.138
Always Code nicotine/tobacco status (F17 OR ZXX) with Hypertension			
Tobacco, nicotine dependence *(cigarette)*	F17.210	**Exposure, tobacco smoke;** second-hand, environmental	Z77.22
in remission	F17.211	occupational exposure	Z57.31
with withdrawal	F17.213	**History of nicotine dependence/tobacco use**	Z87.891
with other nicotine-induced disorder	F17.218	**Vaping-related disorder**	U07.0
		Use additional code(s) to identify manifestations of vaping-related disorders	

RESPIRATORY CONDITIONS

Bronchitis J20 & J44	Code
Bronchitis, acute; *organism unknown*	J20.9
Organism known, *but no code exists it.*	J20.8
Bronchitis, acute; *choose based on organism*	
mycoplasma pneumonia	J20.0
hemophilus influenzae	J20.1
streptococcus	J20.2
coxsackievirus	J20.3
parainfluenza virus	J20.4
respiratory syncytial virus (RSV)	J20.5
rhinovirus	J20.6
echovirus	J20.7
Bronchitis, (acute) w/COPD *codes to COPD*	J44.0
Bronchitis, chronic; *choose from below*	
simple and chronic	J41.0
obstructive ***without*** exacerbation	J44.9
obstructive ***with*** (acute) exacerbation	J44.1
mucopurulent	J41.1
mixed simple & mucopurulent	J41.8
with (acute) lower resp infection *(code also infection)*	J44.0
with acute exacerbation of asthma	J44.1
COPD J44	
Chronic Obstructive Pulmonary Disease	J44.9
with acute exacerbation	J44.1
with (acute) lower resp infection (code also infection)	J44.0
with asthma *(code also Asthma type J45-)*	J44.9
with asthma exacerbation *(code also asthma)*	J44.1

Asthma J45	Code
Asthma, if chronic obstructive, *see COPD w/asthma left column*	
Asthma, mild & intermittent	
uncomplicated	J45.20
with acute exacerbation	J45.21
with status asthmaticus	J45.22
Asthma, mild & persistent	
uncomplicated	J45.30
with acute exacerbation	J45.31
with status asthmaticus	J45.32
Asthma, moderate & persistent	
uncomplicated	J45.40
with acute exacerbation	J45.41
with status asthmaticus	J45.42
Asthma, severe & persistent	
uncomplicated	J45.50
with acute exacerbation	J45.51
with status asthmaticus	J45.52
Asthma, severity not stated	J45.909
with acute exacerbation	J45.901
with status asthmaticus	J45.902
Asthma, exercise induced	J45.990
Asthma, cough variant	J45.991
Family hx asthma/lower resp disease	Z82.5
EMR ICD-10 Search Tips *: Search Asthma* ***by severity*** *(e.g., mild, moderate or severe);* ***then by quality*** *(e.g., intermittent or persistent);* ***then today's status*** *(uncomplicated, exacerbation or asthmaticus).*	

Always Code Tobacco Status F17 and ZXX

Tobacco, nicotine dependence *(cigarette)*	F17.210
in remission	F17.211
with withdrawal	F17.213
with other nicotine-induced disorder	F17.218

Exposure, tobacco smoke; second-hand, environmental	Z77.22
occupational exposure	Z57.31
History of nicotine dependence/tobacco use	Z87.891
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	

Pneumonia J12, J14, J15 & J18	
Pneumonia, no organism specified	J18.9
Pneumonia, viral, *choose from below -*	
adenovirus	J12.0
respiratory syncytial virus (RSV)	J12.1
parainfluenza virus	J12.2
SARS-associated coronavirus	J12.81
viral, unspecified	J12.9
Pneumonia, bacterial, *organism unspecified*	J15.9
Pneumonia, bacterial, *choose from below -*	
hemophilus influenzae	J14
pseudomonas	J15.1
staphylococcus	J15.20
streptococcus, Group A	J15.4
streptococcus, other than Group A	J15.4
anaerobes	J15.8
E.coli (Escherichia coli)	J15.5
other gram-negative bacteria	J15.6-
bacteria, other than above	J15.8
Pneumonia, MRSA	J15.212
Pneumonia, MSSA	J15.211
Pneumonia, idiopathic, interstitial	J84.111
Emphysema J43	
Emphysema, unilateral pulmonary	J43.0
panlobular emphysema	J43.1
centrilobular emphysema	J43.2
other emphysema, *not listed here*	J43.8
unspecified, *(when documentation does not identify)*	J43.9
COVID-19	
COVID-19	U07.1

Respiratory S/S, Status & Hx Codes	
Abnormal; chest sounds/rales	R09.89
x-ray of lung	R91.8
pulmonary function studies	R94.2
Bronchospasm, acute	J98.01
Chest pain on breathing	R07.1
Cough (chronic) *(if smoker's cough, use J41.0)*	R05
Cyanosis	R23.0
Dyspnea / respiratory distress	R06.00
Fatigue, lethargy, or decreased energy	R53.83
Fever	R50.9
Hyperventilation	R06.4
Hypoxia or Hypoxemia	R09.02
Oxygen dependence *(supplemental)*	Z99.81
Pleural effusion	J90
Respiratory; insufficiency	R06.89
Shortness of breath	R06.02
Sputum, abnormal/excessive	R09.3
Stridor	R06.1
Tightness, chest	R07.89
URI	J06.9
Wheezing	R06.2
Status codes (assign when present)	
Tracheostomy, status	Z93.0
Lung transplant status	Z94.2
Personal history of;	
recurrent pneumonia	Z87.01
other respiratory diseases	Z87.09

COVID-19

COVID-19	Code
COVID-19 infection *(confirmed cases only)*	U07.1
Also code associated manifestions	
Encounter for screening for COVID-19	Z11.52
Contact with & (suspected) exposure to COVID-19	Z20.822
Personal history of COVID-19	Z86.16
Multisystem inflammatory syndrome	M35.81
COVID-19 assiciated coagulopathy	D68.8
Other spec systemic involvement of connective tissue	M35.89
Pneumonia due to coronavirus disease 2019	J12.82
Signs/Symptoms with no COVID-19 Diagnosis	
Acute Cough	R05.1
Shortness of breath	R06.02
Fever, unspecified	R50.9
and other signs/symptoms as appropriate	
Pregnancy	
COVID-19 is reason for encounter (first listed)	O98.5-
Also code COVID-19 infection	U07.1
ICD-10 Guidelines: I.C.15.s, see attached	
Newborn	
COVID-19 infection *(confirmed cases only)*	U07.1
Also code associated manifestions	
COVID-19 contracted in utero or during birth process	P35.8
ICD-10 Guidelines: I.C.16.h	
Antibody Testing	
Encounter for antibody response examination	Z01.84
Other COVID-related diagnoses	
Post COVID-19 condition, unspecified	U09.9
Includes Long COVID and Post-acute sequela of COVID-19	
Code first specific condition related to COVID-19, such as:	
chronic respiratory failure	J96.1-
loss of smell	R43.8
loss of taste	R43.8
multi-system inflammatory syndrome	M35.81
pulmonary embolism	I26.-
pulmonary fibrosis	J84.10
Follow up evaluation after COVID-19 resolved (neg t	Z09
+Personal history of COVID-19	Z86.19

See ICD10CM guidelines section 1.C.g.1 for information of diagnosis reporting for COVID19

Report Nicotine influence with Respiratory conditions : ie, Current cigarette smoker F17.210. See page 18 for other nicotine coding options.

COVID-19 Vaccine and Administration CPT Codes	Code
Immunization Admin, any COVID-19 vaccination product	90480
Novovax Product Code:	
5mcg/0.5mL dose, 12 years and older	91304
Pfizer Produc Codes:	
3mcg/0.2mL dose, ages 6 months through 4 years	91318
10mcg/0.2mL dose, ages 5-11 years	91319
30mcg/0.3mL dose, ages 12 years and older	91320
Moderna Produc Codes:	
25mcg/0.25mL dose, ages 6 months through 11 years	91321
50mcg/0.5mL dose, ages 12 years and older	91322
COVID-19 Vaccine ICD-10 Codes	
Encounter for immz safety counseling *(also code one below)*	Z71.85
Encounter for immunization *(administration today)*	Z23
Vaccine not given d/t Patient's refusal	Z28.21
Vaccine not given d/t Patient's decision for other reason	Z28.29
Vaccine not given d/t caregiver refusal	Z28.82
Vaccine not given d/t unavailability of vaccine	**Z28.83**
Vaccine not given for other reason	Z28.89
Underimmunization Status	
Unvaccinated for COVID-19	Z28.310
Partially vaccinated for COVID-19	Z28.311
Other underimmunized status (lapsed/delinquent schedule)	Z28.39
Exposure to COVID-19	
Contact with & (suspected) exposure to other viral communicable diseases	Z20.822

WEIGHT MANAGEMENT

Weight Dx (Adult/Child) *Code also, Adult or Peds BMI*	Code
Abnormal weight gain	R63.5
Obesity complicating pregnancy	O99.21-
Drug-induced obesity	E66.1
Obesity, Class 1	**E66.811**
Overweight	**E66.3**
Code also ADULT BMI from below or PED BMI from right	
BMI 25.0 - 25.9	+Z68.25
BMI 26.0 - 26.9	+Z68.26
BMI 27.0 - 27.9	+Z68.27
BMI 28.0 - 28.9	+Z68.28
BMI 29.0 - 29.9	+Z68.29
Obesity, Class 2	**E66.812**
Obesity due to excess calories	**E66.09**
Other Obesity	E66.8
Code also ADULT BMI from below or PED BMI from right	
BMI 30.0 - 30.9	+Z68.30
BMI 31.0 - 31.9	+Z68.31
BMI 32.0 - 32.9	+Z68.32
BMI 33.0 - 33.9	+Z68.33
BMI 34.0 - 34.9	+Z68.34
BMI 35.0 - 35.9	+Z68.35
BMI 36.0 - 36.9	+Z68.36
BMI 37.0 - 37.9	+Z68.37
BMI 38.0 - 38.9	+Z68.38
BMI 39.0 - 39.9	+Z68.39
Obesity, Class 3	**E66.813**
Morbid Obesity due to excess calories	**E66.01**
Code also ADULT morbid obesity BMI from below	
BMI 40.0 - 44.9	+Z68.41
BMI 45.0 - 49.9	+Z68.42
BMI 50.0 - 59.9	+Z68.43
BMI 60.0 - 69.9	+Z68.44
BMI 70 or greater	+Z68.45
Genetic susceptibility to obesity	Z15.2
Underweight	**R63.6**
BMI of 19.9 or less, adult	+Z68.1
Malnutrition	**E40-E46**
Unspecified protein-calorie malnutrition	E46
Malnutrition; Protein-calorie, mild	E44.1
Malnutrition; Protein-calorie, moderate	E44.0
Malnutrition; Protein-calorie, severe	E43
Nutritional marasmus *(severe)*	E41
Kwashiorkor *(rare in US)*	E40

Pediatric BMI *Code type from the left & BMI from the right.*			Code
Overweight	E66.3	85th to < 95th percentile for age	+Z68.53
Obese	E66.9	= / > 95th percentile for age	+Z68.54
Underweight	R63.6	< 5th percentile for age	+Z68.51

Underweight Conditions (code also BMI)	
Abnormal weight loss	R63.4
Failure to thrive, child *(Faultering growth)*	R62.51
Failure to thrive, adult	R62.7
Physical growth retardation	R62.52
due to malnutrition	E45
Anorexia (*appetite loss, excludes anorexia nervosa F50.0-)*	R63.0
Other Miscellaneous Dx	
Inappropriate diet/eating habits	Z72.4
Inadequate diet *causing nutritional deficiency*	E63.9
Polyphagia (excessive eating)	R63.2
Here to discuss test findings	Z71.2
Dietary counseling and surveillance	Z71.3
Use additional code for associated condition	
Lack of physical exercise	Z72.3
Worried well *(concerns, but no problem)*	Z71.1
Deficiencies, Vitamins	
Vitamin A	E50.-
Thiamine	E51.-
Niacin	E52
Folate (folic acid)	E53.8
Vitamin C	E54
Vitamin D	E55.9
Vitamin E	E56.0
Vitamin K	E56.1
Deficiencies, Elements	
Calcium	E58
Zinc	E60
Other	E61.-
Starvation	
Initial visit	T73.0xxA
FU visit	T73.0xxD
Visit for sequela *(code also the condition)*	T73.0xxS

PREGNANCY

Supervision Normal Pregnancy

Assign *Supervision Normal Pregnancy* if no complications or risk factors exist. Code Z34 codes **may not** be reported with other pregnancy codes.

	Root	* Trimeste		
First normal pregnancy	Z34.0*	1	2	3
Subsequent normal pregnancy	Z34.8*	1	2	3
Routine postpartum follow-up visit	Z39.2			
Pregnancy state, incidental	Z33.1			

Assign gestational weeks for all visits

<8 weeks	Z3A.01	26 weeks	Z3A.26
8 weeks	Z3A.08	27 weeks	Z3A.27
9 weeks	Z3A.09	28 weeks	Z3A.28
10 weeks	Z3A.10	29 weeks	Z3A.29
11 weeks	Z3A.11	30 weeks	Z3A.30
12 weeks	Z3A.12	31 weeks	Z3A.31
13 weeks	Z3A.13	32 weeks	Z3A.32
14 weeks	Z3A.14	33 weeks	Z3A.33
15 weeks	Z3A.15	34 weeks	Z3A.34
16 weeks	Z3A.16	35 weeks	Z3A.35
17 weeks	Z3A.17	36 weeks	Z3A.36
18 weeks	Z3A.18	37 weeks	Z3A.37
19 weeks	Z3A.19	38 weeks	Z3A.38
20 weeks	Z3A.20	39 weeks	Z3A.39
21 weeks	Z3A.21	40 weeks	Z3A.40
22 weeks	Z3A.22	41 weeks	Z3A.41
23 weeks	Z3A.23	42 weeks	Z3A.42
24 weeks	Z3A.24	> 42 weeks	Z3A.49
25 weeks	Z3A.25	Unspecified	Z3A.00

Supervision of High Risk Pregnancy

Assign High Risk Pregnancy codes when:
(1) Patient had a problem in previous pregnancy or,
(2) has had a condition that may complicate this pregnancy or,
(3) has other factors that increase risk in current pregnancy.
* May code high risk w/O00-O08, but not for same condition.
* Do not code high risk O09.xx codes with Z34.xx codes.

→ ***Replace the * with trimester 1, 2 or 3***

	Root	*		
High risk due to; insufficient antenatal care	O09.3*	1	2	3
history of pre-term labor	O09.21*	1	2	3
history of infertility	O09.0*	1	2	3
history of ectopic pregnancy	O09.1*	1	2	3
history of molar pregnancy	O09.A*	1	2	3
current social problems;	O09.7*	1	2	3
elderly primigravida age =/> 35@ delivery	O09.51*	1	2	3
elderly multigravada age =/> 35 @ delivery	O09.52*	1	2	3
young primigravida age< 16 @ delivery	O09.61*	1	2	3
young multigravida age< 16 @ delivery	O09.62*	1	2	3
poor OB Hx, or poor reproductive Hx	O09.29*	1	2	3
other documented reason for high risk	O09.89*	1	2	3

Complications of Pregnancy

Anemia *Assign also code for type of anemia*	O99.01*	1	2	3
UTI in pregnancy	O23.4*	1	2	3
Bladder infection during pregnancy	O23.1*	1	2	3
Kidney infection during pregnancy	O23.0*	1	2	3
Vomiting, mild, before end of 20 weeks	O21.0			
Vomiting after 20 weeks *(excessive vomiting)*	O21.2			

Obesity, Weight & Malnutrition

Obesity *Also report specific type of obesity E66.-*	O99.21*	1	2	3
Weight gain, excessive	O26.0*	1	2	3
Weight gain, low/inadequate	O26.1*	1	2	3
Malnutrition in pregnancy	O25.1*	1	2	3

More Complications of Pregnancy

Bleeding, TA, Preterm & Post Dates	Root	* Trimeste		
Spotting, *Not hemorrhage*	O26.85*	1	2	3
Hemorrhage (other) in early pregnancy	O20.8			
Threatened abortion	O20.0			
Preterm labor without delivery	O60.0*		2	3
False labor before 37 weeks	O47.0*		2	3
Post term pregnancy >40 wks to 42 wks	O48.0			
beyond 42 weeks	O48.1			

Other Complications

Miscarriage/SAB w/o comp; Incomplete	O03.4			
Miscarriage/SAB w/o comp; Complete	O03.9			
Missed abortion	O02.1			
Placenta previa w/o hemorrhage	O44.0*	1	2	3
Placenta previa with hemorrhage	O44.1*	1	2	3
HTN, pre-existing	O10.01*	1	2	3
HTN, gestational w/o significant proteinuria	O13.*	1	2	3
Pre-eclampsia, mild to moderate	O14.0*		2	3
Pre-eclampsia, severe	O14.1*		2	3
HELLP syndrome	O14.2*		2	3
Eclampsia	O15.0*		2	3
Edema, Gestational	O12.0*	1	2	3
Proteinuria, Gestational	O12.1*	1	2	3
Edema & proteinuria, Gestational	O12.2*	1	2	3
Abnormal GTT in pregnancy	O99.810			
GBS carrier in pregnancy	O99.820			
Uterine size date discrepancy	O26.84*	1	2	3

Pre-existing Diabetes

DM2, pre-existing	O24.11*	1	2	3
DM2, pre-existing, postpartum/puerperium	O24.13			
Add code for all DM2's on insulin	Z79.4			
DM1, pre-existing	O24.01*	1	2	3
DM1, pre-existing, postpartum/puerperium	O24.03			

Gestational Diabetes

diet controlled, antepartum	O24.410
insulin controlled, antepartum	O24.414
oral hypoglycemic controlled, antepartum	O24.415
diet controlled, puerperium	O24.430
insulin controlled, puerperium	O24.434
hypoglycemic med controlled, puerperium	O24.435
History of Gestational Diabetes	**Z86.32**

Smoking *Assign also F17.- code below to identify type of nicotine*

Smoking tobacco, antepartum	O99.33*	1	2	3
Smoking tobacco, puerperium	O99.335			

Nicotine Dependence, Exposure, History & Use

Cigarette dependence, uncomp *(no related illness)*	F17.210
Cigarette dependence, in remission	F17.211
Cigarette dependence with withdrawal	F17.213
Vapor/Other tobacco product, dependence	F17.290
Exposure-environmental tobacco smoke	Z77.22
Personal history of nicotine dependence	Z87.891
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorder	

Alcohol & Drug Use *Assign also codes re: abuse/dependence*

Alcohol use in pregnancy *Assign also F10 -*	O99.31*	1	2	3
Drug use in pregnancy *Assign F11-F19 code*	O99.32*	1	2	3

Mental Disorders

Assign this code plus a code for the specific condition. See F20-F99.	O99.34*	1	2	3
Anxiety, generalized	F41.1			
Bipolar, unspec (more options avail.)	F31.9			

FAMILY PLANNING AND STIs

Family Planning/Contraception	Code
INITIAL CONTRACEPTION - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.011
Injectable contraceptive	Z30.013
IUD prescribed but no insertion today	Z30.014
IUD insertion today	Z30.430
Vaginal ring hormone	Z30.015
Transdermal patch hormone	Z30.016
Implantable subdermal	Z30.017
Other method (other than above; e.g. Condoms)	Z30.018
EC Emergency contraception	Z30.012
Follow-Up Contraception - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.41
Injectable contraceptive	Z30.42
IUD: insertion today	Z30.430
Interim **Follow-up**/Routine checking	Z30.431
Removal of IUD only today	Z30.432
Removal and reinsertion of IUD	Z30.433
Vaginal ring hormone	Z30.44
Transdermal patch hormone	Z30.45
Implantable subdermal	Z30.46
Other method (other than above; e.g. Condoms)	Z30.49
EC Emergency contraception	Z30.012
Preventive Examinations	
ANNUAL, COMPLETE: *no abnormal findings*	Z00.00
with abnormal findings today, *(code also)*	Z00.01
If cervical pap today, code also	Z12.4
GYN EX ONLY: *no abnormal findings*	Z01.419
with abnormal findings today, *(code also)*	Z01.411
Screening (Patient w/o signs/symptoms)	
Pregnancy test today - negative	Z32.02
Positive results today	Z32.01
Results cannot be confirmed today	Z32.00
Anemia, iron deficiency	Z13.0
Breast cancer screening exam only today	Z12.39
Breast - ordering mammogram today	Z12.31
Chlamydial infection screening	Z11.8
HIV (screening for)	Z11.4
HPV (screening for)	Z11.51
Screening Other STD/STI	Z11.3
Urinary Concerns	
Cystitis, acute w/o hematuria	N30.00
with hematuria	N30.01
Dysuria	R30.0
Hematuria, gross	R31.0
Hematuria, microscopic - benign	R31.1
Asymptomatic microscopic hematuria	R31.21
Other microscopic hematuria	R31.29
Stress incontinence, female	N39.3
Urethritis, unspecified	N34.1
Urinary frequency	R35.0
Urinary hesitancy	R39.11
Poor urinary stream	R39.12
Urinary straining	R39.16
Urinary urgency	R39.15
UTI (urinary tract infection) *(ID organism)*	N39.0

Female GYN Signs/Symptoms	Code
Amenorrhea, unspecified	N91.2
Cervicitis, unspecified organism	N72
DUB, unspecified	N93.8
Dysmenorrhea *cramps/pain*	N94.6
Dyspareunia, superficial *painful intercourse*	N94.11
Dyspareunia, deep	N94.12
Dypareunia, other specified	N94.19
Irregular menstrual cycle	N92.6
Leukorrhea *DC not confirmed infection*	N89.8
Menorrhagia	N92.0
Metrorrhagia / *break through bleed*	N92.1
Oligomenorrhea *infrequent/light*	N91.5
Pain, abdominal generalized	R10.84
Pelvic and perineal pain unspecified side	R10.20
Pelvic and perineal pain right side	R10.21
Pelvic and perineal pain left side	R10.22
Pelvic and perineal pain bilateral	R10.23
Suprapubic Pain	R10.24
Pain localized to other parts of lower abdomen	R10.3
Premenstrual tension syndrome	N94.3
Vaginal discharge	N89.8
Vaginitis, bacterial *Organism known? See below or ICD10*	N76.0
Vaginitis, yeast *Candidiasis*	B37.3
Vaginitis, acute *Organism known? see below or ICD10*	N76.0
Lesions	
Herpetic ulceration vulva	A60.04
Warts, anogenital (veneral) *C. acuminatum*	A63.0
Conditions Reserved for Males	
Painful coitus or ejaculation, male	N53.12
Benign cyst of testis	N44.2
Erectile dysfunction, organic	N52.9
Hematospermia	R36.1
Herpesviral infection: penis	A60.01
Balanitis (*Add Code - infectious agent: B95-B97)*	N48.1
Orchitis	N45.2
Epididymitis	N45.1
Epididymo-orchitis	N45.3
Penile discharge	R36.9
Prostatitis, acute	N41.0
Stress incontinence, male	N39.3
Varicocele of scrotum	I86.1
Uretheritis, nonspecific	N34.1
Syphilis	
Primary, genital	A51.0
Primary, anal	A51.1
Primary, other sites	A51.2
Infections- By Organism & Anatomy	
Candidiasis, vulvovaginitis or thrush Female	B37.3
Cystitis and urethritis Female/Male	B37.41
Chlamydial Infection, vulvovaginitis FE	A56.02
Cystitis and urethritis FE/M	A56.01
Cervicitis FE	A56.09
Anus and rectum FE/M	A56.3
Lower GU tract, anatomy unspecified FE/M	A56.00
Other chlamydial infect. (eg, epididymitis/orchitis) FE/M	A56.19
Gonorrheal Infection, vulvovaginitis	A54.02
Cystitis and urethritis Female/Male	A54.01
Cervicitis FE	A54.03
Anus FE/M	A54.6
Lower GU tract, anatomy unspecified FE/M	A54.00

FAMILY PLANNING AND STIs

Infections- By Organism & Anatomy - Cont.	Code
Herpesviral, anogenital [h simplex] vaginitis FE	A60.04
Cervicitis FE	A60.03
Perianal skin and rectum FE/M	A60.1
Penis M	A60.01
Male genital organs, other than penis M	A60.02
Herpes, urogenic, unspecified FE/M	A60.00
Hepatitis A, acute	B15.9
Hepatitis B, acute	B16.9
Hepatitis C, chronic	B18.2
HIV *positive & asymptomatic* *(not AIDS)*	Z21
HIV/AIDS	B20
HPV, *Human papillomavirus*	A63.0
Trichomoniasis Infection, vulvovaginitis FE	A59.01
Cystitis and urethritis FE/M	A59.03
Cervicitis FE	A59.09
PID, acute *pelvic inflammatory disease*	N73.0
PID, chronic	N73.1
Nicotine Dependence vs. Tobacco Use & Exposure	
Cigarette, uncomplicated *(no related illness)*	F17.210
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of tobacco dependence	Z87.891
Tobacco use, [no dependence] *avoid*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Counseling	
Counseling re: STI/STD	Z71.89
Counseling re: HIV *negative or positive*	Z71.7
Exposure as a Dx	
Infection, primarily sexual transmission	Z20.2
HIV, *exposure to*	Z20.6
History Of	
Personal hx of infection (e.g., STD)	Z86.19
Procreation Dx	
Procreative counseling	Z31.69
using natural family planning	Z31.61
Infertility, female NOS	N97.9
Infertility, male NOS	N46.9

Risk Issues *(carrier/suspected carrier)*	Code
GC carrier or suspected carrier	Z22.4
STI/STD carrier/suspected carrier	Z22.4
Hepatitis B, chronic, viral; carrier	B18.1
Hepatitis C, chronic, viral;carrier	B18.2
High risk sexual behavior	
Heterosexual	Z72.51
Bisexual	Z72.53
Homosexual	Z72.52
Social Issues as an Add'l Dx	
Homelessness, sheltered	Z59.01
Homelessness, unsheltered	Z59.02
Inadequate housing	Z59.1
Lack of adequate food and drinking water	Z59.4
Extreme poverty	Z59.5
Low income	Z59.6
Insufficient social ins and welfare support	Z59.7
Child in welfare custody (foster care)	Z62.21
Institutional upbringing	Z62.22
Other upbringing away from parents	Z62.29
Problems in relationship w/spouse/partner	Z63.0
Physical Abuse Dx Codes	
Replace dash (-) with; *A = initial (active tx); D = FU (healing); or S = sequela*	
Suspected abuse; physical abuse of an adult	T76.11X-
sexual abuse of adult	T76.21X-
physical abuse of a child	T76.12X-
sexual abuse of a child	T76.22X-
Confirmed abuse; physical abuse of adult	T74.11X-
sexual abuse of adult	T74.21X-
physical abuse of a child	T74.12X-
sexual abuse of a child	T74.22X-
Abuse (physical) of adult has now been ruled-out	Z04.71
Abuse (physical) of child has now been ruled-out	Z04.72
Underdosing of Prescribed Medication by Patient	
Code first, underdosing of medication (T36-T50) with fifth or sixth character of "6", then code intent and reason (below)	
Replace dash (-) with; *A = initial (active tx); D = FU (healing); or S = sequela*	
1. Underdosing, oral contraceptives See ICD for other meds	T38.4X6-
2. Then code also intent and reason from below.	
INTENTIONAL underdosing of med(s) by patient;	
due to financial hardship	Z91.120
for any other reason	Z91.128
UNINTENTIONAL underdosing of med(s) by pt;	
due to age-related debility	Z91.130
for any other reason	Z91.138

PEDIATRIC CONDITIONS

Preventive Visits *(Primary-only dxs)*	Code
Routine infant or child check	Z00.129
with abnormal findings *(code findings)*	Z00.121
Newborn < 8 days old *(e.g., weight/color check)*	Z00.110
8-28 days old	Z00.111
Exam of the ears and hearing *(normal exam)*	Z01.10
following failed hearing screening	Z01.110
with other abnormal findings *(code findings)*	Z01.118
Exam of the eyes/vision *(normal exam)*	Z01.00
with abnormal findings *(code findings)*	Z01.01
Sports physical	Z02.5
Adoption exam	Z02.82
Screenings	
Screening; unspecified developmental delays	Z13.40
autism	Z13.41
for global developmental delays (milestones)	Z13.42
for other developmental delays	Z13.49
Immunizations	
Encounter for immunizations	Z23
Immunization not carried; caregiver refusal	Z28.82
Encounter for prophylactic immunotherapy for RSV	Z29.11
Otitis and Other Ear Infections	
OM, nonsuppurative, serous & acute; RIGHT	H65.01
left ear	H65.02
bilateral	H65.03
recurrent right ear	H65.04
recurrent left ear	H65.05
recurrent bilateral	H65.06
OM, nonsuppurative, serous & CHRONIC; RIGHT	H65.21
left ear	H65.22
bilateral	H65.23
OM, suppurative & acute & TM intact RIGHT	H66.001
left ear	H66.002
bilateral	H66.003
recurrent right ear	H66.004
recurrent left ear	H66.005
recurrent bilateral	H66.006
OM, suppurative & acute TM rupture, RIGHT	H66.011
left ear	H66.012
bilateral	H66.013
recurrent right ear	H66.014
recurrent left ear	H66.015
recurrent bilateral	H66.016
OM, suppurative, tubotympanic, chronic, RIGHT	H66.11
left ear	H66.12
bilateral	H66.13
Otitis externa, acute Right ear	H60.501
left ear	H60.502
bilateral	H60.503
Otitis externa, chronic Right ear	H60.61
left ear	H60.62
bilateral	H60.63

ADHD	Code
predominately inattentive type	F90.0
predominately hyperactive type	F90.1
combined	F90.2
Asthma	**Code**
Asthma, mild & intermittent	
uncomplicated	J45.20
with acute exacerbation	J45.21
with status asthmaticus	J45.22
Asthma, mild & persistent	
uncomplicated	J45.30
w/acute exacerbation	J45.31
with status asthmaticus	J45.32
Asthma, moderate & persistent	
uncomplicated	J45.40
with acute exacerbation	J45.41
with status asthmaticus	J45.42
Asthma, severe & persistent	
uncomplicated	J45.50
with acute exacerbation	J45.51
with status asthmaticus	J45.52
Asthma, severity not stated	J45.909
with acute exacerbation	J45.901
with status asthmaticus	J45.902
Asthma, exercise induced	J45.990
Asthma, cough variant	J45.991
Family history of asthma	Z82.5
Conjunctivitis	
Conjunctivitis, mucopurulent	H10.9
Acute Follicular	
right eye	H10.011
left eye	H10.012
bilateral	H10.013
Other mucopurulent	
right eye	H10.021
left eye	H10.022
bilateral	H10.023
Acute atopic	
right eye	H10.11
left eye	H10.12
bilateral	H10.13
Serous, except viral	
right eye	H10.231
left eye	H10.232
bilateral	H10.233
Viral	B30.9
Sprain ***7th character - A=initial, D=subsequent, S=sequela***	
RIGHT ankle, unspecified ligament	S93.401-
LEFT ankle, unspecified ligament	S93.402-
RIGHT ankle, deltoid ligament	S93.421-
LEFT ankle, deltoid ligament	S93.422-

PEDIATRIC CONDITIONS

Major Depressive Disorder *See DSM5TR pg. 214*	
MDD, single episode, mild	F32.0
MDD, single episode, moderate	F32.1
MDD, single episode, severe w/o psychotic feat.	F32.2
MDD, single episode, severe w/psychotic feat.	F32.3
MDD, single episode, in partial remission	F32.4
MDD, single episode, in full remission	F32.5
Adjustment disorder with depressed mood	F43.21
Rhinitis - *Code tobacco exposure*	
acute	J00
allergic	J30.9
chronic	J31.0
Laryngitis, acute w/o obstruction	J04.0
with obstruction (croup)	J05.0
chronic	J37.0
Pharyngitis, acute	J02.9
Sinusitis - *Code tobacco exposure*	
ethmoidal	J01.20
recurrent	J01.21
chronic	J32.2
frontal, acute	J01.10
recurrent	J01.11
chronic	J32.1
maxillary, acute	J01.00
recurrent	J01.01
chronic	J32.0
pansinusitis, acute	J01.40
recurrent	J01.41
chronic	J32.4
sphenoid, acute	J01.30
recurrent	J01.31
chronic	J32.3

Weight Management *Code type from left & BMI from right. BMI codes are for ages 2-20.*			
Overweight	E66.3	85th to < 95th percentile for age	Z68.53
Obese	E66.9	= / > 95th percentile for age	Z68.54
Underweight	R63.6	< 5th percentile for age	Z68.51
Failure to Thrive child *(Faltering growth)*			R62.51
Newborn			P92.6
Delayed milestones (childhood)			R62.0
Short stature			R62.52

Counseling For:	
Alcohol abuse	Z71.41
Contraception	Z30.09
Dietary (Add code: BMI & underlying condition)	Z71.3
Tobacco	Z71.6

See ICD-10-CM for other counseling diagnoses

Other Respiratory and ENT Dx	Code
Bronchitis, acute	J20.9
Ceruman impaction, Right ear	H61.21
left ear	H61.22
bilateral	H61.23
Cough	R05
Epistaxis	R04.0
Gastroenteritis	K52.9
Otalgia, Right ear	H92.01
left ear	H92.02
Pneumonia	J18.9
Swimmer's ear, Right ear	H60.331
left ear	H60.332
bilateral	H60.333
Tonsillitis, acute	J03.90
chronic	J35.01
Adenoiditis, chronic	J35.02
Tonsillitis with adenoiditis, chronic	J35.03
URI	J06.9
Viral syndrome	B97.89
FOREIGN BODY *(7th - A=initial, D= FU, S=sequela)*	
Nostril	T17.1XX-
Ear; RIGHT	T16.1XX-
LEFT	T16.2XX-
Dermatology	
Acne	L70.8
Eczema	L30.9
Impetigo	L01.00
LICE; Head	B85.0
Body	B85.1
Rash	R21
Plantar wart	B07.0
Sunburn; First degree	L55.0
Second degree	L55.1
Urticaria	L50.9
Tobacco and Nicotine Concerns	
Exposure to environmental tobacco smoke	Z77.22
Cigarette, uncomplicated *(nor directly related to illness)*	F17.210
in remission	F17.211
in withdrawal	F17. 213
Other tobacco product, uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Tobacco use, [no dependence] *avoid*	Z72.0
Occupational exposure to tobacco smoke	Z57.31
History of nicotine dependence	Z87.891
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Underdosing by Patient Coder - Code drug from T36-T50	
intentional NEC	Z91.128
due to financial hardship	Z91.120
unintentional NEC	Z91.138

PEDIATRIC CONDITIONS

GI/GU Dx	Code
Abdominal Pain, acute	R10.0
RUQ	R10.11
LUQ	R10.12
RLQ	R10.31
LLQ	R10.32
Epigastric	R10.13
Periumbilical	R10.33
Generalized	R10.84
Pain localized to flank, unspecified side	R10.A0
Flank pain, Right side	R10.A1
Flank pain, Left side	R10.A2
Flank pain, Bilateral	R10.A3
Abdominal pain of multiple sites	R10.85
Abdominal tenderness	R10.81
Rebound abdominal tenderness	R10.82
Flank tenderness, unspecified	R10.8A9
Tenderness, Right flank	R10.8A1
Tenderness, Left flank	R10.8A2
Tenderness, Suprapubic	R10.8A3
Costovertebral (angle) tenderness, unspecified side	R39.859
Right side	R39.851
Left side	R39.852
Bilateral	R39.853
Dental caries, unspecified	K02.9
Diarrhea	R19.7
UTI	N39.0
Constipation	K59.00
GERD	K21.9
Diabetes Type 1	E10.9
Diabetes Type 2	E11.9
Dysuria	R30.0
Nausea	R11.0
with vomiting	R11.2
Vomiting alone	R11.11
Cannabis hyperemesis syndrome	R11.16

Signs/Symptoms	Code
Chest pain	R07.9
Dizziness	R42
Fatigue	R53.83
Fever	R50.9
Headache	R51
TB Study: Contact or exposure to TB	Z20.1
Nonspec. Reac. to TB skin test w/o active TB	R76.11
Screening respiratory tuberculosis	Z11.1
Syncope	R55
Peds - Misc	
Zika virus	A92.5
Family history of SIDS	Z84.82
Maternal Use Drugs Affecting Newborn	
Newborn affected by maternal use; opiates	P04.14
antidepressants	P04.15
amphetamines	P04.16
sedative-hypnotics	P04.17
Physical Abuse Dx Codes	
Replace dash (-) with; A = initial (active tx); D = FU (healing); or S = sequela	
Suspected abuse; physical abuse of a child	T76.12x-
sexual abuse of a child	T76.22x-
Confirmed abuse; physical abuse of child	T74.12x-
sexual abuse of a child	T74.22x-
Abuse (physical) of child has now been ruled-out	Z04.72

PREVENTION

Typical Preventive Exams	Code
General adult med exam *(Annual Exam)*	Z00.00
without abnormal findings	
with abnormal findings	Z00.01
code also the abnormal finding	*code also*
Completed Pap with above, code also	Z12.4
Routine "GYN only" exam *(with or w/o Pap)*	Z01.419
without abnormal findings	
with abnormal findings	Z01.411
code also the abnormal finding	*code also*
WCC *without* abnormal findings	Z00.129
WCC *with* abnormal findings	Z00.121
code also the abnormal finding	*code also*
Newborn Ck, 1-7 days old *(e.g., wt/color)*	Z00.110
if abnormalities, assign additional code(s)	*code also*
Newborn Ck, 8-28 days old *(e.g., wt/color)*	Z00.111
if abnormalities, assign additional code(s)	*code also*
Special Reasons Dx Codes	
Sports	Z02.5
Immigration, naturalization	Z02.89
School admission	Z02.0
Pre-employment	Z02.1
Recruitment to armed forces	Z02.3
Issue of other med certificate	Z02.79
Paternity	Z02.81
Adoption	Z02.82
Blood-alcohol & blood-drug	Z02.83
Medicare Preventive Visit and Service Diagnoses	
Welcome to MCare Visit (Pts 1st year in Medicare)	Z00.00
Medicare Annual Wellness Visit	
Obesity counseling *(Code also obesity type & BMI)*	Z71.3
Screening; mammogram for breast CA	Z12.31
cardiovascular disorder	Z13.6
diabetes	Z13.1
eye and/or ear disorder	Z13.5
HIV	Z11.4
HPV	Z11.51
sexually transmitted infection	Z11.3
prostate malignancy (could be exam or PSA)	Z12.5
Special screening malignant neoplasm; other sites	Z12.89
Screening for other disorders (without a specific Dx code)	Z13.89
Screening Dx's	
Paps	
Routine cervical pap smear	Z12.4
Mcare screening pap; cervical; low risk, q2 yrs	Z12.4
high risk, q1yr *(code also - other spec risk factors Z91.89)*	Z12.4
vaginal *(if applicable code also - absence of uterus)*	Z12.72
Pap to confirm normal after abnormal	Z01.42
Female Screening - Miscellaneous	
Breast - ordering mammogram today	Z12.31
Chlamydial infection screening	Z11.8
HPV Human papilloma virus	Z11.51
High risk sexual behavior (heterosexual)	Z72.51

Screening for Certain Developmental Disorders in Childhood	
Screening; unspecified developmental delays	Z13.40
autism	Z13.41
for global developmental delays (milestones)	Z13.42
for other developmental delays	Z13.49
Screening for Mental Health and Behavioral Disorders	
Screening; mental health & behavioral disorders, unspec	Z13.30
depression	Z13.31
maternal depression	Z13.32
other mental health and behavioral disorders	Z13.39
Other Screening Studies	
Pregnancy test today - negative	Z32.02
Positive results today	Z32.01
Results cannot be confirmed today	Z32.00
Anemia (iron deficient)	Z13.0
Cardiovascular disorders	Z13.6
Developmental disorders in childhood	Z13.4
Diabetes	Z13.1
Poisoning (chemical / heavy metal-lead)	Z13.88
HIV	Z11.4
Lipoid disorders	Z13.220
Osteoporosis	Z13.820
Routine cervical Pap smear	Z12.4
Respiratory TB	Z11.1
Latent TB	Z11.7
Sexually Transmitted Infection	Z11.3
Thyroid disorders	Z13.29
Initial Contraception - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.011
Injectable contraceptive	Z30.013
IUD prescribed but no insertion today	Z30.014
IUD insertion today	Z30.430
Vaginal ring hormone	Z30.015
Transdermal patch hormone	Z30.016
Implantable subdermal	Z30.017
Other method (other than above; e.g. Condoms)	Z30.018
EC Emergency contraception	Z30.012
Follow-Up Contraception - *by method*	
Advice only today *regarding contraception*	Z30.09
Oral contraceptive pill	Z30.41
Injectable contraceptive	Z30.42
IUD: insertion today	Z30.430
Interim **Follow-up**/Routine checking	Z30.431
Removal of IUD only today	Z30.432
Removal and reinsertion of IUD	Z30.433
Vaginal ring hormone	Z30.44
Transdermal patch hormone	Z30.45
Implantable subdermal	Z30.46
Other method (other than above; e.g. Condoms)	Z30.49
Immunization Dxs	
One Dx code for any number of Immunizations.	Z23
Underimmunized *(as a diagnosis)*	Z28.3

PREVENTION

Special Exams: Eyes/Vision and Ears/Hearing	
Eyes/vision, w/o abnormal findings	Z01.00
with abnormal findings (code findings)	Z01.01
follow failed screen w/o abnormal findings	Z01.020
follow failed screen w/ abnormal findings (code findings)	Z01.021
Screening for glaucoma	Z13.5
Ears/hearing, without abnormal findings	Z01.10
with other abnormal finding (code findings)	Z01.118
following failed hearing screen	Z01.110
Counseling For *(as a diagnosis)*	
Diet (Add code: BMI, underlying condition)	Z71.3
Exercise	Z71.82
Injury prevention	Z71.89
Drug abuse counseling (Type: F11-F16, F18-F19)	Z71.51
Alcohol abuse counseling	Z71.41
Health related to travel	Z71.84
Immunization Dxs	
One Dx code for any number of Immunizations.	Z23
Underimmunized *(as a diagnosis)*	Z28.3
Vaccine not given today because:	
Acute illness	Z28.01
Chronic illness/condition	Z28.02
Immune compromised state	Z28.03
Allergy to vaccine or component	Z28.04
Other contraindication	Z28.09
Patient's belief or group pressure	Z28.1
Patient's refusal	Z28.21
Caregiver refusal	Z28.82
Patient had the disease	Z28.81

Nicotine Dependence vs Tobacco Use and Exposure	
Cigarette, uncomplicated *(no related illness)*	F17.210
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of nicotine dependence	Z87.891
Tobacco use, *[no dependence]* *avoid*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Personal History of Cancer	
Breast	Z85.3
Cervix uteri	Z85.41
Other parts of uterus	Z85.42
Colon	Z85.038
Prostate	Z85.46
Bladder	Z85.51
Family History of	
Breast cancer	Z80.3
Colon cancer	Z80.0
Colonic polyps; adenomatous and/or serrated	Z83.710
; hyperplastic colon polyps	Z83.711
; other colon polyps	Z83.718
; unspecified colon polyps	Z83.719
Diabetes	Z83.3
Cardiovascular disease	Z82.49

ACUTE ILLNESSES

Otitis and Other Ear Concerns	Code
OM, nonsuppurative, serous & acute; RIGHT	H65.01
left ear	H65.02
bilateral	H65.03
recurrent right ear	H65.04
recurrent left ear	H65.05
recurrent bilateral	H65.06
OM, nonsuppurative, serous & CHRONIC; RIGHT	H65.21
left ear	H65.22
bilateral	H65.23
OM, suppurative & acute & TM intact RIGHT	H66.001
left ear	H66.002
bilateral	H66.003
recurrent right ear	H66.004
recurrent left ear	H66.005
recurrent bilateral	H66.006
OM, suppurative & acute TM rupture, RIGHT	H66.011
left ear	H66.012
bilateral	H66.013
recurrent right ear	H66.014
recurrent left ear	H66.015
recurrent bilateral	H66.016
OM, suppurative, tubotympanic, chronic, RIGHT	H66.11
left ear	H66.12
bilateral	H66.13
Otitis externa, acute Right ear	H60.501
left ear	H60.502
bilateral	H60.503
Otitis externa, chronic Right ear	H60.61
left ear	H60.62
bilateral	H60.63
Conjunctivitis	
Conjunctivitis, mucopurulent	H10.9
Acute Follicular	
right eye	H10.011
left eye	H10.012
bilateral	H10.013
Other mucopurulent	
right eye	H10.021
left eye	H10.022
bilateral	H10.023
Acute atopic	
right eye	H10.11
left eye	H10.12
bilateral	H10.13
Serous, except viral	
right eye	H10.231
left eye	H10.232
bilateral	H10.233
Viral	B30.9

Rhinitis - *Code tobacco exposure*	
acute	J00
allergic	J30.9
chronic	J31.0
Laryngitis, acute w/o obstruction	J04.0
with obstruction (croup)	J05.0
chronic	J37.0
Pharyngitis, acute	J02.9
streptococcal	J02.0
Sinusitis - *Code tobacco exposure*	
ethmoidal	J01.20
recurrent	J01.21
chronic	J32.2
frontal, acute	J01.10
recurrent	J01.11
chronic	J32.1
maxillary, acute	J01.00
recurrent	J01.01
chronic	J32.0
pansinusitis, acute	J01.40
recurrent	J01.41
chronic	J32.4
sphenoid, acute	J01.30
recurrent	J01.31
chronic	J32.3
Other Respiratory and ENT Dx	
Bronchitis, acute	J20.9
Ceruman impaction, Right ear	H61.21
left ear	H61.22
bilateral	H61.23
Cough	R05
Epistaxis	R04.0
Otalgia, Right ear	H92.01
left ear	H92.02
Pneumonia	J18.9
Swimmer's ear, Right ear	H60.331
left ear	H60.332
bilateral	H60.333
Tonsillitis, acute	J03.90
chronic	J35.01
Adenoiditis, chronic	J35.02
Tonsillitis with adenoiditis, chronic	J35.03
URI	J06.9
Viral syndrome	B97.89
Foreign Body *7th character: A=initial, D= FU, S=sequela*	
Nostril	T17.1XX-
Ear; RIGHT	T16.1XX-
LEFT	T16.2XX-
Underdosing by Patient Code drug from T36-T50	
intentional NEC	Z91.128
due to financial hardship	Z91.120
unintentional NEC	Z91.138

ACUTE ILLNESSES

GI/GU Dxs - Continued	
Diabetes Type 1	E10.9
Diabetes Type 2	E11.9
Vomiting alone	R11.11
Vomiting, cyclical, not related to migraines	R11.15
Nausea	R11.0
with vomiting	R11.2
Dysuria	R30.0
Dental caries, unspecified	K02.9
Allergy to milk products	Z91.011
E. Coli as cause of disease classified elsewhere	B96.20
Tobacco and Nicotine Concerns	
Exposure to environmental tobacco smoke	Z77.22
Cigarette, uncomplicated *(no directly related illness)*	F17.210
Cigarettes, in remission	F17.211
Cigarettes, in withdrawal	F17. 213
Other tobacco product, uncomplicated	F17.290
Other tobacco product, in remission	F17.291
Other tobacco product, in withdrawal	F17.293
Tobacco use, (no documentation of dependence) *avoid*	Z72.0
Occupational exposure to tobacco smoke	Z57.31
History of nicotine dependence	Z87.891
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Dermatology	
Acne	L70.8
Eczema	L30.9
Impetigo	L01.00
LICE; Head	B85.0
Body	B85.1
Rash	R21
Plantar wart	B07.0
Sunburn; First degree	L55.0
Second degree	L55.1
Urticaria	L50.9
Other Signs/Symptoms	
Chest pain	R07.9
Dizziness	R42
Fatigue	R53.83
Fever	R50.9
Headache with orthostatic component, NEC	R51.0
Headache, unspecified	R51.9
TB Study: Contact or exposure to TB	Z20.1
Nonspecific reaction TB test w/o active TB	R76.11
Screening respiratory tuberculosis	Z11.1
Syncope	R55

GI/GU Dxs	
Abdominal Pain, acute	R10.0
RUQ	R10.11
LUQ	R10.12
RLQ	R10.31
LLQ	R10.32
Epigastric	R10.13
Periumbilical	R10.33
Generalized	R10.84
Pain localized to flank, unspecified side	R10.A0
Flank pain, Right side	R10.A1
Flank pain, Left side	R10.A2
Flank pain, Bilateral	R10.A3
Abdominal pain of multiple sites	R10.85
Abdominal tenderness	R10.81
Rebound abdominal tenderness	R10.82
Flank tenderness, unspecified	R10.8A9
Tenderness, Right flank	R10.8A1
Tenderness, Left flank	R10.8A2
Tenderness, Suprapubic	R10.8A3
Costovertebral (angle) tenderness, unspecified side	R39.859
Right side	R39.851
Left side	R39.852
Bilateral	R39.853
Gastroenteritis	K52.9
Allergic (Add code: food allergy = Z91.01-, Z91.02-)	K52.2-
Diarrhea	R19.7
UTI	N39.0
Acute cystitis without hematuria	N30.00
Acute cystitis with hematuria	N30.01
Acute pyelonephritis	N10
Diverticulitis of small intestine without;	
perforation or abscess w/o bleeding	K57.12
perforation with bleeding	K57.13
Diverticulitis of large intestine without;	
perforation or abscess w/o bleeding	K57.32
of perforation with bleeding	K57.33
Constipation	K59.00
Other esophagitis without bleeding	K20.80
Other esophatgitis with bleeding	K20.81
Esophagitis, unspecified without bleeding	K20.90
Esophagitis, unspecified with bleeding	K20.91
GERD with exophagitis, without bleeding	K21.00
GERD with exophagitis, with bleeding	K21.01
Adverse Effect: Assign additional drug code from T36-T50	
7th character: A=initial, D= FU, S=sequela	
Adverse effect of penicillin	T36.0X5-
Misc	
Zika virus	A92.5

INJURIES (Fractures, Burns, Lacerations) (A=Initial/Active treatment. D=Subsequent/Healing. S=Sequela)

UPPER EXTREMITY	RIGHT	LEFT
SHOULDER/HUMERUS: ***Replace dash with 7th character EOC;***		
A=initial (active tx);D= FU (healing); or S=sequela	RIGHT	LEFT
Contusion: shoulder	S40.011-	S40.012-
Upper arm	S40.021-	S40.022-
Pain in shoulder	M25.511	M25.512
Stiffness, shoulder	M25.611	M25.612
Sprain, rotator cuff	S43.421-	S43.422-
Strain, rotator cuff	S46.011-	S46.012-
biceps, long head	S46.111-	S46.112-
Swelling (disorder, soft tissue)	M79.9	M79.9
Joint effusion, shoulder	M25.411	M25.412
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Dislocation shoulder [more detail available]	S43.004-	S43.005-
Recurrent dislocation shoulder	M24.411	M24.412
ELBOW REGION - *Replace dash with 7th character EOC*		
A=initial (active tx);D= FU (healing); or S=sequela		
Contusion	S50.01X-	S50.02X-
Pain	M25.521	M25.522
Stiffness	M25.621	M25.622
Sprain, elbow [more detail available]	S53.401-	S53.402-
Swelling (soft tissue)	M79.9	M79.9
Elbow joint effusion	M25.421	M25.422
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Nursemaid elbow	S53.031-	S53.032-
WRIST REGION - *Replace dash with 7th character EOC;*		
A=initial (active tx);D= FU (healing); or S=sequela		
Contusion	S60.211-	S60.212-
Pain	M25.531	M25.532
Stiffness	M25.631	M25.632
Sprain, wrist [more detail available]	S63.501-	S63.502-
Swelling (soft tissue)	M79.9	M79.9
Wrist joint effusion	M25.431	M25.432
Carpal tunnel syndrome	G56.01	G56.02
Ganglion cyst	M67.431	M67.432
Laceration, forearm, without foreign body	S51.811-	S51.812-
Burn, forearm, second degree	T22.211-	T22.212-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Fx: distal radius, non-displaced	S52.501-	S52.502-
Fx: Colles'	S52.531-	S52.532-
HAND - *Replace dash with 7th character EOC;*		
A=initial (active tx);D= FU (healing); or S=sequela		
Contusion	S60.221-	S60.222-
Pain	M79.641	M79.642
Pain in finger(s)	M79.644	M79.645
Stiffness	M25.641	M25.642
Sprain unspecified part(s) hand	S63.91X-	S63.92X-
Sprain finger, unspecified finger/region	S63.619-	S63.619-
Hand joint effusion	M25.441	M25.442
Burn, palm, second degree	T23.251-	T23.252-
Burn, palm, third degree	T23.351-	T23.352-
Laceration, hand, without foreign body	S61.411-	S61.412-
Laceration, thumb, without foreign body	S61.011-	S61.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
FX 5th metacarpal shaft, nondisplaced,	S62.356-	S62.357-
FX navicular, w/o specificity [many choices]	S62.001-	S62.002-
FX phalanx, index, nondisplaced	S62.600-	S62.601-
Joint effusion, hand	M25.441	M25.442
Joint (wrist) effusion	M25.431	M25.432

LOWER EXTREMITY	RIGHT	LEFT
KNEE - ***Replace dash with 7th character EOC;***		
A=initial (active tx);D= FU (healing); or S=sequela	RIGHT	LEFT
Contusion of the knee	S80.01X-	S80.02X-
Pain	M25.561	M25.562
Stiffness	M25.661	M25.662
Sprain, CRUCIATE ligament, unspecified	S83.501-	S83.502-
Sprain, LATERAL collateral ligament	S83.421-	S83.422-
Sprain, MEDIAL collateral ligament	S83.411-	S83.412-
Tear, meniscus, undescribed	S83.206-	S83.207-
Subluxation, lateral patella	S83.011-	S83.012-
Joint effusion knee	M25.461	M25.462
Swelling - soft tissue disorder	M79.9	M79.9
Laceration, knee, without foreign body	S81.011-	S81.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Patella fx	S82.001-	S82.002-
ANKLE - *Replace dash with 7th character EOC;*		
A=initial (active tx);D= FU (healing); or S=sequela		
Contusion	S90.01X-	S90.02X-
Pain	M25.571	M25.572
Stiffness	M25.671	M25.672
Sprain; deltoid ligament	S93.421-	S93.422-
calcaneofibular ligament	S93.411-	S93.412-
tibiofibular ligament	S93.431-	S93.432-
other specified ligament (eg., talofibular)	S93.491-	S93.492-
Joint effusion, ankle	M25.471	M25.472
Swelling (soft tissue)	M79.9	M79.9
Burn, calf, second degree	T24.231-	T24.232-
Laceration, ankle, without foreign body	S91.011-	S91.012-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Dislocation	S93.04X-	S93.05X-
FOOT/TOES - *Replace dash with 7th character EOC;*		
A=initial (active tx);D= FU (healing); or S=sequela		
Contusion	S90.31X-	S90.32X-
Pain	M25.571	M25.572
Stiffness	M25.674	M25.675
Sprain [more detail available]	S93.601-	S93.602-
Joint effusion, foot	M25.474	M25.475
Swelling, skin and subcutaneous tissue	R22.41	R22.42
Laceration, foot, without foreign body	S91.311-	S91.312-
Laceration, foot, with foreign body	S91.321-	S91.322-
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
FX great toe, displaced, unspec phalanx	S92.401-	S92.402-
FX, lesser toe, displaced, unspec phalanx	S92.501-	S92.502-
FX, 1st metatarsal, displaced	S92.311-	S92.312-

INJURIES (Fractures, Burns, Lacerations) (A=Initial/Active treatment. D=Subsequent/Healing. S=Sequela)

CERVICAL SPINE - *Replace dash with 7th character EOC;*	
A=initial (active tx);D= FU (healing); or S=sequela	**Code**
Contusion	S10.93X-
Pain - Cervicalgia	M54.2
Stiffness	M43.6
Sprain cervical ligament(s)	S13.4XX-
Strain muscles, fascia and tendons neck	S16.1XX-
Swelling, skin and subcutaneous tissue	R22.1
Injury (undefined) *avoid*	S19.9XX-
Radiculopathy	M54.12

LUMBAR SPINE - *Replace dash with 7th character EOC*	
A=initial (active tx);D= FU (healing); or S=sequela	
Contusion	S30.0XX-
Pain, low back, w/sciatica, right side	M54.41
Pain, low back, w/sciatica, left side	M54.42
Pain, low back, **without** sciatica	M54.5
Sprain ligament(s)	S33.5XX-
Strain muscles, fascia, tendons, low back	S39.012-
Swelling, soft tissue	M79.9
Fx, vertebra due to osteoporosis	M80.08X-
Radiculopathy, lumbar	M54.16
lumbosacral	M54.17
Burn, lower back, second degree	T21.24X-

PELVIS & FEMUR - *Replace dash with 7th character EOC*		
A=initial (active tx);D= FU (healing); or S=sequela	**RIGHT**	**LEFT**
Contusion, pelvis	S30.0XX-	S30.0XX-
Contusion, thigh	S70.11X-	S70.12X-
Pain, thigh	M79.651	M79.652
Strain, thigh [more detail available]	S76.911-	S76.912-
Strain, hip	S76.011-	S76.012-
Burn, thigh, second degree	T24.211-	T24.212-
Sprain, hip [more detail available]	S73.101-	S73.102-
Effusion, hip	M25.451	M25.452
Fractures EMR Search: FX, L/R bone, closed, nondisplaced & EOC		
Burns: EMR Search: burn, second degree, right palm & EOC		
Second degree palm; initial eval.	T23.251-	T23.252-
Code also percent of body surface burned	Code Also	
Less than 10% of body surface burned	T31.0	
10% - 19% of body surface burned	T31.10	
20% - 29% of body surface burned, add	T31.20	

NICOTINE DEPEND vs TOBACCO USE & EXPOSURE	
Cigarette, uncomplicated *(no related illness)*	F17.240
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke expos.	Z57.31
History of nicotine dependence	Z87.891
Tobacco use, *[no dependence]*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	

LACERATIONS

Lacerations: Generally right/left specific, with or w/o foreign body. Fingers are specific, e.g. index, little, middle, ring; thumb has it's own section. All with or w/o nail damage.

Replace dash with 7th character EOC;		
A=initial (active tx);D= FU (healing); or S=sequela	RIGHT	LEFT
foot, except toes:	S91.311-	S91.312-
with foreign body	S91.321-	S91.322-
forehead	S01.81X-	
with foreign body	S01.82X-	
eyelid w/o foreign body	S01.111-	S01.112-
ear	S09.91X-	
scalp w/o foreign body	S01.01X-	
with foreign body	S01.02X-	
face, unsp	S09.93X-	
hand	S61.411-	S61.412-
with foreign body	S61.421-	S61.422-
knee	S81.011-	S81.012-
with foreign body	S81.021-	S81.022-
thumb	S61.011-	S61.012-
with foreign body	S61.021-	S61.022-
with damage to nail	S61.111-	S61.112-
with foreign body and nail damage	S61.121-	S61.122-

OTHER MISCELLANEOUS INJURIES		
Black Eye NOS	S00.11X-	S00.12X-
Foreign body		
eye	T15.91X-	T15.92X-
ear	T16.1XX-	T16.2XX-
nose	T17.-XX-	
pharynx	T17.2 - - -	
Frostbite		
face	T33.0 - - -	
hand	T33.5 - - -	
foot	T33.8 - - -	
Heatstroke	T67.0XX-	
Disruption of wound		
internal surgical wound	T81.32X-	
external surgical wound	T81.31X-	

PHYSICAL ABUSE DIAGNOSIS CODES - Replace dash	
Replace dash (-) w/ ***A*** *=initial (active tx);* ***D*** *= FU (healing); or* ***S*** *=sequela*	
Suspected abuse;	
physical abuse of an adult	T76.11X-
sexual abuse of adult	T76.21X-
physical abuse of a child	T76.12X-
sexual abuse of a child	T76.22X-
Confirmed abuse;	
physical abuse of adult	T74.11X-
sexual abuse of adult	T74.21X-
physical abuse of a child	T74.12X-
sexual abuse of a child	T74.22X-

PSYCHIATRIC AND RELATED CONDITIONS

Screening for Mental Health and Behavioral Disorders	Code
Screening; mental health & behavioral disorders, unspec	Z13.30
depression	Z13.31
maternal depression	Z13.32
other mental health and behavioral disorders	Z13.39
autism	Z13.41
ADHD - *Features are predominately…(choose)*	
ADHD; inattentive type	F90.0
ADHD; hyperactive type	F90.1
ADHD; combined (inattentive and hyperactive types)	F90.2
ADHD; other type, *which is not considered as above three type*	F90.8
Bipolar Disorders F31	
Consider: manic, depressed or mixed, & mild, moderate or severe. *If "severe" select code based on presence/absence of psychosis.*	
Bipolar, current episode is **manic & mild**	F31.11
Bipolar; current episode is; **manic & moderate**	F31.12
manic & severe *WITHOUT* psychotic features	F31.13
manic & severe and *WITH psychotic features*	F31.2
Bipolar, current episode **depressed & mild**	F31.31
current episode depressed & moderate	F31.32
depressed *but WITHOUT* psychotic features	F31.4
depressed *and WITH psychotic features*	F31.5
Bipolar, current episode **mixed** (manic & dep.) **mild**	F31.61
Bipolar; current episode mixed & moderate	F31.62
mixed & severe, *WITHOUT* *psychotic features*	F31.63
mixed & severe, and *WITH psychotic features*	F31.64
Bipolar, current episode **hypomanic**	F31.0

Bipolar Disorders *IN REMISSION* *(Partial or Full Remission)*			
Bipolar PARTIAL remission		Bipolar **FULL** remission	
hypomanic	F31.71	hypomanic	F31.72
manic	F31.73	manic	F31.74
depressed	F31.75	depressed	F31.76
mixed	F31.77	mixed	F31.78
Bipolar II disorder			F31.81

Manic Episode F30	
Manic episode w/o psychotic symptoms **mild**	F30.11
Manic episode w/o psychotic symptoms **moderate**	F30.12
Manic episode w/o psychotic symptoms **severe**	F30.13
Manic episode ***with*** psychotic symptoms **severe**	F30.2
Other manic episodes (like hypomania)	F30.8
Manic episode in PARTIAL remission	F30.3
Manic episode in FULL remission	F30.4
Persistent mood (affective) disorders F34	
Cyclothymic disorder	F34.0
Dysthymic disorder *DSM5 = persistent depressive disorder*	F34.1
Disruptive mood dysregulation disorder	F34.81
Other specified persistent mood disorder	F34.89
Mood disorder, unspec. (Active psychosis NOS) *avoid*	F39

Factitious Disorders	Code
Factitious disorder imposed on self; unspecified	F68.10
with predominantly psychological sgns and symptoms	F68.11
with predominantly physical sgns and symptoms	F68.12
with combined psychological physical sgns and symptoms	F68.13
Factitious disorder imposed on another	F68.A
Emotional State Dx Codes *(Any age)*	
Nervousness	R45.0
Irritability & Anger	R45.4
Impulsiveness	R45.87
Emotional Liability	R45.86
Demoralization/Apathy	R45.3
Other emotional state	R45.89
Anxiety and Related	
Anxiety; generalized	F41.1
Anxiety, mixed (*with prominent features of other disorde*	F41.3
Panic disorder; *w/o agoraphobia (panic attack)* *DEF in note*	F41.0
with agoraphobia	F40.01
Separation anxiety (*of childhood*)	F93.0
Other specified anxiety disorder (*doc in record, but no code)*	F41.8
Social phobia (anxiety) disorder, generalized	F40.11
Acute stress reaction	F43.0
Post-traumatic Stress Disorder	
PTSD; acute	F43.11
PTSD; chronic	F43.12
Anxiety; unspecified *avoid*	F41.9
Major Depressive Disorders (MDD)	
MDD, single episode code choices	
"Single episode" is the first-ever episode. DSM-5-TR, pg 214: Dx code for MDD based on single vs recurrent and severity.	
MDD, single episode; *(The patient's 1st Dx of MDD - may last months/years)*	
MDD, single episode; **mild severity**	F32.0
MDD, single episode, **moderate severity**	F32.1
MDD, single; **severe, *WITHOUT* psychotic symptoms**	F32.2
MDD, single; **severe, *WITH* psychotic symptoms**	F32.3
MDD, single episode; **in PARTIAL remission**	F32.4
MDD, single episode; **in FULL remission**	F32.5
MDD, **single** episode; *severity cannot be specified* *avoid*	F32.9
MDD, recurrent episode code choices ***(more common than single episode)***	
An "episode" likely to last many mos/years. DSM-5-TR, pg 214: "recurrent" = interval of ≥ 2 consecutive months between separate episodes in which criteria for MDD are not met.	
MDD, recurrent episode; **mild**	F33.0
MDD, recurrent episode; **& moderate severity**	F33.1
MDD, recurrent; severe, *WITHOUT* psychotic symptom	F33.2
MDD, recurrent; severe, *WITH* psychotic symptoms	F33.3
MDD, recurrent episode **in *PARTIAL* remission**	F33.41
MDD, recurrent episode **in *FULL* remission**	F33.42
MDD, other reccurrent depressive disorder *(specified)*	F33.8
MDD, recurrent episode, *unspecified* *avoid*	F33.9
Other Depressive Episodes	
Premenstrual dysphoric disorder	F32.81
Other specified depressive episode *(specified in record)*	F32.89

PSYCHIATRIC AND RELATED CONDITIONS

Cognitive Defects (*Any age*)	Code
Attention/concentration	R41.840
Cognitive communication	R41.841
Visuospatial	R41.842
Psychomotor	R41.843
Frontal lobe/executive function	R41.844
Other cognitive deficits	R41.89
Dementia in disease classified elsewhere	F02.80
Code first, underlying condition	
with behavioral disturbances	F02.81
Personality Disorders F60	
Antisocial	F60.2
Avoidant	F60.6
Borderline	F60.3
Dependent	F60.7
Histrionic	F60.4
Narcissistic	F60.81
Obsessive-compulsive	F60.5
Paranoid	F60.0
Schizoid	F60.1
Schizophrenia/Schizoaffective	
Paranoid	F20.0
Disorganized	F20.1
Catatonic	F20.2
Undifferentiated	F20.3
Residual	F20.5
Schizophreniform disorder	F20.81
Schizophrenia *(is documented but no code exists)*	F20.89
Schizoaffective disorder, bipolar type	F25.0
depressive type	F25.1
Schizoaffective disorder, unspecified *avoid*	F25.9
Personal History of Mental Disorders *(Any age)*	
Affective disorders	Z86.59
Neurosis	Z86.59
Alcoholism	F10.21
Combat and operational stress	Z86.51
Other mental disorders	Z86.59
Unspecified mental disorder *avoid*	Z86.59
Family hx of psychiatric condition	Z81.8
Personal History of Abuse in Childhood *(Excludes Current)*	
physical and sexual abuse	Z62.810
psychological abuse	Z62.811
neglect	Z62.812
unspecificed abuse	Z62.819
Exploitation Dx Codes (*Any age*)	
Exam and observation; following forced sexual exploitation	Z04.81
following forced labor exploitation	Z04.82
Forced labor or sexual exploitation in childhood	Z62.813
Forced labor or sexual exploitation	Z91.42

Adjustment Disorders	Code
Adjustment disorder; with depressed mood (*grief reaction)*	F43.21
with anxiety	F43.22
with mixed mood (anxiety & depression)	F43.23
with disturbance of conduct	F43.24
with mixed disturbance (emotion/conduct)	F43.25
with other symptoms not noted in available codes	F43.29
Adjustment disorder unspecified *avoid*	F43.20
Obsessive-compulsive disorder (OCD) F42	
Mixed obsession thoughts and acts	F42.2
Hoarding disorder	F42.3
Excoriation (skin-picking) disorder	F42.4
Other obsessive-compulsive dis. *(documented, but not listed above*	F42.8
Obsessive-compulsive disorder, unspecified *avoid*	F42.9
Signs and Symptoms *(Any age)*	
Memory loss	R41.3
Excessive crying	R45.83
Altered mental status	R41.82
Other general symptoms	R68.89
Lack of coordination	R27.9
Abnormal weight gain	R63.5
Abnormal weight loss	R63.4
Other speech disturbance	R47.89
Senility w/o mention psychosis	R41.81
Headache	R51
Sleep disturbance	G47.9
Hallucinations	R44.3
Dizziness/giddiness	R42
Decreased libido	R68.82
Fatigue	R53.83
Generalized pain	R52
Night terrors (child)	F51.4
Other/Miscellaneous Dxs *(Any Age)*	
Insomnia	G47.00
Hypersomnia *Several codes available Check F51.0 - F51.9*	F51.11
Self mutilation (personal hx)	Z91.5
Noncompliance	Z91.19
Anorexia nervosa	F50.00
Bulimia nervosa	F50.2
Intellectual Disabilities; mild	F70
moderate	F71
severe	F72

PSYCHIATRIC AND RELATED CONDITIONS

CHILD MALTREATMENT		ADULT MALTREATMENT	
*Replace dash with **A**-initial, **D**-FU or **S**-sequela*	**Code**	*Replace dash with **A**-initial, **D**-FU or **S**-sequela*	**Code**
Child physical abuse, confirmed	T74.12X -	Adult physical abuse, confirmed	T74.11X -
Psychological abuse, confirmed	T74.32X -	Psychological abuse, confirmed	T74.31X -
Sexual abuse, confirmed	T74.22X -	sexual	T74.21X -
Child neglect	T74.02X -	other abuse and neglect	T74.01X -
Shaken infant syndrome	T74.4XX -	Adult neglect (nutritional)	T74.01X -
Sexual exploitation, confirmed	T74.52X-	Sexual exploitation, confirmed	T74.51X-
Sexual exploitation, suspected	T76.52X-	Sexual exploitation, suspected	T76.51X-
Labor exploitation, confirmed	T74.62X-	Labor exploitation, confirmed	T74.61X-
Labor exploitation, suspected	T76.62X-	Labor exploitation, suspected	T76.61X-
Other Child Dxs		**Adult Related Info Dx Codes**	
Autistic disorder	F84.0	Perpetrator of spousal/partner abuse	Z69.12
Heller's syndrome	F84.3	Parent child problems, unspecified.	Z71.89
Child psychosis NOS	F84.9	Perpetrator of parental child abuse	Z69.011
Schizophrenia, childhood type	F84.5	Parent-biological child problem	Z71.89
Child Conduct Disorders		Counseling: parent-adopted child problem	Z71.89
Oppositional defiant disorder	F91.3	Counseling: parent-foster child problem	Z71.89
Adolescent onset type	F91.2	Parental overprotection	Z62.1
Childhood onset type	F91.1	Problems with aged parents or in-laws	Z63.79
Other conduct disorders	F91.8	Alcoholism in family	Z63.72
Disorder - Social Functioning Child/Adolescence		Substance abuse in family	Z63.72
Selective mutism	F94.0	Personal current military deployment	Z65.8
Reactive attachment disorder	F94.1	Personal Hx return from military deploy	Z65.5
Disinhibited attachment disorder	F94.2	**Occupational concerns**, loss of job	Z56.0
Child - Additional Social Status Dxs		Change of job	Z56.1
Parent-biological child problem	Z62.820	Threat of loss of job	Z56.2
Parent-adopted child conflict	Z62.821	Stressful work schedule	Z56.3
Parent-foster child conflict	Z62.822	Discord with boss and workmates	Z56.4
Parent-step child conflict	Z62.823	Difficult conditions at work	Z56.5
Sibling Rivalry	Z62.891	Other physical and mental strain related to work	Z56.6
Runaway (from current living environment)	Z62.892	Social maladjustment	Z60.3
Alcoholism in family	Z63.72	Legal circumstances	Z65.3
Substance abuse in family	Z63.72	Refusal of tx for religious reasons	Z53.1
Other psychosocial circumstances	Z65.8	Bereavement (disappearance/death)	Z63.4
Acculturation difficulty/ Social maladjustment	Z60.3	Religious or spiritual problem	Z65.8
Problems r/t legal circumstances	Z65.3	Life circumstance problem	Z65.8
Refusal of tx for religious reasons	Z53.1	Person awaiting admission to facility	Z75.0
Problems r/t unwanted pregnancy	Z64.0	**(OB) Puerperium Mental & Behavioral Disorders**	
Bereavement, uncomplicated	Z63.4	**Postpartum depression**	F53.0
Couseling victim of parental child abuse	Z96.010	**Peurperal psychosis**	F53.1
Absence of family member d/t military deployment	Z65.8		
Basic services unavailable in physical environment	Z58.81		

PSYCHIATRIC AND RELATED CONDITIONS

Dx - Medication Management *Code also clinical condition(s)*	
Code: Therapeutic drug level monitoring	Z51.81
Code + Long term (current) drug therapy	Z79.899
Code + Long term (current) use of opiate analgesic	Z79.891
Code also the medical/psych diagnosis(es)	*See code*

"PROVISIONAL DX" / "RULE OUT DX" TODAY??	
ICD-10 Guidelines prohibit assignment of a diagnosis when that Dx. is only being "considered" at this time. One might consider assignment of R69 in cases where a definitive diagnosis cannot yet be assigned. R69 May or may not represent reimbursement problems, Coder/biller should monitor.	
Mental illness, NOS	F99
Illness, unspecified	R69

Other Patient Noncompliance Diagnoses	
Other med. noncompliance *(e.g., self overdosing)*	Z91.14
Noncompliance involving ***other than*** medication	Z91.19
Noncompliance with diet	Z91.11

Underdosing of Prescribed Medication by Patient (requires 2 codes)	
Refer these cases to coder for code assignment	
Code first, underdosing of medication (T36-T50) with fifth or sixth character of "6", then code intent and reason (below)	
1. Look up med or med class in ICD	TXX.XXX -
Patient Medication Noncompliance by Self Underdosing of;	
Replace dash (-) w/ ***A*** *=initial (active tx);* ***D*** *= FU (healing); or* ***S*** *=sequela*	
tetracyclic antidepressants	T43.026 -
tricyclic antidepressants	T43.016 -
other antidepressant	T43.296 -
antipsychotics (phenothiazine)	T43.3x6 -
amphetamines	T43.626 -
other psychostimulant	T43.696 -
antipsychotics and neuroleptics	T43.596 -
barbiturates	T42.3x6 -
benzodiazepines	T42.4x6 -
butyrophenone/thiothixene narcoleptics	T43.4x6 -
cannabis	T40.7x6 -
MAOIs	T43.1x6 -
methadone	T40.3x6 -
methyphenidate (ADD)	T43.636 -
narcotics (synthetic)	T40.4x6 -
opium	T40.0x6 -
other opioid	T40.2x6 -
psychotropic (other)	T43.8x6 -
SSRIs	T43.226 -
2. Code also intent and reason from self underdosing	
INTENTIONAL underdosing of med(s) by patient;	
due to financial hardship	Z91.120
for any other reason	Z91.128
UNINTENTIONAL underdosing by patient;	
due to age-related debility	Z91.130
for any other reason	Z91.138

CHRONIC PAIN AND SUBSTANCE USE DISORDERS

Chronic Pain & Medication Management	Code
Coding chronic pain management: List 1st the chronic pain Dx, then the clinical reason Dx, followed by "Therapeutic monitoring" Dx, and finally High-risk medication Dx, if appropriate. See 1-4 below.	
1. **Chronic Pain Syndrome**	G89.4
Chronic Pain, unspecified	G89.29
due to; trauma	G89.21
neoplasm related	G89.3
2. ***Common conditions causing chronic pain***	
Arthropathy	M12.9
Fibromyalgia	M79.7
Lumbago	M54.5
Rheumatoid arthritis	M06.9
Pain disorder with related psychological factors	F45.42
Medication Management *(detailed documentation)*	
3. **Therapeutic drug monitoring** *(code also #4 and/or #5)*	Z51.81
4. **+** Long term (current) use of opiate analgesic	Z79.891
5. **+** Other long term (current) drug therapy	Z79.899
Alcohol Abuse *("mild") See DSM5*	
Alcohol abuse; uncomplicated	F10.10
Alcohol abuse; in remission	F10.11
with alcohol-induced; with anxiety disorder	F10.180
with mood disorder	F10.14
with psychotic disorder with delusions	F10.150
with psychotic disorder with hallucinations	F10.151
with sexual dysfunction	F10.181
with sleep disorder	F10.182
Alcohol abuse with intoxication; uncomplicated (toda	F10.120
with delirium	F10.121
Alcohol abuse with withdrwal; uncomplicated	F10.130
unspecified	F10.139
Alcohol Dependence *(DSM "moderate / severe")*	
Alcohol dependence; uncomplicated	F10.20
Alcohol dependence; in remission	F10.21
with withdrawal; uncomplicated	F10.230
with delirium	F10.231
with perceptual disturbance	F10.232
with alcohol-induced; with anxiety disorder	F10.280
with mood disorder	F10.24
with persisting amnesic disorder	F10.26
with persisting dementia	F10.27
with psychotic disorder delusions	F10.250
with psychotic disorder hallucinations	F10.251
with sexual dysfunction	F10.281
with sleep disorder	F10.282
Alcohol dependence with intoxication; uncomplicate	F10.220
with delirium	F10.221

Lab Studies - Search for additionals in EMR	Code
[Urine drug screen] Encounter other specified exam.	Z01.89
Finding, abnormal substance in urine	R82.99
Blood test for alcohol/drugs *Code results*	Z02.83
Codes for results listed below, assign if known	
Abnormal findings in blood study	
Opiate drug in blood	R78.1
Cocaine in blood	R78.2
Hallucinogen in blood	R78.3
Psychotropic in blood	R78.5
Other addictive substance in blood	R78.4
Other substance in blood	R78.9
Alcohol Use (w/o abuse or dependence) **& Alcohol Poisoning**	
Alcohol use, unpsecified with withdrwal; uncomplicated	F10.930
unspecified	F10.939
Alcohol use unspec w/ unspec alcohol-induced disorder	F10.99
See F10.9x for other alcohol "use" diagnoses	
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	
Alcohol poisoning - *intent undetermined*	T51.0x4 -

Blood alcohol level codes

< 20 mg/100 ml	Y90.0	100-119 mg	Y90.5
20-39 mg/100 ml	Y90.1	120-199 mg	Y90.6
40-59 mg/100 ml	Y90.2	200-239 mg	Y90.7
60-79 mg/100 ml	Y90.3	240mg or >	Y90.8
80-99 mg/100 ml	Y90.4	Level not specified	Y90.9

Cannabis Abuse *("mild") See DSM5*	
Cannabis abuse; uncomplicated	F12.10
Cannabis abuse; in remission	F12.11
with cannabis-induced; with anxiety disorder	F12.180
with psychotic disorder with delusions	F12.150
with psychotic disorder with hallucinations	F12.151
Cannabis abuse with intoxication; uncomplicated	F12.120
with delirium	F12.121
with perceptual disturbance	F12.122
Cannabis abuse with withdrwal	F12.13
Cannabis Dependence *(DSM "moderate / severe")*	
Cannabis dependence; uncomplicated	F12.20
Cannabis dependence; in remission	F12.21
Cannabis dependence; with withdrawal	F12.23
with cannabis-induced; with anxiety disorder	F12.280
with psychotic disorder with delusions	F12.250
with psychotic disorder with hallucinations	F12.251
Cannabis dependence with intoxication; uncomplicat	F12.220
with delirium	F12.221
with perceptual disturbance	F12.222
Cannabis Use *(w/o abuse or dependence)* **& Cannabis Poisoning**	
Cannabis use, unspecified & uncomplicated	F12.90
See F12.9x for other cannabis "use" diagnoses	
Cannabis poisoning - *intent undetermined*	T40.7x4 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	

SUBSTANCE USE DISORDERS

Cocaine Abuse *("mild") See DSM5*	**Code**
Cocaine abuse; uncomplicated	F14.10
Cocaine abuse; in remission	F14.11
Cocaine abuse; with other cocaine-induced disorder	F14.188
with cocaine-induced; with anxiety disorder	F14.180
with mood disorder	F14.14
with psychotic disorder with delusions	F14.150
with psychotic disorder with hallucinations	F14.151
with sexual dysfunction	F14.181
with sleep disorder	F14.182
Cocaine abuse with intoxication; uncomplicated	F14.120
with delirium	F14.121
with perceptual disturbance	F14.122

Cocaine Dependence *(DSM "moderate / severe")*	
Cocaine dependence; uncomplicated	F14.20
Cocaine dependence; in remission	F14.21
with withdrawal;	F14.23
with cocaine-induced; with anxiety disorder	F14.280
with mood disorder	F14.24
with psychotic disorder with delusions	F14.250
with psychotic disorder with hallucinations	F14.251
with sexual dysfunction	F14.281
with sleep disorder	F14.282
Cocaine dependence with intoxication; uncomplicate	F14.220
with delirium	F14.221
with perceptual disturbances	F14.222
Cocaine abuse, unpsecified with withdrwal	F14.13

Cocaine Use *(w/o abuse or dependence)* **& Cocaine Poisoning**	
Cocaine use unspecified & uncomplicated	F14.90
See F14.9x for other cocaine "use" diagnoses	
Cocaine poisoning -*intent undetermined*	T40.5x4 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	
Cocaine use, unpsecified with withdrwal	F14.93

Opioid Abuse *("mild") See DSM5*	
Opioid abuse; uncomplicated	F11.10
Opioid abuse; in remission	F11.11
with opioid-induced; with mood disorder	F11.14
with psychotic disorder with delusions	F11.150
with psychotic disorder with hallucinations	F11.151
with sexual dysfunction	F11.181
with sleep disorder	F11.182
Opioid abuse with other induced disorder	F11.188
Opioid abuse with intoxication; uncomplicated	F11.120
with delirium	F11.121
with perceptual disturbance	F11.122
Opioid abuse with withdrwal	F11.13

Opioid Dependence *(DSM "moderate / severe")*	**Code**
Opioid dependence; uncomplicated	F11.20
Opioid dependence; in remission	F11.21
with withdrawal	F11.23
with opioid-induced; with mood disorder	F11.24
with psychotic disorder with delusions	F11.250
with psychotic disorder with hallucinations	F11.251
with sexual dysfunction	F11.281
with sleep disorder	F11.282
Opioid dependence with other induced disorder	F11.288
Opioid dependence with intoxication; uncomplicated	F11.220
with delirium	F11.221
with perceptual disturbances	F11.222

Opioid Use *(w/o abuse or dependence)* **& Opioid Poisoning**	
Opioid use unspecified & uncomplicated	F11.90
See F11.9x for other opioid "use" diagnoses	
Opioid poisoning - *Intent undetermined*	T40.2x4 -
Fentanyl poisoning - *Intent undetermined*	T40.414 -
Tramadol poisoning - *Intent undetermined*	T40.424 -
Other synthetic narcotic poisoning - *Intent undetermined*	T40.494 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	

Stimulant Abuse *("mild") See DSM5*	
Stimulant abuse; uncomplicated	F15.10
Other stimulant abuse; in remission.	F15.11
with stimulant induced; with anxiety disorder	F15.180
with mood disorder	F15.14
with psychotic disorder with delusions	F15.150
with psychotic disorder with hallucinations	F15.151
with sexual dysfunction	F15.181
with sleep disorder	F15.182
Stimulant abuse with intoxication; uncomplicated	F15.120
with delirium	F15.121
with perceptual disturbance	F15.122
Other stimulant abuse with withdrwal	F15.13

Stimulant Dependence	
Stimulant dependence; uncomplicated	F15.20
Stimulant dependence; in remission	F15.21
with withdrawal	F15.23
with stimulant-induced; anxiety disorder	F15.280
with mood disorder	F15.24
with psychotic disorder with delusions	F15.250
with psychotic disorder with hallucinations	F15.251
with sexual dysfunction	F15.281
with sleep disorder	F15.282
Stimulant dependence with intoxication; uncomplica	F15.220
with delirium	F15.221
with perceptual disturbances	F15.222

Stimulant Use *(w/o abuse or dependence)* & Stimulant Poisoning	
Stimulant use unspecified/uncomplicated	F15.90
See F15.9x for other stimulant "use" diagnoses	
Stimulant poisoning - *Intent undetermined*	T43.604 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	

SUBSTANCE USE DISORDERS

Psychoactive Abuse (*"mild") See DSM5*	Code
Psychoactive abuse; uncomplicated	F19.10
Other psychoactive substance abuse; in remission	F19.11
with psychoactive-induced; anxiety disorder	F19.180
with mood disorder	F19.14
with persisting amnestic disorder	F19.16
with persisting dementia	F19.17
with psychotic disorder with delusions	F19.150
with psychotic disorder with hallucinations	F19.151
with sexual dysfunction	F19.181
with sleep disorder	F19.182
Psychoactive abuse with other induced disorder	F19.188
Psychoactive abuse with intoxication; uncomplicated	F19.120
with delirium	F19.121
with perceptual disturbance	F19.122
Psychoactive abuse with withdrwal; uncomplicated	F19.130
unspecified	F19.139
Psychoactive Dependence *(DSM "moderate / severe")*	
Psychoactive dependence; uncomplicated	F19.20
Psychoactive dependence; in remission	F19.21
with withdrawal; uncomplicated	F19.230
with delirium	F19.231
with perceptual disturbance	F19.232
with Psychoactive-induced; with anxiety disorder	F19.280
with mood disorder	F19.24
with psychotic disorder with delusions	F19.250
with psychotic disorder with hallucinations	F19.251
with sexual dysfunction	F19.281
with sleep disorder	F19.282
Psychoactive dependence with other induced disorc	F19.288
Psychoactive dependence with intoxication; uncomp	F19.220
with delirium	F19.221
with perceptual disturbances	F19.222
Psychoactive Use *(not abuse)* **& Poisoning**	
Psychoactive use unspecified & uncomplicated	F19.90
See F19.9x for other psychoactive "use" diagnoses	
Psychoactive poisoning -*intent undetermined*	T43.94x -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	
Sedative/hypnotic/anxiolytic Abuse *("mild") See DSM5*	
Sedative abuse; uncomplicated	F13.10
Sedative, hypnotic or anxiolytic abuse; in remission	F13.11
with sedative-induced; with anxiety disorder	F13.180
with mood disorder	F13.14
with psychotic disorder with delusions	F13.150
with psychotic disorder with hallucinations	F13.151
with sexual dysfunction	F13.181
with sleep disorder	F13.182
Sedative abuse with other induced disorder	F13.188
Sedative abuse with intoxication; uncomplicated	F13.120
with delirium	F13.121
Sedative abuse with withdrwal; uncomplicated	F13.130
unspecified	F13.139

Sedative Dependence *(DSM "moderate / severe")*	Code
Sedative dependence; uncomplicated	F13.20
Sedative dependence; in remission	F13.21
with withdrawal; uncomplicated	F13.230
with delirium	F13.231
with perceptual disturbance	F13.232
with sedative-induced; with anxiety disorder	F13.280
with mood disorder	F13.24
with persisting amnestic disorder	F13.26
with persisting dementia	F13.27
with psychotic disorder delusions	F13.250
with psychotic disorder hallucinations	F13.251
with sexual dysfunction	F13.281
with sleep disorder	F13.282
Sedative dependence with other induced disorder	F13.288
Sedative dependence with intoxication; uncomplicate	F13.220
with delirium	F13.221
Sedative Use *(w/o abuse or dependence)* & Sedative Poisoning	
Sedative use unspecified & uncomplicated	F13.90
See F13.9x for other sedative "use" diagnoses	
Sedative poisoning - *intent undetermined*	T42.74x -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	
Hallucinogen Related Abuse *("mild") See DSM5*	
Hallucinogen abuse; uncomplicated	F16.10
Hallucinogen abuse; in remission	F16.11
with Hallucinogen-induced; with anxiety disorder	F16.180
with induced mood disorder	F16.14
with persisting perception disorder (flashbacks)	F16.183
with psychotic disorder with delusions	F16.150
with psychotic disorder with hallucinations	F16.151
Hallucinogen abuse with other induced disorder	F16.188
Hallucinogen abuse with intoxication; uncomplicated	F16.120
with delirium	F16.121
with perceptual disturbance	F16.122
Hallucinogen Dependence *(DSM "moderate / severe")*	
Hallucinogen dependence; uncomplicated	F16.20
Hallucinogen dependence; in remission	F16.21
with Hallucinogen-induced; with anxiety disorder	F16.280
with mood disorder	F16.24
with persisting perception disorder (flashbacks)	F16.283
with psychotic disorder with delusions	F16.250
with psychotic disorder with hallucinations	F16.251
Hallucinogen dependence with other induced disorc	F16.288
Hallucinogen dependence with intoxication; uncomp	F16.220
with delirium	F16.221
Hallucinogen Use (w/o abuse or dependence) & Poisoning	
Hallucinogen use unspecified & uncomplicated	F16.90
See F16.9x for other sedative "use" diagnoses	
Hallucinogen poisoning; *intent undetermined*	T40.904 -
Replace dash (-) with; A=initial (active tx);D= FU (healing); or S=sequela	

SUBSTANCE USE DISORDERS

Nicotine Dependence & Exposure *See DSM5*	Code
Cigarette; uncomplicated (current smoker) *(no related illness)*	F17.210
in remission	F17.211
in withdrawal	F17.213
Vapor or "Other" uncomplicated	F17.290
in remission	F17.291
in withdrawal	F17.293
Chewing tobacco, uncomplicated	F17.220
in remission	F17.221
in withdrawal	F17.223
2nd hand tobacco smoke exposure	Z77.22
Occupational tobacco smoke exposure	Z57.31
History of tobacco dependence	Z87.891
Tobacco use, *[no dependence]* *avoid*	Z72.0
Vaping-related disorder	U07.0
Use additional code(s) to identify manifestations of vaping-related disorders	
Screening for	
Alcoholism	Z13.89
Behavioral disorder	
Depression	
Neurologic disorder	
HIV	Z11.4
STD/STI	Z11.3
Intellectual disability	Z13.4
Malnutrition	Z13.29
Patient Medication Noncompliance by Self Underdosing of;	
Replace dash (-) w/ ***A*** *=initial (active tx);* ***D*** *= FU (healing); or* ***S*** *=sequela*	
tetracyclic antidepressants	T43.026 -
tricyclic antidepressants	T43.016 -
other antidepressant	T43.296 -
antipsychotics (phenothiazine)	T43.3x6 -
amphetamines	T43.626 -
other psychostimulant	T43.696 -
antipsychotics and neuroleptics	T43.596 -
barbiturates	T42.3x6 -
benzodiazepines	T42.4x6 -
butyrophenone & thiothixene neuroleptics	T43.4x6 -
cannabis	T40.7x6 -
MAOIs	T43.1x6 -
methadone	T40.3x6 -
methyphenidate (ADD)	T43.636 -
narcotics (synthetic)	T40.4x6 -
opium	T40.0x6 -
other opioid	T40.2x6 -
psychotrophic (other)	T43.8x6 -
SSRIs	T43.226 -
Code also PATIENT'S INTENT of underdosing	
INTENTIONAL underdosing of med(s) by patient;	
due to financial hardship	Z91.120
for any other reason	Z91.128
UNINTENTIONAL underdosing by patient;	
due to age-related debility	Z91.130
for any other reason	Z91.138

Other Patient Noncompliance Diagnoses	Code
Other med. noncompliance *(e.g., self overdosing)*	Z91.14
Noncompliance with other medical treatment and regimen	Z91.19
Patient's noncompliance with dietary regimen	Z91.11
Personal History and Family History Diagnosis Codes	
Personal History of; Alcoholism	F10.21
Combat and operational stress	Z86.51
Other Mental & Behavioral Disorders	Z86.59
Family History of psychiatric condition	Z81.8
Family History of substance abuse	Z81.4
Substance Abuse In Pregnancy (see ICD Chapter 15)	
Use additional code(s) from F10 to identify manifestations of alcohol use	
Alcohol use complicating pregnancy; 1st trimester	O99.311
2nd trimester	O99.312
3rd trimester	O99.313
Use additional code(s) from F11-F16 to identify manifestations of the drug use	
Drug use complicating pregnancy; 1st trimester	O99.321
2nd trimester	O99.322
3rd trimester	O99.323
Use additional code(s) from F17 to identify type of tobacco nicotine dependence	
Smoking complicating pregnancy: 1st trimester	O99.331
2nd trimester	O99.332
3rd trimester	O99.333
Miscellaneous and Signs/Symptoms	
Noncompliance with medical treatment	Z91.19
Abnormal involuntary movements	R25.9
Abnormal weight gain	R63.5
Abnormal weight loss	R63.4
Underweight	R63.6
BMI of 19 or less	Z68.1
Malnourished; moderate	E44.0
Abnormality of gait	R26.9
Altered mental status	R41.82
Decreased libido	R68.82
Dizziness/giddiness	R42
Excessive crying	R45.83
Fatigue	R53.83
Generalized pain	R52
Headache	R51
Hepatitis C, chronic, viral; carrier	B18.2
Hepatitis C, acute	B17.10
Insomnia	G47.00
Memory loss	R41.3
Nausea	R11.0
Senility w/o mention psychosis	R41.81
Sleep disturbance	G47.9

SOCIAL DETERMINANTS OF HEALTH (SDoH)

Education and Literacy	Code
Illiteracy and low-level literacy	Z55.0
Underachievement in school	Z55.3
Edu. maladjustment, discord w/ teachers & classmates	Z55.4
Other problems r/t education and literacy	Z55.8
Problems related to health literacy	Z55.6
Employment and Unemployment	
Unemployment, unspecified	Z56.0
Change of job	Z56.1
Threat of job loss	Z56.2
Stressful work schedule	Z56.3
Discord with boss and workmates	Z56.4
Other physical and mental strain related to work	Z56.6
Physical Environment Risk Factors	
Inadequate *(lack of)* drinking-water	Z58.6
Basic services unavailable (internet, telephone, utilities)	Z58.81
Other problems related to physical environment	Z58.89
Housing and Economic Circumstances	
Homelessness, sheltered	Z59.01
Homelessness, unsheltered	Z59.02
Inadequate housing	
Environmental temperature	Z59.11
Utilities	Z59.12
Other (pest infestation, space restrictions, etc.)	Z59.19
Problems r/t in residential institution	Z59.3
Food insecurity	Z59.41
Extreme poverty	Z59.5
Low income	Z59.6
Insufficient health insurance coverage	Z59.71
Insufficient welfare support	Z59.72
Housing instability	
housed with risk of homelessness	Z59.811
housed, homelessness in past 12 months	Z59.812
Transportation insecurity	Z59.82
Financial insecurity, difficulty paying utilities	Z59.861
Other specified financial insecurity	Z59.868
Material hardship d/t limited financial resources	Z59.87
Social Environment	
Problems related to living alone	Z60.2
Acculturation difficulty	Z60.3
Social exclusion and rejection	Z60.4
Other problems related to social environment	Z60.8
Upbringing	
Foster care (status)	Z62.21
Institutional upbringing	Z62.22
Child in custody of non-parental relative	Z62.23
Child in custody of non-relative guardian	Z62.24
Other upbringing away from parents	Z62.29
Parent-child conflict	Z62.820
Parent-setp child conflict	Z62.823
Non-parental relative-child conflict	Z62.831
Runaway	Z62.892
Personal history of abuse in childhood (*Excludes current)*	
physical and sexual abuse	Z62.810
psychological abuse	Z62.811
neglect	Z62.812
forced labor or sexual exploitation	Z62.813
Intimate partner abuse in childhood	Z62.815

Primary Support Group, Inc Family Circumstances	Code
Problems in relationship with spouse/partner	Z63.0
Absence of family member due to military deployment	Z63.31
Other absence of family member	Z63.32
Disruption of family by separation and divorce	Z63.5
Stress on family d/t return of family member from military	Z63.71
Alcohol/drug addiction in family	Z63.72
Problem r/t primary support group, unspecified	Z63.9
Other Psychosocial Circumstances	
Conviction civil/criminal proceedings w/o imprisonment	Z65.0
Imprisonment and other incarceration	Z65.1
Problems related to release from prison	Z65.2
Problems related to other legal circumstances	Z65.3
Victim of a crime and terrorism	Z65.4
Occupational exposure to risk factors	
Noise	Z57.0
Radiation	Z57.1
Dust	Z57.2
Environmental tobacco smoke	Z57.31
Other air contaminants	Z57.39
Toxic agents in agriculture	Z57.4
Toxic agents in other industries	Z57.5
Extreme temperature	Z57.6
Vibration	Z57.7
Other risk factors	Z57.8
Lifestyle	
Lack of physical exercise	Z72.3
Inappropriate diet and eating habits	Z72.4
High risk sexual behavior	
heterosexual behavior	Z72.51
homosexual behavior	Z72.52
bisexual behavior	Z72.53
Anti-social behavior	
child and adolescent antisocial behavior	Z72.810
adult antisocial behavior	Z72.811
Problem r/t sleep	
sleep deprivation	Z72.820
inadequate sleep hygiene	Z72.821
Life Management Difficulty	
Burn-out	Z73.0
Type A behavoir pattern	Z73.1
Stress, NEC	Z73.3
Inadequate social skills, NEC	Z73.4
Social role conflict, NEC	Z73.5
Limitation of activites due to disability	Z73.6
Care Provider Dependency	
No household member to render care	Z74.2
Medical Facilities and Other Health Care	
Holiday relief care	Z75.5
Dependence on Enabling Machines/Devices, NEC	
Wheelchair dependence *Code first cause of dependence*	Z99.3
Dependence on supplemental oxygen	Z99.81
Personal Risk Factors, NEC	
Personal history of adult physical and sexual abuse	Z91.410
Personal history of adult psychological abuse	Z91.411

From the American Medical Association ICD-10-CM 2026 The Complete Official Codebook:

Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC)

In the 1970s, Medicare began demonstration projects contracting with health maintenance organizations (HMOs) to provide care for Medicare beneficiaries in exchange for prospective payments. By 1985, this program became a permanent part of Medicare under Part C. The Balanced Budget Act (BBA) of 1997 established Medicare's Part C managed care program Medicare+Choice, and the Medicare Modernization Act (MMA) of 2003 again renamed it to Medicare Advantage (MA).

Today, roughly one-third of Medicare beneficiaries are enrolled in MA plans. Due to the great variance in the health status of Medicare beneficiaries, risk adjustment provides a means of adequately compensating those plans with large numbers of seriously ill patients while not overburdening other plans that have healthier individuals. Medicare Advantage (MA) plans have been using the Hierarchical Condition Category (HCC) risk adjustment model since 2004.

The Risk Adjustment Model

The primary purpose of a risk adjustment model Is to predict (on average) the future health care costs for specific consortiums enrolled In Medicare Advantage (MA) health plans. CMS is then able to provide capitation payments to these private health plans. Capitation payments are prospective per-member, per-month payments designed to Incentivize health plans to enroll not only healthier Individuals but those with chronic conditions or who are more seriously ill by removing some of the financial burden.

The MA risk adjustment model uses HCCs to assess the disease burden of enrollees. HCC diagnostic groupings were developed based on historical claims data to identify enrollees with similar disease processes and similar expected healthcare expenditures. Enrollees with comparable conditions are pooled into larger datasets, allowing the model to calculate average expenditure rates for those conditions. The medical conditions included in HCC categories are those that most predictably impact health status and healthcare costs for individuals. Several important principles to the risk adjustment model and the development of the HCC categories include but are not limited to:

1. The HCC diagnostic categories should be clinically meaningful.
    a. Diagnostic categories are well-defined.
    b. Clinically specific diseases or medical conditions are grouped into each category.
2. The HCC diagnostic categories should predict medical expenditures.
    a. The diagnoses grouped into a specific category should have as close to the same cost burden as possible, not only in the current year but also in future years.
3. The HCC diagnostic categories should have adequate sample sizes, and discretionary categories should be excluded to be as accurate and stable in their estimate of costs as possible.
    a. A diagnostic category that groups extremely rare diseases or conditions would not be reliably effective in determining current or future costs.
    b. Codes that are not credible as cost predictors, or that may be subject to coding variation, should be excluded whenever possible.
4. The HCC diagnostic categories should be both hierarchical and additive.
    a. Hierarchical measurement is used within a specific disease process.
    b. Disease processes that are unrelated to each other are measured additively.
    c. The diagnostic classification should encourage specificity and should not reward coding proliferation.
    d. More diagnosis codes, and vague diagnosis codes, do not equal a greater disease burden.

Model Refinement

CMS continues to refine the Hierarchical Condition Category (HCC) risk adjustment methodology to reflect current clinical practice, ICD-10-CM coding specificity, and health care utilization patterns. The FY2026 CMS-HCC model includes 115 payment HCCs, up from 86 in the prior version, enhancing both accuracy and predictive value.

The expanded model introduces new categories to better capture clinical distinctions and disease severity while consolidating or removing conditions that do not reliably predict costs. CMS rebuilt the model using more recent claims and denominator-year data and applied constraints to limit the impact of coding variation among Medicare Advantage organizations.

These refinements result in more clinically valid and cost-predictive relative weights, aligning payments more closely with disease burden and utilization trends. Individual and plan-level risk scores may shift depending on each beneficiary's diagnosis profile.

Revisions to the condition categories are guided by CMS's Ten Principles of Risk Adjustment, emphasizing clinical relevance, predictive accuracy, and model stability. Clinician input and cost analyses informed the reclassification process to:

- Capture ICD-10-CM coding specificity and documentation patterns;
- Reflect current care and expenditure trends; and
- Exclude conditions lacking clear diagnostic criteria or cost predictability.

Changes to the condition categories are based on each condition category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that do not predict costs well or do not have well-specified diagnosis coding are not included in the model.

Risk Adjustment Factors

The CMS-HCC risk adjustment model continues to use "risk adjustment factors" (RAFs) to calculate a risk score for each Medicare Advantage (MA) member. This score represents the member's expected cost of care relative to other members, summarizing both demographic and clinical complexity. Each member's RAF is determined using demographic and health status information, calculated as the sum of weighted factors reflecting their estimated contributions to overall risk. Factors include the member's age, sex, disability status, frailty, end-stage renal disease (ESRD), Medicaid eligibility (full or partial), Medicare enrollment status (new or established), prescription drug use, and care setting (community versus institutional).

The model relies exclusively on diagnostic and demographic data; no procedure codes, CPT, or ICD-10-PCS codes are used in the MA risk adjustment calculation. Not all ICD-10-CM diagnoses map to an HCC, and there is no specific sequencing requirement for submission. The CMS-HCC model is both additive and hierarchical. The additive component allows multiple HCCs to be assigned to a single patient, providing a more comprehensive view of clinical complexity and anticipated resource utilization. The hierarchical component ranks diagnoses with similar disease processes by severity, ensuring that a patient is classified to the most severe condition within each category while less severe related diagnoses are superseded. This combination allows the model to capture illness severity across multiple disease processes while still recognizing the additive impact of unrelated conditions.

Certain combinations of coexisting diagnoses can increase expected medical costs, and the CMS-HCC model accounts for these interactions through disease interaction factors. For each member, the assigned HCCs, along with demographic and disease interaction factors, are combined to produce a single RAF score. This score reflects all HCCs submitted to CMS from any source during a given calendar year.

Separate models exist for new enrollees and continuing members. The new enrollee model relies primarily on demographic factors such as age, sex, and disability status and is used when less than 12 months of clinical history are available. The community model includes demographic factors, original reason for Medicare entitlement, Medicaid eligibility, and clinical conditions captured through HCCs. Expected costs are then adjusted for outliers and ESRD status to refine the RAF calculation.

The RAF score is used to guide MA plan payments. A score of 1.0 represents the benchmark for an average healthy patient with similar demographic and diagnostic characteristics. Scores above 1.0 indicate members who are expected to require higher-than-average resources due to greater clinical complexity. Scores below 1.0 suggest lower-than-average expected resource use, but may also reflect incomplete or inaccurate coding, insufficient documentation, or missing clinical data. Conversely, a high RAF may accurately reflect a sicker patient, but it may also be artificially elevated due to overcoding, undocumented diagnoses, or repetitive inclusion of resolved conditions from past encounters or problem lists. Accurate coding and documentation remain essential to ensure that RAFs truly reflect patient risk and resource needs.

Documentation Requirements

Payment Is made per HCC category (not per diagnosis code). No matter how many times in the year the diagnosis codes are reported, a single payment Is made to the MA plan each year. Each year the list of HCCs and the RAF for each patient is “reset.” This means the annual health assessment is extremely important, and adequate documentation Is critical. Accurate risk adjustment payment relies on complete medical record documentation and diagnosis coding. CMS requires that all applicable diagnosis codes be reported and that all diagnoses be reported to the highest level of specificity and that these be substantiated by the medical record.

CMS's Guiding Principle:

The risk adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter, coded in accordance with the ICD-10-CM Guidelines for Coding and Reporting. Diagnoses should be assigned based on dates of service within the applicable data collection period and submitted to the Medicare Advantage (MA) organization from an appropriate risk adjustment provider type and an acceptable risk adjustment physician data source.

A “face-to-face” health service encounter is defined as an interaction between the patient and a qualified healthcare provider, which may include physicians (MD, DO) or qualified nonphysician practitioners (NPPs), such as nurse practitioners or physician assistants, who personally furnish the service directly to the patient. CMS provides an updated list of acceptable provider specialty types for risk adjustment data submission, previously outlined in the 2012 Regional Technical Assistance Participant Guide, with ongoing clarifications available through current CMS guidance. The only exception to the face-to-face encounter requirement remains the professional component of pathology services.

Following the COVID-19 public health emergency, CMS continues to allow certain telehealth services for risk adjustment purposes when provided using interactive audio and video technology that enables real-time, interactive communication. However, CMS does not provide a definitive list of all services considered face-to-face for risk adjustment; it does outline services that are not acceptable. For example, diagnostic radiology does not qualify because radiologists typically do not

document confirmed diagnoses. Similarly, diagnostic results that have not been interpreted, such as laboratory reports, are not acceptable for risk adjustment.

Medical record documentation must demonstrate that the direct face-to-face service was personally provided by the physician or qualified NPP and must be authenticated by the provider. Acceptable examples include office visits, hospital visits, preoperative anesthesia assessments, and surgical or invasive procedures. Each documented encounter must reflect only that visit and contain sufficient detail to support the assignment of diagnosis codes, which directly impacts the patient's risk score.

Risk adjustment relies on comprehensive, annual health information. Each enrollee is assigned an individual risk score derived from the health status information represented by the diagnosis codes on claims. The CMS-HCC model requires ICD-10-CM coding at the highest level of specificity supported by the medical record documentation. Providers should fully document and accurately code all severe and chronic conditions, ensuring that the clinical record reflects the complexity and intensity of care provided. Conditions affecting treatment or management should be documented at least once per year, as clinically appropriate, to accurately convey the patient's true health complexity. Inaccurate or incomplete coding may result in underrepresentation of medical decision-making, evaluation, and management provided.

Documentation to support risk adjustment conditions may be found anywhere within the face-to-face encounter note. Providers should ensure that the note accurately reflects all chronic conditions impacting patient care. Each page of progress notes must be properly authenticated, including the patient's name and the date. Clinical diagnoses should be documented to the highest level of specificity per encounter, including all complications, manifestations, and causal links. Only confirmed conditions should be coded; suspected, rule-out, or clinically insignificant abnormal findings should not be reported. Chronic conditions that affect care should be noted at least annually, and providers should describe clinical significance and relevant changes using precise terminology, such as decreased, increased, worsening, improving, unchanged, or abnormal findings.

Documentation Tips

- Document all cause-and-effect relationships.
- Report the most specific diagnosis code available that is supported by the documentation.
- Include all active diagnoses as part of the current medical decision-making and document them at every visit.
- Identify diagnoses that are current or chronic problems rather than part of past medical history or previous/resolved conditions.
- Document history of heart attack, status codes, etc., that affect the patient's care as "history of" or "PMH" when they are no longer active conditions.
- Ensure each progress note has the date, signature, and credentials/specialty.
- Document clinical reasoning and the thought processes used to assess each condition.
- Know high-revenue HCCs that are often undiagnosed or undercoded.
- Avoid "unspecified" codes, whenever possible.
- Ensure the codes reported are accurate and complete.
- Ensure each encounter is billed as documented.
- Review rejection reports and audit reports to assess risks.

Audits

Because reimbursement Is calculated per-patient, rather than based on an average of the entire population, and is based upon documentation, there is the potential risk for upcoding if diagnoses are not properly supported. Audits are conducted by the

MA plan and CMS recovery auditors (RACs).

Initial Validation Audit (IVA)

CMS requires that MA plans validate HCCs to ensure accurate risk adjustment. This is usually performed by an independent auditor working directly with the plan or a contracted vendor. During the audit, the MA plan submits one complete medical record for each HCC identified for a beneficiary, representing the documentation that best supports the condition. The auditor reviews the records to confirm that the diagnoses are properly documented and support the HCC as submitted, including legible, dated, and signed records that clearly link the provider to the diagnosis.

Risk Adjustment Data Validation Audit

Risk adjustment data validation (RADV) audits were introduced in 2011 and updated in 2015. They are performed by CMS to validate the integrity and accuracy of risk-adjusted payments by verifying that the diagnosis codes the MA plans submit are supported by the medical record documentation for each member.

MA plans can be selected by CMS for RADV audits annually. If chosen, they are required to submit their members' medical records to CMS. Providers are required to assist the MA plan by providing the medical record documentation included in the audit. While each diagnosis only needs to be reported once per calendar year, during a RADV audit, up to five dates of service may be submitted to support a single HCC.

CMS audits every MA plan contract annually, reviewing 200 records per contract, and has committed to completing a backlog of 2018–2024 audits by early 2026. Audit findings may be extrapolated to calculate recoupments and overpayments. While the target of the audit is the MA plan, documentation comes from the provider, and incomplete or unsupported documentation may result in clawbacks passed down to the clinic.

To be validated, medical record documentation must meet CMS criteria and standards. Even if a diagnosis is documented and coded correctly, any deficiency in the documentation can render the encounter and HCC invalid. Diagnoses that cannot be validated are considered payment errors. The results of the audit are communicated to the MA plan, which in turn communicates these results to the provider. Under- and overpayments are subject to payment adjustment. CMS regulations include a RADV appeal process, a document dispute process, and a procedures for obtaining physician signature attestations.

The following items are reviewed during the validation process:

- The record Is for the correct enrollee.
- The record Is from the correct calendar year for the payment year being audited.
- The record is legible.
- The date of service is present on the record and is for a face-to-face visit.
- The record Is from a valid provider type.
- Valid credentials and/or a valid physician specialty are documented on the record.
- The record contains a signature from an acceptable physician type.
- There Is a diagnosis documented on the record.
- The diagnosis supports an HCC.
- The diagnosis supports the submitted HCC.

Mitigate audit risk by coding each reportable diagnosis each time it meets reporting guidelines. Conduct regular audits to identify areas of risk, capture conditions that are documented but not coded, and check for additional qualifying HCCs. Ensure claims are submitted timely and that corrected claims are submitted when indicated. There are three main claims submission

deadlines: January, March, and September. CMS adjusts each member's risk score twice a year, with the final reconciliation occurring in August of the year following the plan year.

By emphasizing accurate coding and documentation and performing internal audits to identify risks and prepare for external audits, the likelihood of incorrect payment is reduced. For additional information on risk adjustment coding, see Optum's Risk Adjustment Coding and HCC Guide.