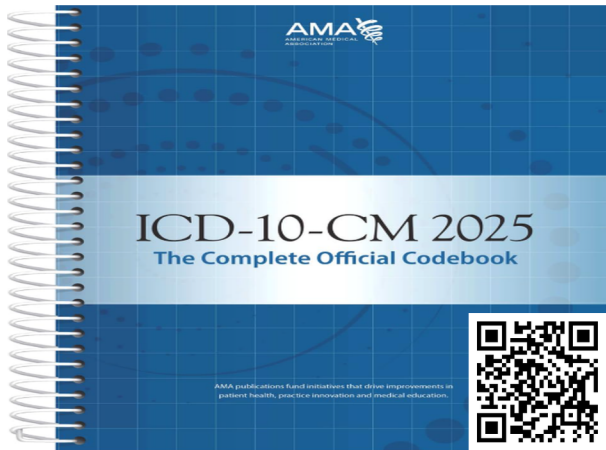


ICD-10-CM 2025 The Complete Official Codebook PDF

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ICD-10-CM 2025

The Complete Official Codebook

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2025 Code Changes

See the "What's New" section for more detailed information.

New	751
Revised	15
deleted	3

Excerpts from the ICD-10-CM Official Guidelines for Coding and Reporting

Below are a few commonly used coding guidelines. The ICD-10-CM Official Guidelines for Coding and Reporting can be found following the "10 Steps to Correct Coding" section in the front of this book.

WWW	"Not Coded Here" — Excludes 1 identifies codes that cannot be reported together. Exception: When the two conditions are clearly unrelated to each other, both codes may be reported.
NI	"Not Included Here" — Excludes 2 identifies conditions that are not included in the condition represented by the code. Both codes can be used when the patient has both conditions.
And	When used in narrative statement or code title "and" may be interpreted as "and/or."
With	When used in a code title, the Alphabetic Index, or an instructional note in the Tabular List, "with" should be interpreted to mean "associated with" or "due to." A causal relationship is presumed when two terms are linked by the word "with." The conditions should be coded as related except when the provider specifically documents that the conditions are unrelated or when another guideline exists that specifically requires documented linkage.

Tabular Notations

See the "How to Use ICD-10-CM" section for more detailed information.

N	New Code	Codes new to the classification midyear
A	Revised Code Title	Changes in that code's title midyear
N	New Code	Codes new to the classification
A	Revised Code Title	Changes in that code's title
—	Revised Text	Changes to a parenthetical note
—	Strikethrough Text	Deletion from the classification

ICD-10-CM 2025 with Official Guidelines for Coding and Reporting (FY 2025)

The American Medical Association (AMA) is pleased to provide you with the ICD-10-CM 2025 codebook that includes the Official Guidelines for Coding and Reporting (FY 2025).

Product Updates

Any changes and updates for this codebook, including the updates for April 1, 2025, will be provided on the AMA's product updates page at ama-assn.org/product-updates.

ICD-10-CM 2025

The Complete Official Codebook

AMA publications fund initiatives that drive improvements in patient health, practice innovation and medical education.

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BQ49:09/24

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All of the content entries below are bookmarked to the left for quick
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How to Use ICD-10-CM: The Complete Official Codebook 2025

Introduction

ICD-10-CM: The Complete Official Codebook 2025 is your definitive coding resource, combining the work of the National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and Publisher experts to provide the information you need for coding accuracy.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is an adaptation of ICD-10, copyrighted by the World Health Organization (WHO). The development and maintenance of this clinical modification (CM) is the responsibility of the NCHS as authorized by WHO. Any new concepts added to ICD-10-CM are based on an established update process through the collaboration of WHO's Update and Revision Committee and the ICD-10-CM Coordination and Maintenance Committee.

In addition to the ICD-10-CM classification, other official government source information has been included in this manual. Depending on the source, updates to information may be annual or quarterly. This manual provides the most current information that was available at the time of publication. For updates to the source documents that may have occurred after this manual was published, please refer to the following:

- **NCHS, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)**

<https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm>

- **CMS Integrated Outpatient Code Editor (IOCE), version 25.2**

<https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html>

- **CMS-HCC Risk Adjustment Model, version 28**
- **CMS ESRD-HCC Risk Adjustment Model, version 24**
- **CMS RxHCC Risk Adjustment Model, version 08**

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk->

- **HHS-HCC Commercial Risk Adjustment Model, version 07**

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance>

- **CMS Quality Payment Program (QPP)**

<https://qpp.cms.gov/mips/explore-measures>

- **AHA Coding Clinics**

<https://www.codingclinicadvisor.com/>

The official NCHS ICD-10-CM classification includes three main sections: the guidelines, the indexes, and the tabular list, all of which make up the bulk of this coding manual. To complement the classification, Optum’s coding experts have incorporated Medicare-related coding edits and proprietary features, such as supplementary notations, coding tools, and appendixes, into a comprehensive and easy-to-use reference. This publication is organized as follows:

[What’s New for 2025](#)

This section provides a high-level overview of the code changes made for fiscal 2025. The list of codes provided identifies new, revised, and deleted codes. Asterisk codes identify prior midyear changes that were made to the classification, effective April 1, 2024. All changes are based on official addenda, provided by the NCHS.

[Conversion Table](#)

The conversion table was developed by NCHS to help facilitate data retrieval as new codes are added to the ICD-10-CM classification. This table provides a crosswalk from each fiscal 2025 new code to the equivalent code(s) assigned, prior to October 1, 2024, for that diagnosis or condition. Asterisk codes identify prior midyear additions, effective April 1, 2024. For the full conversion table, refer to the Conversion Table zip file at <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm>.

[10 Steps to Correct Coding](#)

This step-by-step tutorial walks the coder through the process of finding the correct code — from locating the code in the official indexes to verifying the code in the tabular section — while following applicable conventions, guidelines, and instructional notes. Specific examples are provided with detailed explanations of each coding step along with advice for proper sequencing.

[Official ICD-10-CM Guidelines for Coding and Reporting](#)

This section provides the full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. These conventions and guidelines are published by the U.S. Department of Health and Human Services (DHHS) and approved by the cooperating parties (American Health Information Management Association [AHIMA], NCHS, Centers for Disease Control and Prevention [CDC], and the American Hospital Association [AHA]).

[Indexes](#)

[Index to Diseases and Injuries](#)

The Index to Diseases and Injuries is arranged in alphabetic order by terms specific to a disease, condition, illness, injury, eponym, or abbreviation as well as terms that describe circumstances other than a disease or injury that may require attention from a health care professional.

[Neoplasm Table](#)

The Neoplasm Table is arranged in alphabetic order by anatomical site. Codes are then listed in individual columns based upon the histological behavior (malignant, in situ, benign, uncertain, or unspecified) of the neoplasm.

[Table of Drugs and Chemicals](#)

The Table of Drugs and Chemicals is arranged in alphabetic order by the specific drug or chemical name. Codes are listed in individual columns based upon the associated intent (poisoning, adverse effect, or underdosing). Drugs with an asterisk identify substances added to the table by Optum subject matter experts.

[External Causes Index](#)

The External Causes Index is arranged in alphabetic order by main terms that describe the cause, the intent, the place of occurrence, the activity, and the status of the patient at the time the injury occurred or health condition arose.

Index Notations

With

The word “with” or “in” should be interpreted to mean “associated with” or “due to.” The classification presumes a causal relationship between the two conditions linked by these terms in the index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them unless the documentation clearly states the conditions are unrelated or when another guideline specifically requires a documented

linkage between two conditions (e.g., the sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”). For conditions not specifically linked by these relational terms in the classification or when a guideline requires explicit documentation of a linkage between two conditions, provider documentation must link the conditions to code them as related.

The word “with” in the index is sequenced immediately following the main term, not in alphabetical order.

Dermatopolymyositis M33.90
with
 myopathy M33.92
 respiratory involvement M33.91
 specified organ involvement NEC M33.99
 amyopathic M33.93

See

When the instruction “see” follows a term in the index, it indicates that another term must be referenced to locate the correct code.

Hematoperitoneum — *see* Hemoperitoneum

See Also

The instructional note “see also” simply provides alternative terms the coder may reference that may be useful in determining the correct code but are not necessary to follow if the main term supplies the appropriate code.

Hematuria — *see also* Hemaglobinuria
 malarial B50.8

Default Codes

In the index, the default code is the code listed next to the main term and represents the condition most commonly associated with that main term. This code may be assigned when documentation does not support reporting a more specific code. Alternatively, it may provide an unspecified code for the condition.

Hemiatrophy R68.89
 cerebellar G31.9
 face, facial, progressive (Romberg) G51.8
 tongue K14.8

Parentheses

Parentheses in the indexes enclose nonessential modifiers, supplementary words that may

be present or absent in the statement of a disease without affecting the code.

Pseudomeningocele (cerebral) (infective) (post-traumatic) G96.198
postprocedural (spinal) G97.82

Brackets

ICD-10-CM has a coding convention addressing code assignment for manifestations that occur as a result of an underlying condition. This convention requires the underlying condition to be sequenced first, followed by the code or codes for the associated manifestation. In the index, italicized codes in brackets identify manifestation codes.

Polyneuropathy (peripheral) G62.9
alcoholic G62.1
amyloid (Portuguese) E85.1 [*G63*]
transthyretin-related (ATTR) familial E85.1 [*G63*]

Shaded Guides

Exclusive vertical shaded guides in the Index to Diseases and Injuries and External Causes Index help the user easily follow the indent levels for the subentries under a main term. Sequencing rules may apply depending on the level of indent for separate subentries.

Hemicrania
congenital malformation Q00.0
continua G44.51
meaning migraine — *see also* Migraine G43.909
paroxysmal G44.039
 chronic G44.049
 intractable G44.041
 not intractable G44.049
 episodic G44.039
 intractable G44.031
 not intractable G44.039
 intractable G44.031
 not intractable G44.039

Following References

The Index to Diseases and Injuries includes “following” references to assist in locating out-of-sequence codes in the tabular list. Out-of-sequence codes contain an alphabetic character (letter) in the third- or fourth-character position. These codes are placed according to the classification rules — according to condition — not according to alphabetic or numeric sequencing rules.

Carcinoma (malignant) — *see also* Neoplasm, by site, malignant

neuroendocrine — *see also* Tumor, neuroendocrine
high grade, any site C7A.1 (*following* C75)
poorly differentiated, any site C7A.1 (*following* C75)

Additional Character Required

The Index to Diseases and Injuries, Neoplasm Table, and External Causes Index provide an icon after certain codes to signify to the user that additional characters are required to make the code valid. The tabular list should be consulted for appropriate character selection.

Fall, falling (accidental) W19 ✓
building W20.1 ✓

Tabular List of Diseases

ICD-10-CM codes and descriptions are arranged numerically within the tabular list of diseases with 19 separate chapters providing codes associated with a particular body system or nature of injury or disease. There is also a chapter providing codes for external causes of an injury or health conditions, a chapter for codes that address encounters with healthcare facilities for circumstances other than a disease or injury, and finally, a chapter for codes that capture special circumstances such as new diseases of uncertain etiology or emergency use codes.

Code and Code Descriptions

ICD-10-CM is an alphanumeric classification system that contains categories, subcategories, and valid codes. The first character is always a letter with any additional characters represented by either a letter or number. A three-character category without further subclassification is equivalent to a valid three-character code. Valid codes may be three, four, five, six, or seven characters in length, with each level of subdivision after a three-character category representing a subcategory. The final level of subdivision is a valid code.

Boldface

Boldface type is used for all codes and descriptions in the tabular list.

Italics

Italicized type is used to identify manifestation codes, those codes that should not be reported as first-listed diagnoses.

Deleted Text

~~Strikethrough~~ on a code and code description indicates a deletion from the classification for the current year.

Key Word

Green font is used throughout the Tabular List of Diseases to differentiate the key words that appear in similar code descriptions in a given category or subcategory. The key word convention is used only in those categories in which there are multiple codes with very similar descriptions with only a few words that differentiate them.

For example, refer to the list of codes below from category H55:

✓4 th	H55 Nystagmus and other irregular eye movements
✓5 th	H55.0 Nystagmus
	H55.00 Unspecified nystagmus
	H55.01 Congenital nystagmus
	H55.02 Latent nystagmus
	H55.03 Visual deprivation nystagmus
	H55.04 Dissociated nystagmus
	H55.09 Other forms of nystagmus

The portion of the code description that appears in **green font** in the tabular list helps the coder quickly identify the key terms and the correct code. This convention is especially useful when the codes describe laterality, such as the following codes from subcategory H40.22:

✓6 th	H40.22 Chronic angle-closure glaucoma	
	Chronic primary angle closure glaucoma	
✓7 th	H40.221 Chronic angle-closure glaucoma, right eye	Rx
✓7 th	H40.222 Chronic angle-closure glaucoma, left eye	Rx
✓7 th	H40.223 Chronic angle-closure glaucoma, bilateral	Rx
✓7 th	H40.229 Chronic angle-closure glaucoma, unspecified eye	Rx

Tabular Notations

Official parenthetical notes as well as Optum's supplementary notations are provided at the chapter, code block, category, subcategory, and individual code level to help the user assign proper codes. The information in the notation can apply to one or more codes depending on where the citation is placed.

Official Notations

Includes Notes

The word **INCLUDES** appears immediately under certain categories to further define, clarify, or give examples of the content of a code category.

Inclusion Terms

Lists of inclusion terms are included under certain codes. These terms indicate some of the conditions for which that code number may be used. Inclusion terms may be synonyms with the code title, or, in the case of “other specified” codes, the terms may also provide a list of various conditions included within a classification code. The inclusion terms are not exhaustive. The index may provide additional terms that may also be assigned to a given code.

Excludes Notes

ICD-10-CM has two types of excludes notes. Each note has a different definition for use. However, they are similar in that they both indicate that codes excluded from each other are independent of each other.

Excludes 1

An **EXCLUDES 1** note is a “pure” excludes. It means “NOT CODED HERE!” An Excludes 1 note indicates mutually exclusive codes: two conditions that cannot be reported together. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

An exception to the Excludes 1 definition is when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes 1 note are related or not, query the provider. For example, code F45.8 Other somatoform disorders, has an Excludes 1 note for “sleep related teeth grinding (G47.63)” because “teeth grinding” is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep-related teeth grinding. In this case, the two conditions are clearly unrelated to each other, so it would be appropriate to report F45.8 and G47.63 together.

Excludes 2

An **EXCLUDES 2** note means “NOT INCLUDED HERE.” An Excludes 2 note indicates that although the excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time. Therefore, when an Excludes 2 note appears under a code, it may be acceptable to use both the code and the excluded code together if supported by the medical documentation.

Note

The term “NOTE” appears as an icon and precedes the instructional information. These notes function as alerts to highlight coding instructions within the text.

Code First/Use additional code

These instructional notes provide sequencing instruction. They may appear independently of each other or to designate certain etiology/manifestation paired codes. These instructions signal the coder that an additional code should be reported to provide a more complete picture of that diagnosis.

In etiology/manifestation coding, ICD-10-CM requires the underlying condition to be sequenced first, followed by the manifestation. In these situations, codes with “In diseases classified elsewhere” in the code description are never permitted as a first-listed or principal diagnosis code and must be sequenced following the underlying condition code.

Code Also

A “code also” note alerts the coder that more than one code may be required to fully describe the condition. The sequencing depends on the circumstances of the encounter. Factors that may determine sequencing include severity and reason for the encounter.

Revised Text

The revised text ►◀ “bow ties” alert the user to changes in official notations for the current year. Revised text may include the following:

- A change in a current parenthetical description
- A change in the code(s) associated with a current parenthetical note
- A change in how a current parenthetical note is classified (e.g., an Excludes 1 note that changed to an Excludes 2 note)
- Addition of a new parenthetical note(s) to a code

Deleted Text

~~Strikethrough~~ on official notations indicate a deletion from the classification for the current year.

Publisher Notations

AHA Coding Clinic Citations

Coding Clinics are official American Hospital Association (AHA) publications that provide coding advice specific to ICD-10-CM and ICD-10-PCS.

Coding Clinic citations included in this manual are current up to the second quarter of 2024.

These citations identify the year, quarter, and page number of one or more Coding Clinic publications that may have coding advice relevant to a particular code or group of codes. With the most current citation listed first, these notations are preceded by the symbol **AHA:** and appear in purple type.

I15.1 Hypertension secondary to other renal disorders

AHA: 2016, 3Q, 22

Definitions

Definitions explain a specific term, condition, or disease process in layman's terms. These notations are preceded by the symbol **DEF:** and appear in purple type.

✓^{5th} M51.4 Schmorl's nodes

DEF: Irregular bone defect in the margin of the vertebral body that causes herniation into the end plate of the vertebral body.

Coding Tips

The tips in the tabular list offer coding advice that is not readily available within the ICD-10-CM classification. It may relate official coding guidelines, indexing nuances, or advice from *AHA's Coding Clinic for ICD-10-CM/PCS*. These notations are preceded by the symbol **TIP:** and appear in brown type.

✓^{5th} M11.2 Other chondrocalcinosis

Chondrocalcinosis NOS

AHA: 2018,3Q,20

TIP: Pseudogout is captured with codes in this subcategory.

Icons

Note: The following icons are placed to the left of the code.

Changes to ICD-10-CM codes since the last published edition of this manual are highlighted in two ways:

The following green icons identify new or revised codes effective April 1, 2024:

- **New Code — Midyear**
- ▲ **Revised Code — Midyear**

The following black icons identify new or revised codes effective October 1, 2024:

- **New Code**
- ▲ **Revised Code**
- ✓ **Additional Characters Required**

✓^{4th} This symbol indicates that the code requires a 4th character.

✓^{5th} This symbol indicates that the code requires a 5th character.

✓^{6th} This symbol indicates that the code requires a 6th character.

✓^{7th} This symbol indicates that the code requires a 7th character.

✓5th **H60.3 Other infective otitis externa**

✓6th **H60.31 Diffuse otitis externa**

H60.311 Diffuse otitis externa, right ear

H60.312 Diffuse otitis externa, left ear

H60.313 Diffuse otitis externa, bilateral

H60.319 Diffuse otitis externa, unspecified ear

✓x7th **Placeholder Alert**

This symbol indicates that the code requires a 7th character following the placeholder “X”. Codes with fewer than six characters that require a 7th character must contain placeholder “X” to fill in the empty character(s).

✓x7th **T16.1 Foreign body in right ear**

This manual provides the most current information that was available at the time of publication. Except where otherwise noted, the icons and/or color bars reflect edits provided in the Integrated Outpatient Code Editor (IOCE) quarterly files utilized under the outpatient prospective payment system (OPPS). Because the October 2024 quarterly files were not available at the time this book was printed, the edits in this manual are based on the July 2024 quarterly files.

The following is a list of IOCE edits specifically identified in this manual:

- Age
- Manifestation
- Unacceptable principal diagnosis

Note: The following icons are placed at the end of the code description.

Age Edits

N Newborn Age: 0

These diagnoses are intended for newborns and neonates and the patient’s age must be 0 years.

N47.0 Adherent prepuce, newborn

P Pediatric Age: 0-17

These diagnoses are intended for children and the patient’s age must be between 0 and 17 years.

L21.1 Seborrheic infantile dermatitis

M Maternity Age: 9-64

These diagnoses are intended for childbearing patients between the age of 9 and 64 years.

002.9 Abnormal product of conception, unspecified

COM M

Adult Age: 15-124

These diagnoses are intended for patients between the age of 15 and 124 years.

R54 Age-related physical debility

Frailty
Old age
Senescence
Senile asthenia
Senile debility

EXCLUDES 1 *age-related cognitive decline (R41.81)*
sarcopenia (M62.84)
senile psychosis (F03.-)
senility NOS (R41.81)

Sex Edits

Effective April 1, 2024, the Integrated Outpatient Code Editor (IOCE), a program used to process claims for outpatient providers, has deactivated the sex conflict edit. There will no longer be a female or male edit restriction for ICD-10-CM codes.

Unacceptable Principal Diagnosis

This icon identifies codes that are not appropriate as a first-listed code for *outpatient* encounters. These codes describe circumstances that influence an individual's health status but are not a current illness or injury, or that are not specifically manifestations but may be due to an underlying cause.

✓7th T48.5X5 Adverse effect of other anti-common-cold drugs

UPD

CMS-HCC Condition

This icon identifies codes that are considered a CMS-HCC (hierarchical condition category) diagnosis.

The HCC codes represented in this manual have been updated to reflect the 2025 Initial ICD-10-CM Mappings for CMS-HCC Model v28. Midyear final mappings were not available at the time this publication went to print; refer to the following CMS website for final mappings: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>.

P12.2 Epicranial subaponeurotic hemorrhage due to birth injury

Subgaleal hemorrhage

HCC

Rx HCC Condition

This icon identifies codes that are included in the Rx-HCC risk-adjustment model, which covers the Part D (prescription drug) benefit.

The Rx-HCC codes represented in this manual have been updated to reflect the 2025 Initial ICD-10-CM Mappings for CMS Rx-HCC Model v08. Midyear final mappings were not available at the time this publication went to print; refer to the following CMS website for final mappings: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>.

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

HCC Rx ESR COM

ESRD HCC Condition

This icon identifies codes that are included in the end-stage renal disease (ESRD) HCC risk-adjustment model.

The ESRD HCC codes represented in this manual have been updated to reflect the 2025 Initial ICD-10-CM Mappings for CMS ESRD HCC Model v24. Midyear final mappings were not available at the time this publication went to print; refer to the following CMS website for final mappings: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>.

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

HCC Rx ESR COM

COM Commercial HCC Condition

This icon identifies codes that are included in the commercial HHS-HCC risk-adjustment model.

The commercial HCC codes represented in this manual are based on the commercial HCC Model v07. These mappings can be found at the following: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance>.

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

HCC Rx ESR COM

Q QPP Condition

This icon identifies codes recognized as a quality measure for claims-based reporting under CMS's Merit-based Incentive Payment System (MIPS) Claims Single Source v6.0.

K22.70 Barrett's esophagus without dysplasia

Barrett's esophagus NOS

Q

PDx Z-code as First-Listed Diagnosis

Section IV of the official guidelines states that the term "first-listed diagnosis" is used instead of principal diagnosis in the outpatient setting and represents the

diagnosis that is chiefly responsible for the services provided during the encounter. This icon identifies Z codes that, in general, may be reported only as a first-listed diagnosis. According to guideline I.C.21.c.16, these are the only Z codes that are specifically meant to be utilized as a first-listed diagnosis; all other Z codes may be either first-listed or secondary diagnoses, depending upon the circumstances of the encounter, coding instructions, and guidelines.

Note: The codes identified with this icon may be used as a secondary diagnosis if the patient has multiple encounters on the same day and those medical records are combined.

A comprehensive list of all Z codes primarily used as first-listed diagnoses appears in [appendix D](#), at the back of this book.

Z52.21 Bone donor, autologous

PDx

Color Bars

Manifestation Code

Codes defined as manifestation codes appear in italic type, with a blue color bar over the code description. A manifestation cannot be reported as a first-listed code; it is sequenced as a secondary diagnosis with the underlying disease code listed first.

G32.89 *Other specified degenerative disorders of nervous system in diseases classified elsewhere*

Degenerative encephalopathy in diseases classified elsewhere

Unspecified Diagnosis

Codes that appear with a gray color bar over the alphanumeric code identify unspecified diagnoses. These codes should be used in limited circumstances, when neither the diagnostic statement nor the documentation provides enough information to assign a more specific diagnosis code. The abbreviation NOS, “not otherwise specified,” in the tabular list may be interpreted as “unspecified.”

G03.9 Meningitis, unspecified
Arachnoiditis (spinal) NOS

COM

Chapter-Level Notations

Chapter-specific Guidelines with Coding Examples

Each chapter begins with the Official Guidelines for Coding and Reporting specific to that chapter, where provided. Coding examples specific to outpatient care settings have been provided to illustrate the coding and/or sequencing guidance in these guidelines.

Muscle and Tendon Table

ICD-10-CM categorizes certain muscles and tendons in the upper and lower extremities by their action (e.g., extension or flexion) as well as their anatomical location. The Muscle/Tendon table is provided at the beginning of [chapter 13](#) and [chapter 19](#) to help users when code selection depends on the action of the muscle and/or tendon.

Note: This table is not all-inclusive, and proper code assignment should be based on the provider's documentation.

[Appendixes](#)

The additional resources described below have been included as appendixes for this book. These resources further instruct the professional coder on the appropriate application of the ICD-10-CM code set.

[Appendix A: Valid 3-character ICD-10-CM Codes](#)

The user may consult this table to confirm that no further specificity, such as the use of 4th, 5th, 6th, or 7th characters or placeholders (X), is necessary. All ICD-10-CM codes that are valid at the three-character level are listed.

[Appendix B: Pharmacology List 2025](#)

This reference is a comprehensive but not all-inclusive list of pharmacological agents used to treat acute and/or chronic conditions. Drugs are listed in alphabetical order by their brand and/or generic names along with their drug action and indications for which they may commonly be prescribed. Some drugs have also been mapped to their appropriate Z code for long-term drug use.

[Appendix C: Z Codes for Long-Term Drug Use with Associated Drugs](#)

This resource correlates Z codes that are used to identify current long-term drug use with a list of drugs that are typically categorized to that class of drug.

Note: These tables are not all-inclusive but list some of the more commonly used drugs.

[Appendix D: Z Codes Only as Principal/First-Listed Diagnosis](#)

This resource provides a comprehensive list of Z codes that are primarily used as first-listed diagnoses for outpatient encounters.

[Appendix E: Centers for Medicare & Medicaid Services Hierarchical Condition Categories \(CMS-HCC\)](#)

This resource provides the framework behind the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage (MA) program, a risk-adjustment model developed as a means of compensating health care plans with large numbers of Medicare Part C beneficiaries. It includes a brief synopsis of the evolution of the program from its

inception and insight into the various elements needed to predict risk, including the principles used to develop the hierarchical condition categories (HCCs), which make up one of the fundamental components of the risk-adjustment model. This appendix also outlines the audit process used to ensure the accuracy of payments made to MA plans.

Appendix F: Centers for Medicare & Medicaid Services Quality Payment Program

This resource provides an overview of the Medicare Access and CHIP Reauthorization Act (MACRA), which replaced Medicare's sustainable growth rate (SGR) methodology with the Quality Payment Program (QPP). It summarizes the Merit-based Incentive Payment System (MIPS) track used by those who opt to participate in traditional Medicare and not an advanced alternative payment model (APM). This includes eligibility requirements and an overview of the four performance categories that combine to make up the MIPS.

Illustrations

This section includes illustrations of normal anatomy with ICD-10-CM-specific terminology.

What's New for 2025

Official Updates

A summary of changes to the official ICD-10-CM code set is provided below, identifying changes made for fiscal 2025, effective October 1, 2024, to September 30, 2025.

Asterisked codes identify prior midyear changes that were made to the classification, effective April 1, 2024. All code changes were made by the agency charged with maintaining and updating the ICD-10-CM code set, the National Center for Health Statistics (NCHS), a section of the Centers for Disease Control and Prevention (CDC).

252 New Codes

C81.0A	C81.1A	C81.2A	C81.3A	C81.4A
C81.7A	C81.9A	C82.0A	C82.1A	C82.2A
C82.3A	C82.4A	C82.5A	C82.6A	C82.8A
C82.9A	C83.0A	C83.1A	C83.390	C83.398
C83.3A	C83.5A	C83.7A	C83.8A	C83.9A
C84.0A	C84.1A	C84.4A	C84.6A	C84.7B
C84.9A	C84.AA	C84.ZA	C85.1A	C85.2A
C85.8A	C85.9A	C86.00	C86.01	C86.10
C86.11	C86.20	C86.21	C86.30	C86.31
C86.40	C86.41	C86.50	C86.51	C86.60
C86.61	C88.00	C88.01	C88.20	C88.21
C88.30	C88.31	C88.40	C88.41	C88.80
C88.81	C88.90	C88.91	D61.03	E10.A0
E10.A1	E10.A2	E16.A1	E16.A2	E16.A3
E34.00	E34.01	E34.09	E66.811	E66.812
E66.813	E66.89	E74.820	E74.829	E88.82
F50.010	F50.011	F50.012	F50.013	F50.014
F50.019	F50.020	F50.021	F50.022	F50.023
F50.024	F50.029	F50.20	F50.21	F50.22
F50.23	F50.24	F50.25	F50.810	F50.811
F50.812	F50.813	F50.814	F50.819	F50.83
F50.84	G40.841	G40.842	G40.843	G40.844
G90.81	G90.89	G93.45	I26.03	I26.04
I26.95	I26.96	J34.8200	J34.8201	J34.8202

J34.8210	J34.8211	J34.8212	J34.829	K60.30
K60.311	K60.312	K60.313	K60.319	K60.321
K60.322	K60.323	K60.329	K60.40	K60.411
K60.412	K60.413	K60.419	K60.421	K60.422
K60.423	K60.429	K60.50	K60.511	K60.512
K60.513	K60.519	K60.521	K60.522	K60.523
K60.529	L29.81	L29.89	L66.10	L66.11
L66.12	L66.19	L66.81	L66.89	M51.360
M51.361	M51.362	M51.369	M51.370	M51.371
M51.372	M51.379	M62.85	M65.90	M65.911
M65.912	M65.919	M65.921	M65.922	M65.929
M65.931	M65.932	M65.939	M65.941	M65.942
M65.949	M65.951	M65.952	M65.959	M65.961
M65.962	M65.969	M65.971	M65.972	M65.979
M65.98	M65.99	Q23.81	Q23.82	Q23.88
Q87.86	R41.85	T45.AX1A	T45.AX1D	T45.AX1S
T45.AX2A	T45.AX2D	T45.AX2S	T45.AX3A	T45.AX3D
T45.AX3S	T45.AX4A	T45.AX4D	T45.AX4S	T45.AX5A
T45.AX5D	T45.AX5S	T45.AX6A	T45.AX6D	T45.AX6S
T81.320A	T81.320D	T81.320S	T81.321A	T81.321D
T81.321S	T81.328A	T81.328D	T81.328S	T81.329A
T81.329D	T81.329S	Z15.1	Z15.2	Z17.21
Z17.22	Z17.31	Z17.32	Z17.410	Z17.411
Z17.420	Z17.421	Z51.A	Z59.71	Z59.72
Z67.A1	Z67.A2	Z67.A3	Z67.A4	Z68.55
Z68.56	Z83.72	Z86.0100	Z86.0101	Z86.0102
Z86.0109	Z92.26			

13 Revised Codes

Note: Each code is listed with its revised description only.

- A77.41 Ehrlichiosis chaffeensis [E. chaffeensis]
- F98.21 Rumination disorder of infancy and childhood
- G93.42 Megalencephalic leukoencephalopathy with subcortical cysts
- H44.2A3 Degenerative myopia with choroidal neovascularization, bilateral
- H44.2B3 Degenerative myopia with macular hole, bilateral
- H44.2C3 Degenerative myopia with retinal detachment, bilateral
- H44.2D3 Degenerative myopia with foveoschisis, bilateral
- H44.2E3 Degenerative myopia with other maculopathy, bilateral

I26.93	Single subsegmental thrombotic pulmonary embolism without acute cor pulmonale
I26.94	Multiple subsegmental thrombotic pulmonary emboli without acute cor pulmonale
K58.9	Irritable bowel syndrome, unspecified
Q13.81	Rieger anomaly
Z68.54	Body mass index [BMI] pediatric, 95th percentile for age to less than 120% of the 95th percentile for age

3 Deleted Codes

T81.32XA	Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter
T81.32XD	Disruption of internal operation (surgical) wound, not elsewhere classified, subsequent encounter
T81.32XS	Disruption of internal operation (surgical) wound, not elsewhere classified, sequela

Proprietary Updates

The following proprietary features have also been added:

- New definitions that describe, in lay terms, a specific condition or disease process
- New coding tips that provide coding advice beyond the code classification
- Updated *AHA Coding Clinic* references through second quarter 2024

Conversion Table of ICD-10-CM Codes

The FY 2025 (October 1, 2024-September 30, 2025) Conversion Table for new ICD-10-CM codes is provided to assist users in data retrieval. For each new code the table shows its previously assigned code equivalent. Asterisks identify new codes added to the classification April 1, 2024.

Code Assignment Beginning 10/1/2024	Previous Code(s) Assignment
C81.0A	Z85.71
C81.1A	Z85.71
C81.2A	Z85.71
C81.3A	Z85.71
C81.4A	Z85.71
C81.7A	Z85.71
C81.9A	Z85.71
C82.0A	Z85.72
C82.1A	Z85.72
C82.2A	Z85.72
C82.3A	Z85.72
C82.4A	Z85.72
C82.5A	Z85.72
C82.6A	Z85.72
C82.8A	Z85.72
C82.9A	Z85.72
C83.0A	Z85.72
C83.1A	Z85.72
C83.390	Z85.72
C83.398	Z85.72
C83.3A	Z85.72
C83.5A	Z85.72

C83.7A	Z85.72
C83.8A	Z85.72
C83.9A	Z85.72
C84.0A	Z85.72
C84.1A	Z85.72
C84.4A	Z85.72
C84.6A	Z85.72
C84.7B	Z85.72
C84.AA	Z85.72
C84.ZA	Z85.72
C84.9A	Z85.72
C85.1A	Z85.72
C85.2A	Z85.72
C85.8A	Z85.72
C85.9A	Z85.72
C86.00	C86.0
C86.01	Z85.72
C86.10	C86.1
C86.11	Z85.72
C86.20	C86.2
C86.21	Z85.72
C86.30	C86.3
C86.31	Z85.72
C86.40	C86.4
C86.41	Z85.72
C86.50	C86.5
C86.51	Z85.72
C86.60	C86.6
C86.61	Z85.72
C88.00	C88.0
C88.01	Z85.79
C88.20	C88.2
C88.21	Z85.79

C88.30	C88.3
C88.31	Z85.79
C88.40	C88.4
C88.41	Z85.79
C88.80	C88.8
C88.81	Z85.79
C88.90	C88.9
C88.91	Z85.79
D61.03	D61.09
E10.A0	R73.03
E10.A1	R73.03
E10.A2	R73.03
E16.A1	E16.2
E16.A2	E16.2
E16.A3	E16.2
E34.00	E34.0
E34.01	E34.0
E34.09	E34.0
E66.811	E66.8
E66.812	E66.8
E66.813	E66.8
E66.89	E66.8
E74.820	E74.89
E74.829	E74.89
E88.82	E88.89
F50.010	F50.01
F50.011	F50.01
F50.012	F50.01
F50.013	F50.01
F50.014	F50.01
F50.019	F50.01
F50.020	F50.02

F50.021	F50.02
F50.022	F50.02
F50.023	F50.02
F50.024	F50.02
F50.029	F50.02
F50.20	F50.2
F50.21	F50.2
F50.22	F50.2
F50.23	F50.2
F50.24	F50.2
F50.25	F50.2
F50.810	F50.81
F50.811	F50.81
F50.812	F50.81
F50.813	F50.81
F50.814	F50.81
F50.819	F50.81
F50.83	F50.89
F50.84	F50.89
G40.841	G40.89
G40.842	G40.89
G40.843	G40.89
G40.844	G40.89
G90.81	G90.8
G90.89	G90.8
G93.45	G93.49
I26.03	I26.09
I26.04	I26.09
I26.95	I26.99
I26.96	I26.99
J34.8200	J34.89
J34.8201	J34.89

J34.8202	J34.89
J34.8210	J34.89
J34.8211	J34.89
J34.8212	J34.89
J34.829	J34.89
K60.30	K60.3
K60.311	K60.3
K60.312	K60.3
K60.313	K60.3
K60.319	K60.3
K60.321	K60.3
K60.322	K60.3
K60.323	K60.3
K60.329	K60.3
K60.40	K60.4
K60.411	K60.4
K60.412	K60.4
K60.413	K60.4
K60.419	K60.4
K60.421	K60.4
K60.422	K60.4
K60.423	K60.4
K60.429	K60.4
K60.50	K60.5
K60.511	K60.5
K60.512	K60.5
K60.513	K60.5
K60.519	K60.5
K60.521	K60.5
K60.522	K60.5
K60.523	K60.5
K60.529	K60.5

L29.81	L29.8
L29.89	L29.8
L66.10	L66.1
L66.11	L66.1
L66.12	L66.1
L66.19	L66.1
L66.81	L66.8
L66.89	L66.8
M51.360	M51.36
M51.361	M51.36
M51.362	M51.36
M51.369	M51.36
M51.370	M51.37
M51.371	M51.37
M51.372	M51.37
M51.379	M51.37
M62.85	M62.89
M65.90	M65.9
M65.911	M65.9
M65.912	M65.9
M65.919	M65.9
M65.921	M65.9
M65.922	M65.9
M65.929	M65.9
M65.931	M65.9
M65.932	M65.9
M65.939	M65.9
M65.941	M65.9
M65.942	M65.9
M65.949	M65.9
M65.951	M65.9
M65.952	M65.9

M65.959	M65.9
M65.961	M65.9
M65.962	M65.9
M65.969	M65.9
M65.971	M65.9
M65.972	M65.9
M65.979	M65.9
M65.98	M65.9
M65.99	M65.9
Q23.81	Q23.8
Q23.82	Q23.8
Q23.88	Q23.8
Q87.86	Q87.89
R41.85	R41.89
T45.AX1A	T45.1X1A
T45.AX1D	T45.1X1D
T45.AX1S	T45.1X1S
T45.AX2A	T45.1X2A
T45.AX2D	T45.1X2D
T45.AX2S	T45.1X2S
T45.AX3A	T45.1X3A
T45.AX3D	T45.1X3D
T45.AX3S	T45.1X3S
T45.AX4A	T45.1X4A
T45.AX4D	T45.1X4D
T45.AX4S	T45.1X4S
T45.AX5A	T45.1X5A
T45.AX5D	T45.1X5D
T45.AX5S	T45.1X5S
T45.AX6A	T45.1X6A
T45.AX6D	T45.1X6D
T45.AX6S	T45.1X6S

T81.320A	T81.32XA
T81.320D	T81.32XD
T81.320S	T81.32XS
T81.321A	T81.32XA
T81.321D	T81.32XD
T81.321S	T81.32XS
T81.328A	T81.32XA
T81.328D	T81.32XD
T81.328S	T81.32XS
T81.329A	T81.32XA
T81.329D	T81.32XD
T81.329S	T81.32XS
Z15.1	Z15.89
Z15.2	Z15.89
Z17.21	None
Z17.22	None
Z17.31	None
Z17.32	None
Z17.410	None
Z17.411	None
Z17.420	None
Z17.421	None
Z51.A	Z51.89
Z59.71	Z59.7
Z59.72	Z59.7
Z67.A1	None
Z67.A2	None
Z67.A3	None
Z67.A4	None
Z68.55	Z68.54
Z68.56	Z68.54
Z83.72	Z83.718

Z86.0100	Z86.010
Z86.0101	Z86.010
Z86.0102	Z86.010
Z86.0109	Z86.010
Z92.26	Z92.29

10 Steps to Correct Coding

Follow the 10 steps below to correctly code encounters for health care services.

Step 1: Identify the reason for the visit or encounter (i.e., a sign, symptom, diagnosis and/or condition).

The medical record documentation should accurately reflect the patient's condition, using terminology that includes specific diagnoses and symptoms or clearly states the reasons for the encounter.

Choosing the main term that best describes the reason chiefly responsible for the service provided is the most important step in coding. If symptoms are present and documented but a definitive diagnosis has not yet been determined, code the symptoms. *For outpatient cases, do not code conditions that are referred to as “rule out,” “suspected,” “probable,” or “questionable.”* Diagnoses often are not established at the time of the initial encounter/visit and may require two or more visits to be established. Code only what is documented in the available outpatient records and only to the highest degree of certainty known at the time of the patient's visit. For inpatient medical records, uncertain diagnoses may be reported if documented at the time of discharge.

Step 2: After selecting the reason for the encounter, consult the alphabetic index.

The most critical rule is to begin code selection in the alphabetic index. Never turn first to the tabular list. The index provides cross-references, essential and nonessential modifiers, and other instructional notations that may not be found in the tabular list.

Step 3: Locate the main term entry.

The alphabetic index lists conditions, which may be expressed as nouns or eponyms, with critical use of adjectives. Some conditions known by several names have multiple main entries. Reasons for encounters may be located under general terms such as admission, encounter, and examination. Other general terms such as history, status (post), or presence (of) can be used to locate other factors influencing health.

Step 4: Scan subterm entries.

Scan the subterm entries, as appropriate, being sure to review continued lines and additional subterms that may appear in the next column or on the next page. Shaded vertical guidelines in the index indicate the indentation level for each subterm in relation

to the main terms.

Step 5: Pay close attention to index instructions.

- Parentheses () enclose nonessential modifiers, terms that are supplementary words or explanatory information that may or may not appear in the diagnostic statement and do not affect code selection.
- Brackets [] enclose manifestation codes that can be used only as secondary codes to the underlying condition code immediately preceding it. If used, manifestation codes must be reported with the appropriate etiology codes.
- Default codes are listed next to the main term and represent the condition most commonly associated with the main term or the unspecified code for the main term.
- “*See*” cross-references, identified by italicized type and “code by” cross-references indicate that another term *must be referenced* to locate the correct code.
- “*See also*” cross-references, identified by italicized type, provide alternative terms that may be useful to look up but *are not mandatory*.
- “Omit code” cross-references identify instances when a code is not applicable depending on the condition being coded.
- “With” subterms are listed out of alphabetic order and identify a presumed causal relationship between the two conditions they link.
- “Due to” subterms identify a relationship between the two conditions they link.
- “NEC,” abbreviation for “not elsewhere classified,” follows some main terms or subterms and indicates that there is no specific code for the condition even though the medical documentation may be very specific.
- “NOS,” abbreviation for “not otherwise specified,” follows some main terms or subterms and is the equivalent of unspecified; NOS signifies that the information in the medical record is insufficient for assigning a more specific code.
- *Following* references help coders locate alphanumeric codes that are out of sequence in the tabular section.
- Check-additional-character symbols flag codes that require additional characters to make the code valid; the characters available to complete the code should be verified in the tabular section.

Step 6: Choose a potential code and locate it in the tabular list.

To prevent coding errors, always use both the alphabetic index (to identify a code) and the tabular list (to verify a code), as the index does not include the important instructional notes found in the tabular list. An added benefit of using the tabular list, which groups

like things together, is that while looking at one code in the list, a coder might see a more specific one that would have been missed had the coder relied solely on the alphabetic index. Additionally, many of the codes require a fourth, fifth, sixth, or seventh character to be valid, and many of these characters can be found only in the tabular list.

Step 7: Read all instructional material in the tabular section.

The coder must follow any Includes, Excludes 1 and Excludes 2 notes, and other instructional notes, such as “Code first” and “Use additional code,” listed in the tabular list for the chapter, category, subcategory, and subclassification levels of code selection that direct the coder to use a different or additional code. Any codes in the tabular range A00.0–T88.9, Z00–Z99.8, and U00–U85 may be used to identify the diagnostic reason for the encounter. The tabular list encompasses many codes describing disease and injury classifications (e.g., infectious and parasitic diseases, neoplasms, symptoms, nervous and circulatory system, etc.).

Codes that describe symptoms and signs, as opposed to definitive diagnoses, should be reported when an established diagnosis has not been made (confirmed) by the physician. [Chapter 18](#) of the ICD-10-CM code book, “Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified” (codes R00–R99), contains many, but not all, codes for symptoms.

ICD-10-CM classifies encounters with health care providers for circumstances other than a disease or injury in [chapter 21](#), “Factors Influencing Health Status and Contact with Health Services” (codes Z00–Z99). Circumstances other than a disease or injury often are recorded as chiefly responsible for the encounter.

A code is invalid if it does not include the full number of characters (greatest level of specificity) required. Codes in ICD-10-CM can contain from three to seven alphanumeric characters. A three-character code is to be used only if the category is not further subdivided into four-, five-, six-, or seven-character codes. Placeholder character X is used as part of an alphanumeric code to allow for future expansion and as a placeholder for empty characters in a code that requires a seventh character but has no fourth, fifth, or sixth character. Note that certain categories require seventh characters that apply to all codes in that category. Always check the category level for applicable seventh characters for that category.

Step 8: Consult the official ICD-10-CM conventions and guidelines.

The *ICD-10-CM Official Guidelines for Coding and Reporting* govern the use of certain codes. These guidelines provide both general and chapter-specific coding guidance.

Step 9: Confirm and assign the code.

Having reviewed all relevant information concerning the possible code choices, assign the

code that most completely describes the condition.

Repeat steps 1 through 9 for all additional documented conditions that meet the following criteria:

- They exist at the time of the visit *AND*
- They require or affect patient care, treatment, or management

Step 10: Sequence codes correctly.

Sequencing is the order in which the codes are listed on the claim. List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for the encounter/visit that is shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. Follow the official coding guidelines (see the guidelines, section II, “Selection of Principal Diagnosis”; section III, “Reporting Additional Diagnoses”; and section IV, “Diagnostic Coding and Reporting Guidelines for Outpatient Services”) on proper sequencing of codes.

Coding Examples

Diagnosis: Anorexia

Step 1: The reason for the encounter was the condition, anorexia.

Step 2: Consult the alphabetic index.

Step 3: Locate the main term “Anorexia.”

Step 4: Two possible subterms are available, “hysterical” and “nervosa.” Neither is documented in this instance, however, so they cannot be used in code selection.

Step 5: The code listed next to the main term is called the default code selection. Because the two subentries (essential modifiers) do not apply in this instance, the default code (R63.0) should be used.

Step 6: Turn to code R63.0 in the tabular list and read all instructional notes.

Step 7: The Excludes 1 note at code R63.0 indicates that anorexia nervosa and loss of appetite determined to be of nonorganic origin should be reported with a code from [chapter 5](#). The diagnostic statement does not describe the condition as anorexia nervosa, however, and does not indicate that the anorexia is of a nonorganic origin. There is no further division of the category past the fourth-character subcategory. Therefore, code R63.0 is at the highest level of specificity.

Step 8: Review of official guideline I.C.18 indicates that a symptom code is appropriate when a more definitive diagnosis is not documented.

Step 9: The default code, R63.0 Anorexia, is the correct code selection.

Repeat steps 1 through 9 for any concomitant diagnoses.

Step 10: Since anorexia is listed as the chief reason for the health care encounter, the first-listed, or principal, diagnosis is R63.0. Note that this is a [chapter 18](#) symptom code but can be assigned for both inpatient and outpatient records since the provider did not establish a more definitive diagnosis, according to sections II.A and IV.D.

Diagnosis: Acute bronchitis

Step 1: The reason for the encounter was the condition, acute bronchitis.

Step 2: Consult the alphabetic index.

Step 3: Locate the main term “Bronchitis.”

Step 4: There is a subterm for “acute or subacute.” Additional subterms are not included in the diagnostic statement.

Step 5: Nonessential modifiers (with bronchospasm or obstruction) are terms that do not affect code assignment. Since no other subterms indented under “acute” apply here, the code listed next to this subentry—in this case J20.9—should be chosen.

Step 6: Turn to code J20.9 in the tabular list and read all instructional notes.

Step 7: The Includes note under category J20 lists alternative terms for acute bronchitis. Note that the list is not exhaustive but is only a representative selection of diagnoses that are included in the subcategory. The Excludes 1 note refers to category J40 for bronchitis and tracheobronchitis NOS. There are several conditions in the Excludes 2 notes that, if applicable, can be coded in addition to this code.

Note that the codes included in J20 represent acute bronchitis due to various infectious organisms that could be selected if identified in the documentation. In this case, the organism was not identified and there is no further division of the category past the fourth character subcategory. Therefore, code J20.9 is at the highest level of specificity.

Step 8: Review of official guideline I.C.10 provides no additional information affecting the code selected.

Step 9: Assign code J20.9 Acute bronchitis, unspecified.

Repeat steps 1 through 9 for any concomitant diagnoses.

Step 10: In the absence of additional diagnoses that may affect sequencing, code J20.9 should be sequenced as the first-listed, or principal, diagnosis.

Diagnosis: Cerebellar ataxia in myxedema

Step 1: The reason for the encounter was the condition, cerebellar ataxia.

Step 2: Consult the alphabetic index.

Step 3: Locate the main term “Ataxia.”

Step 4: Available subterms include “cerebellar (hereditary),” with additional indented subterms for “in” and “myxedema,” all essential modifiers that are included in the diagnostic statement. Two codes are provided, E03.9 and G13.2, the latter of which is in brackets.

Step 5: Note the nonessential modifier (in parentheses) after the subterm cerebellar includes the term “hereditary.” Because it is in parentheses, this term is not required in the diagnostic statement for this subentry to apply. The brackets around G13.2 identify this code as a manifestation of the condition described by code E03.9 and indicate that the two must be reported together and sequencing rules apply.

Step 6: Locate codes E03.9 and G13.2 in the tabular list, and read all instructional notes.

Step 7: For code E03.9, there are no instructional notes in the tabular list at the category E03 or code level that indicate that this condition should be coded elsewhere in the classification or that additional codes are required. Without further information from the diagnostic statement, myxedema, not otherwise specified (NOS), is appropriately reported with code E03.9 Hypothyroidism, unspecified, according to the inclusion term at this code.

Code G13.2 in the tabular list has an instructional note to “Code first underlying disease,” which includes conditions found in category E03.-. Based on this note, codes E03.9 and G13.2 are to be coded together, with G13.2 listed only as a secondary diagnosis. This correlates with what the alphabetic index indicated. As there is no further division of codes in category G13 beyond the fourth character, G13.2 is at the highest level of specificity.

Step 8: Although there are some general conventions, such as how to interpret brackets in the alphabetic index, no chapter-specific guidelines apply to this coding scenario.

Step 9: Assign codes E03.9 Hypothyroidism, unspecified, and G13.2 Systemic atrophy primarily affecting the central nervous system in myxedema.

Repeat steps 1 through 9 for any concomitant diagnoses.

Step 10: Based on the alphabetic index and tabular instructional notations, code E03.9 should be sequenced as the first-listed, or principal, diagnosis followed by G13.2 as a secondary diagnosis.

Diagnosis: Decubitus ulcer of right elbow with skin loss and necrosis of subcutaneous tissue

Step 1: The reason for the encounter was the condition, decubitus ulcer.

Step 2: Consult the alphabetic index.

Step 3: Locate the main term “Ulcer.”

Step 4: For the subterm “decubitus,” there is no code provided or additional subterms indented, but a cross-reference is listed.

Step 5: The italicized cross-reference instructs the coder to “*see Ulcer, pressure, by site.*”

Repeat steps 3 through 5 for the cross-reference:

Step 3: Locate the main term “Ulcer.”

Step 4: Review the subentries for the subterm “pressure.” The next level of indent lists either the site of the ulcer or the specific stage of the ulcer (stage 1–4, unstageable, and unspecified stages). The diagnostic statement provides the site, right elbow, and the extent of tissue damage (skin loss and necrosis of subcutaneous tissue) but does not specifically state that the ulcer is stage 1, stage 2, etc. Nonessential modifiers (in parentheses) at each stage include a description of the typical extent of damage at each stage. For example, stage 1 describes “pre-ulcer skin changes limited to persistent focal edema.” Based on the documentation in the record, the coder can correlate the documentation to the nonessential modifiers and choose the specific stage from the index. The coder can also go directly to the body site, choosing the stage of the ulcer after reviewing the code options and instructional notations in the tabular list.

The diagnostic statement indicates that the extent of the damage to the elbow includes skin loss and necrosis of subcutaneous tissue, coinciding with the nonessential modifier next to the subentry “stage 3.” The body site of elbow (L89.0-) is listed as another level of indent with other body sites.

Step 5: Note that code L89.0 is followed by a dash and an additional-character-required icon, which indicate that more characters are needed to complete the code. From here, the tabular listing for L89.0- can be consulted.

Step 6: Locate code L89.0- in the tabular list and read all instructional notes.

Step 7: The tabular listing at category L89 has an Includes note for “decubitus ulcer,” which confirms that category L89 is the appropriate category to represent what is documented in the diagnostic statement.

Several Excludes 2 notes are also listed at the category level. Excludes 2 notes represent conditions that can occur concomitantly with the decubitus ulcer and can be coded in addition to code L89, if supported by the documentation.

The subcategory codes under L89.0 indicate that the fifth character describes laterality. Locate the right elbow at subcategory L89.01. See that an additional sixth character to specify the stage of the ulcer is now needed to complete the code. The stage can be

determined either by the specific documentation of the stage (e.g., stage 1, stage 2) or, in this case, a description that matches one of the inclusion terms that follow each stage code. For example, the diagnostic description in this case of “skin loss and necrosis of the subcutaneous tissue” matches the inclusion term under L89.013 Pressure ulcer of right elbow, stage 3. No additional characters are required because code L89.013 is at its highest level of specificity.

Step 8: The official guidelines contain quite a bit of information relating to pressure ulcers in chapter-specific guideline I.C.12 as well as information in general guideline I.B.14. These and any other pertinent guidelines should be reviewed to ensure appropriate code assignment.

Step 9: Assign code L89.013 Pressure ulcer of right elbow, stage 3.

Repeat steps 1 through 9 for any concomitant diagnoses.

Step 10: Since the decubitus ulcer is listed as the chief reason for the health care encounter, the first-listed, or principal, diagnosis is L89.013. However, according to the code first instructional note at the L89 category level, gangrene (I96) would be sequenced before the pressure ulcer if it were documented.

Diagnosis: Emergency department visit for bimalleolar fracture of the right ankle due to trauma

Step 1: The reason for the encounter was the condition, bimalleolar fracture.

Step 2: Consult the alphabetic index.

Step 3: Locate the main term “Fracture.” Note that many main terms represent fractures: “Fracture, burst,” “Fracture, chronic,” “Fracture, insufficiency,” “Fracture, nontraumatic NEC,” “Fracture, pathological,” and “Fracture, traumatic.” Since the diagnostic statement specifically states that this fracture was the result of trauma, the main term “Fracture, traumatic” should be used.

Step 4: Subterms that should be referenced are “ankle” and “bimalleolar (displaced),” which lists code S82.84-.

Step 5: A nonessential modifier (in parentheses) next to the term bimalleolar for “displaced” indicates that S82.84- is the default category unless the fracture is specifically identified as “nondisplaced.”

Note that code S82.84- is followed by a dash and an additional-character icon, both of which indicate that more characters are required. From here, the tabular list can be consulted.

Step 6: Locate code S82.84- in the tabular list and read all instructional notes.

Step 7: The instructional notes at category S82 indicate that fractures not specified as

displaced or nondisplaced default to displaced and that fractures not designated as open or closed default to closed. Additional instructional notes can be found at the category level but none pertain to the current scenario.

Read through the subcategory codes under S82.84, and note that the sixth character specifies displaced or nondisplaced and laterality. Based on the index nonessential modifier (displaced) and the code note at category S82, code selection should identify a displaced fracture of the right side. A displaced bimalleolar fracture of the right lower leg is coded to S82.841.

To complete the code, a seventh character must be assigned to identify the type of encounter (initial, subsequent, or sequela) and whether the fracture is open or closed. Most of the codes in category S82 require a seventh character represented in the list at the category level. However, it is important to note that some subcategories have their own specific set of seventh characters. In this instance, subcategory S82.84- does not have a unique set of seventh characters and the list provided at the category level should be used. Without documentation of the fracture being open, the tabular notation indicates that the default is closed. Character A, representing “initial encounter for closed fracture,” listed in the box at the category level is the most appropriate option.

Step 8: Assign code S82.841A Displaced bimalleolar fracture of right lower leg, initial encounter for closed fracture.

Step 9: Review chapter-specific guideline I.C.19. and any other official conventions or guidelines to ensure appropriate code assignment.

Repeat steps 1 through 9 for any concomitant diagnoses.

Step 10: Additional codes can be applied to relate the specific cause of the injury, the place of occurrence, the activity of the patient at the time of the injury, and the patient’s status, when this information is available in the record. However, coding this information is voluntary and reporting requirements depend on state mandates and/or facility-specific reporting requirements. If assigned, the external cause codes should be reported as secondary diagnoses only with the injury (fracture) sequenced first. Most codes in [chapter 20](#), “External Causes of Morbidity,” require a seventh character to identify the type of encounter. The seventh character assigned to an external cause code should match the seventh character of the code assigned for the associated injury or condition for the encounter.

2025 ICD-10-CM Official Guidelines for Coding and Reporting

Narrative changes effective October 1, 2024 appear in **bold** text

Narrative changes effective April 1, 2024 appear in **shaded** text

Items underlined have been moved within the guidelines since the April 2024, FY 2024 version

Italics are used to indicate revisions to heading changes

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been 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 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). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines

that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

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

A. Conventions for the ICD-10-CM

1. The Alphabetic Index and Tabular List
2. Format and Structure:
3. Use of codes for reporting purposes
4. Placeholder character
5. 7th Characters
6. Abbreviations
 - a. Alphabetic Index abbreviations
 - b. Tabular List abbreviations
7. Punctuation
8. Use of “and”
9. Other and Unspecified codes
 - a. “Other” codes
 - b. “Unspecified” codes
10. Includes Notes
11. Inclusion terms
12. Excludes Notes
 - a. Excludes1
 - b. Excludes2
13. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
14. “And”
15. “With”
16. “See” and “See Also”
17. “Code also” note
18. Default codes
19. Code assignment and Clinical Criteria

B. General Coding Guidelines

1. Locating a code in the ICD-10-CM
2. Level of Detail in Coding
3. Code or codes from A00.0 through T88.9, Z00-Z99.8, U00-U85
4. Signs and symptoms
5. Conditions that are an integral part of a disease process
6. Conditions that are not an integral part of a disease process
7. Multiple coding for a single condition
8. Acute and Chronic Conditions
9. Combination Code
10. Sequela (Late Effects)

11. Impending or Threatened Condition
12. Reporting Same Diagnosis Code More than Once
13. Laterality
14. Documentation by Clinicians Other than the Patient's Provider
15. Syndromes
16. Documentation of Complications of Care
17. Borderline Diagnosis
18. Use of Sign/Symptom/Unspecified Codes
19. Coding for Healthcare Encounters in Hurricane Aftermath
 - a. Use of External Cause of Morbidity Codes
 - b. Sequencing of External Causes of Morbidity Codes
 - c. Other External Causes of Morbidity Code Issues
 - d. Use of Z codes

C. Chapter-Specific Coding Guidelines

1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9
 - a. Human Immunodeficiency Virus (HIV) Infections
 - b. Infectious agents as the cause of diseases classified to other chapters
 - c. Infections resistant to antibiotics
 - d. Sepsis, Severe Sepsis, and Septic Shock Infections resistant to antibiotics
 - e. Methicillin Resistant Staphylococcus aureus (MRSA) Conditions
 - f. Zika virus infections
 - g. Coronavirus infections
2. Chapter 2: Neoplasms (C00-D49)
 - a. Admission/Encounter for treatment of primary site
 - b. Admission/Encounter for treatment of secondary site
 - c. Coding and sequencing of complications
 - d. Primary malignancy previously excised
 - e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy
 - f. Admission/encounter to determine extent of malignancy
 - g. Symptoms, signs, and abnormal findings listed in [Chapter 18](#) associated with neoplasms
 - h. Admission/encounter for pain control/management
 - i. Malignancy in two or more noncontiguous sites
 - j. Disseminated malignant neoplasm, unspecified
 - k. Malignant neoplasm without specification of site
 - l. Sequencing of neoplasm codes
 - m. Current malignancy versus personal history of malignancy
 - n. Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history
 - o. Aftercare following surgery for neoplasm
 - p. Follow-up care for completed treatment of a malignancy
 - q. Prophylactic organ removal for prevention of malignancy
 - r. Malignant neoplasm associated with transplanted organ
 - s. Breast Implant Associated Anaplastic Large Cell Lymphoma
 - t. Secondary malignant neoplasm of lymphoid tissue
3. Chapter 3: Disease of the blood and blood-forming organs and certain disorders involving the