2023 COMMON HCC ICD-10 CODES

When documenting chronic conditions remember: 1) Coding is based on clear documentation. Any condition that is taken into account or affects patient care, treatment or management at the time of the encounter should be documented and coded. 2) The encounter note should be a face-to-face visit and be complete, legible, concise, and contain the provider signature with credentials. 3) Avoid the use of uncertain diagnoses such as “suggestive of,” “suspected,” “consistent with” or “probable,” and code to the highest level of certainty for the encounter/visit.

Diabetes Mellitus (DM)	TYPE 1	TYPE 2
Diabetes mellitus without complications	E10.9	E11.9
Combination Codes: Utilize combination codes that link the complications of a disease. If there are multiple complications of diabetes mellitus then be sure to code each of the diabetes mellitus combination codes.		
Diabetes mellitus with hyperglycemia	E10.65	E11.65
Hyperglycemia: When hyperglycemia, poorly controlled, inadequately controlled or out of control is documented, diabetes mellitus with hyperglycemia should be coded. The word uncontrolled can mean either hypo- or hyperglycemia; therefore, it is insufficient documentation to code E10.65/E11.65.		
Diabetes mellitus with diabetic neuropathy, unspecified	E10.40	E11.40
Diabetes mellitus with polyneuropathy	E10.42	E11.42

Diabetes mellitus with kidney complications	TYPE 1	TYPE 2
Diabetes mellitus with diabetic chronic kidney disease	E10.22	E11.22
Diabetic chronic kidney disease (CKD) and nephropathy: When diabetic nephropathy and CKD are documented, code diabetic CKD, not nephropathy.		
Diabetes mellitus with diabetic nephropathy	E10.21	E11.21
Use additional code to also to identify stage of CKD.	N18.1- N18.6	N18.1- N18.6

Diabetes mellitus with ophthalmic complications	TYPE 1	TYPE 2
Diabetes mellitus with unspecified diabetic retinopathy	E10.31	E11.31
Ophthalmic complications: If adequately documented, code specifically as to type and designate right, left, bilateral or unspecified eye.	*E10.3-*	*E11.3-*

Diabetes mellitus with circulatory complications	TYPE 1	TYPE 2
Diabetic peripheral angiopathy without gangrene	E10.51	E11.51
Diabetic peripheral angiopathy with gangrene	E10.52	E11.52
Diabetes mellitus with foot ulcer	E10.621	E11.621
Use additional code to identify site of ulcer.	L97.4- , L97.5-	L97.4- , L97.5-

Endocrine, Nutritional, and Metabolic Disorders	CODE
Cachexia	R64
Protein-calorie malnutrition, moderate	E44.0
Protein-calorie malnutrition, mild	E44.1
Protein-calorie malnutrition, unspecified	E46
The specific type of malnutrition (such as severe, moderate, Kwashiorkor, etc.) must be indicated by the provider and cannot by assumed. When documentation only states "malnutrition," assign E46.	
Morbid (severe) obesity due to excess calories	E66.01
Evaluate for morbid obesity in patients with BMI > or = to 40. Also evaluate for morbid obesity for patients with comorbidities affected by weight.	

Mental, Behavioral and Neurodevelopmental	CODE
Dementia, unspecified without behavioral disturbance	F03.90-
Dementia, unspecified with behavioral disturbance	F03.91-
Alzheimer’s disease unspecified	G30.9
Alzheimer’s disease: Must be specifically confirmed by the physician to code. It is essential that the Alzheimer’s code be paired with the additional **F02.8** – codes as a manifestation of Alzheimer’s. The physician does not have to mention dementia to code it.	
Major Depressive Disorder, single episode, mild	F32.0
Major Depressive Disorder, single episode, moderate	F32.1
Major Depressive Disorder, single episode, severe, without psychotic features	F32.2
Major Depressive Disorder, single episode, severe, with psychotic features	F32.3
Major Depressive Disorder, single episode, in partial remission	F32.4
Major Depressive Disorder, single episode, in full remission	F32.5
Major Depressive Disorder, recurrent, mild	F33.0
Major Depressive Disorder, recurrent, moderate	F33.1
Major Depressive Disorder, recurrent, severe, without psychotic features	F33.2
Major Depressive Disorder, recurrent, severe, with psychotic features	F33.3
Major Depressive Disorder, recurrent, in remission, unspecified	F33.40
Major Depressive Disorder, recurrent, in partial remission	F33.41
Major Depressive Disorder, recurrent, in full remission	F33.42
Other Recurrent Depressive Disorders	F33.8
Major Depressive Disorder, recurrent, unspecified	F33.9
Document the following components of depression: **1.** Degree (mild, moderate, severe); **2.** Episode (single or recurrent); **3.** Status (partial or full remission); **4.** Presence or absence of psychotic features.	
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909
Do not assign R56.9 when a patient has had a seizure disorder or recurrent seizures. When a seizure disorder or recurrent seizures are present utilize appropriate code from Category G40.	
Unspecified convulsions	R56.9

Circulatory Conditions	CODE
Essential (primary) hypertension	I10
Linking codes presume a causal relationship between hypertension, heart and kidney involvement. It is important to code as linked unless documentation states they are not related.	
Hypertensive heart disease with heart failure	I11.0
Use additional code to identify type of heart failure.	I50.-
Hypertensive heart disease without heart failure	I11.9
Hypertensive heart disease without heart failure can be coded when there is a hypertension diagnosis and a heart disease code from the range I51.4-I51.7; I51.89; I51.9. No additional code is needed other than I11.9.	
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	I12.0
Use additional code to identify stage of CKD.	N18.5-N18.6
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I12.9
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure with stage 1 through 4 chronic kidney disease or unspecified chronic kidney disease	I13.10
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure and with stage 5 chronic kidney disease or end stage renal disease	I13.11
Use additional code to identify stage of CKD.	N18.5, N18.6
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage kidney disease	I13.2
Use additional code to identify the type of heart failure and stage of CKD.	I50.- N18.5, N18.6
Angina pectoris, unspecified	I20.9

Atherosclerotic heart disease of native coronary artery, with angina pectoris (code specific based on type of angina)	I25.110, I25.111, I25.118, I25.119
Atrial fibrillation (AF)/flutter: When assigning a code for atrial fibrillation or atrial flutter, assign the most specific code according to the diagnostic statements given by the provider.	
Paroxysmal atrial fibrillation	I48.0
Longstanding persistent atrial fibrillation	I48.11
Defined as persistent and continuous lasting longer than a year	
Other persistent atrial fibrillation	I48.19
Code I48.19 when documented as chronic persistent AF.	
Chronic atrial fibrillation, unspecified	I48.20
Only code Chronic AF when documented by the provider.	
Permanent atrial fibrillation	I48.21
Not to be confused with persistent; assign only when permanent AF is documented	
Unspecified atrial fibrillation	I48.91
Unspecified atrial flutter	I48.92
Sick sinus syndrome	I49.5
Left ventricular failure, unspecified	I50.1
End stage heart failure	I50.84
Use additional code to identify the type of heart failure as systolic, diastolic, or combined, if known (I50.2-I50.43)	
Heart Failure, unspecified	I50.9

Vascular Disorders	CODE
Atherosclerosis (code specific based on location)	I70.-
Peripheral vascular disease, unspecified	I73.9
Disorder of Arteries and Arterioles, unspecified	I77.9
Use this code when Carotid Artery Disease is documented and is not specified as due to occlusion or stenosis.	
Thoracic Aortic Aneurysm, w/o rupture	I71.2-
Abdominal aortic aneurysm, w/o rupture	I71.4-
Thoracoabdominal aortic aneurysm, w/o rupture	I71.6-
Aortic aneurysm of unspecified site, w/o rupture	I71.9
Aneurysm of unspecified site	I72.9
Aortic ectasia, unspecified site	I77.819

Diseases of the Respiratory System	CODE
Unspecified chronic bronchitis	J42
Emphysema, unspecified	J43.9
Chronic obstructive pulmonary disease with (acute) lower respiratory infection	J44.0
Use additional code to identify the infection.	
Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1
If COPD with acute exacerbation and COPD with lower respiratory infection are present: document and code both.	
Chronic obstructive pulmonary disease, unspecified	J44.9
Respiratory failure	J96.1-J96.92

Diseases of the Digestive System	CODE
Crohn's Disease, unspecified	K50.9-
Ulcerative colitis, unspecified	K51.9-

Diseases of the Musculoskeletal System and Connective Tissue	CODE
Rheumatoid Arthritis, unspecified	M06.9
Rheumatoid Arthritis: If known, code specifically regarding with or without rheumatoid factor. Also code specific site as documented.	M05-M06.8A
Systemic lupus erythematosus, unspecified	M32.9
Systemic Lupus Erythematosus (SLE) Documentation must confirm and specify Lupus as systemic to assign a code from category M32.	M32.0-M32.9
Sicca syndrome (Sjogren), unspecified	M35.00

Genitourinary Conditions	CODE
When both acute kidney failure and CKD are present, code both conditions.	
Acute kidney failure, unspecified	N17.9
Chronic kidney disease, stage 1	N18.1
Chronic kidney disease, stage 2 (mild)	N18.2
Chronic kidney disease, stage 3 unspecified	N18.30
Chronic kidney disease, stage 3a	N18.31
Chronic kidney disease, stage 3b	N18.32
Chronic kidney disease, stage 4 (severe)	N18.4
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Use additional code to identify dialysis status in end stage renal disease.	Z99.2

Factors Influencing Health Status	CODE
BMI	Z68.1-Z68.45
Long-term (current) use of insulin	**Z79.4**
If the patient is treated with both oral hypoglycemic drugs and insulin, code both Z79.84 and Z79.4.	
Personal history of malignant neoplasm (code specific history of cancer code)	Z85.-
Personal history of transient ischemic attack (TIA)/ cerebral infarction (CVA) without residual effects	Z86.73
Acquired absence of toe(s), foot and ankle	**Z89.4-Z89.449**
Acquired absence of leg below knee	**Z89.5-Z89.519**
Acquired absence of leg above knee	**Z89.6-Z89.619**
Tracheostomy Status	**Z93.0**
Gastrostomy status	**Z93.1**
Ileostomy status	**Z93.2**
Colostomy status	**Z93.3**
Cystostomy status	**Z93.5- Z93.59**
Artificial opening status, unspecified	**Z93.9**
Heart transplant status	**Z94.1**
Lung transplant status	**Z94.2**
Heart and lung transplant status	**Z94.3**
Liver transplant status	**Z94.4**
Bone marrow transplant status	**Z94.81**
Dependence on renal dialysis	**Z99.2**
Status codes in **Bold** rise to HCC	

Differentiating between "Active" and "History of" Cancer: When determining active versus history of cancer look for active treatment, such as chemotherapy, radiation, hormone therapy, watchful waiting, or patient refusal of treatment.

TIA/CVA: Use history of codes unless patient is having active symptoms of TIA or CVA during the visit. If the patient has residual of a CVA, code the residual symptoms or sequelae to the highest level of specificity I69.3- (i.e., monoplegia, hemiplegia, hemiparesis, etc).

Body mass index (BMI): Reported BMI ≥ 40 requires the diagnostic statement "Morbid Obesity" to rise to an HCC.

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

For more coding and documentation tips, visit AlabamaBlue.com/Providers/CodingCorner.

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