AUDIT-READY RESOURCE CENTER

ICD-10-CM Guideline Notes

High-value reminders for sequencing, specificity, documentation integrity, and defensible diagnosis coding.

Purpose of This Guide

This original reference aid reinforces an audit-minded approach to diagnosis coding. It summarizes common review checkpoints without reproducing official code-set language. Always verify final code assignment against the current ICD-10-CM code set, Official Guidelines for Coding and Reporting, applicable payer requirements, and organizational policy.

1. Start With the Reason for the Encounter

Identify the condition, symptom, screening purpose, follow-up need, or other documented reason that drove the service. The clinical story should support the primary diagnosis selection.

2. Sequence With Intent

Apply applicable instructional notes before finalizing code order. Confirm that the first-listed diagnosis reflects the encounter and that secondary diagnoses add supported clinical context.

3. Code to the Highest Supported Specificity

Capture documented site, laterality, acuity, episode, severity, manifestation, and associated condition details. Do not select greater specificity than the record supports.

4. Respect the Care-Setting Rule

Diagnosis status rules differ by setting. Do not treat tentative language as confirmed when the setting requires coding to the highest degree of certainty known for the encounter.

5. Evaluate Signs and Symptoms

Determine whether a sign or symptom remains independently reportable or is routinely associated with a confirmed diagnosis. The documentation must support separate clinical significance when reported.

6. Review Tabular Instructions

Check code-first, use-additional-code, excludes, inclusion, and other instructional notes. Alphabetic lookup alone is not sufficient for final code validation.

7. Protect Documentation Integrity

Do not infer unsupported causal relationships, severity, laterality, complications, or disease status from test results or clinical indicators alone. Query when clarification is necessary and permitted.

8. Validate Active, Historical, and Follow-Up Status

Confirm whether the condition is active, resolved, historical, under surveillance, or relevant to ongoing care. Status must be supported by the current record.

Think Like an Auditor

Before finalizing diagnosis coding, ask three questions:

1. **Does the documentation support every element of the selected code?**
2. **Have sequencing instructions and applicable tabular notes been reviewed?**
3. **Is the diagnosis status appropriate for the documented care setting?**

Common Audit Risks

- Selecting a code that includes details not documented in the record.
- Sequencing from habit rather than applying encounter-specific instructions.
- Reporting a suspected condition as confirmed in a setting where that is not permitted.
- Ignoring tabular instructions after locating a code in the alphabetic index.
- Carrying forward historical diagnoses without current relevance or support.
- Inferring a causal relationship or complication that the provider did not establish.

Educational-use notice: This independently developed guide is a review aid only. It does not replace the current ICD-10-CM code set, Official Guidelines for Coding and Reporting, payer policy, or organization-specific coding guidance.