Excludes Notations and Code Notes

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Q. How do I use Excludes 1 and Excludes 2 instructions in *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10CM)?

A. Put simply, the Excludes 1 notation means that you cannot code any excluded code with the main (listed) code. Conditions listed with Excludes 1 are mutually exclusive. For example, code E11 (type 2 diabetes mellitus) has an Excludes 1 notation with the following codes listed:

- Diabetes mellitus due to underlying condition (E08.-)
- Drug or chemical induced diabetes mellitus (E09.-)
- Gestational diabetes (O24.4-)
- Neonatal diabetes mellitus (P70.2)
- Postpancreatectomy diabetes mellitus (E13.-)
- Postprocedural diabetes mellitus (13.-)
- Secondary diabetes mellitus NEC [not elsewhere classified] (E13.-)
- Type 1 diabetes mellitus (E10.-)

In general, these codes are mutually exclusive by definition, so they make sense to a clinician. For example, a patient with type 2 diabetes can never be diagnosed with concurrent type 1 diabetes, because the patient has either type 1 or type 2 diabetes—never both.

The Excludes 2 notation indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. It is acceptable to use both the code and the excluded code(s) together, when appropriate. For example, code J03 (acute tonsillitis) lists an Excludes 2 notation for code J35.0 (chronic tonsillitis) because the patient can present with both conditions at the same time. If the medical record indicates that the patient does have chronic tonsillitis and presents to your office today with acute tonsillitis, it would be appropriate to code both J03 and J35.0 for the visit. The Excludes 2 notation, however, indicates that a patient with simple chronic tonsillitis should never receive a diagnosis of acute tonsillitis unless both conditions are actually present. ■

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Q. I get confused when I see "code first," "code also," and "use additional code" notes. Can you explain the differences?

A. Codes that have both an underlying etiology and multiple body system manifestations because of the underlying etiology require that the underlying condition be coded first, and then the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes: etiology, followed by manifestation.

In most cases, the manifestation codes will have in the code title "in diseases classified elsewhere." Codes with this title are a component of the etiology–manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed after the underlying condition.

CODING Q&A

"A 'code also' note is an instruction that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the office visit."

For example, code H42 (glaucoma in diseases classified elsewhere) has "code first" underlying conditions, such as these:

- Amyloidosis (E85.-)
- Aniridia (Q13.1)
- Lowe syndrome (E72.03)
- Rieger anomaly (Q13.01)
- Specified metabolic disorder (E70–E88)

For a patient with glaucoma caused by amyloidosis, you would code E85.- (amyloidosis) first and then code H42 (glaucoma in diseases classified elsewhere) on the claim form.

A "code also" note is an instruction that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the office visit.

For example, for a patient who presents with a lobar pneumonia just shortly after a visit for documented influenza, the provider would code J11.08 (influenza due to unidentified influenza virus with specified pneumonia). This code has a note to code also another specified type of pneumonia, J18.1 (lobar pneumonia, unspecified organism), so the provider would next review the documentation to see what type of pneumonia the patient has and then assign that code as well (i.e., J12.9, viral pneumonia, unspecified). Although the patient may actually no longer have an active influenza infection, this coding process is designed to allow tracking of pneumonia incidence that is directly attributable to known influenza infections.

In other cases where two codes are required to describe a condition, a "use additional code" note will be present at a complication or manifestation code to indicate that more codes are needed. The additional codes used are secondary codes that are to be sequenced after any underlying cause and after the main manifestation. For example, code J10.83 (influenza due to other identified influenza virus with otitis media) has a "use additional code" note to remind the coder to code for any associated perforated tympanic membrane (H72.-). You would list code J10.83 first and then choose an appropriate code in the H72 range, like H72.01 (central perforation of tympanic membrane, right ear). ■