2025 COMMON HCC ICD-10 CODES

When documenting chronic conditions, remember: 1) Coding is based on clear documentation that includes a diagnostic statement and ongoing treatment plan. 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
Diabetes mellitus with diabetic nephropathy	E10.21	E11.21
Diabetic chronic kidney disease (CKD) and nephropathy: When diabetic nephropathy and CKD are documented, code diabetic CKD, not nephropathy.		
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
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-
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 full remission	F32.5
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
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.	
Anorexia nervosa, unspecified	F50.00
Anorexia nervosa, restricting type	F50.01
Anorexia nervosa, binge eating/purging type	F50.02
Bulimia nervosa	F50.2
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.	
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909
Unspecified convulsions	R56.9
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.	

Cardiovascular Conditions	CODE
Hypertensive heart disease with heart failure	I11.0
Use additional code to identify type of heart failure.	I50.-
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 stage 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
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
Pulmonary hypertension, unspecified	I27.20
Pulmonary hypertension due to left heart disease	I27.22
Pulmonary hypertension due to lung disease and hypoxia	I27.23
Cor pulmonale (Chronic)	I27.81
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
Unspecified systolic (congestive) heart failure	I50.20
Acute systolic (congestive) heart failure	I50.21

Chronic systolic (congestive) heart failure	I50.22
Acute on chronic systolic (congestive) heart failure	I50.23
Unspecified diastolic (congestive) heart failure	I50.30
Acute diastolic (congestive) heart failure	I50.31
Chronic diastolic (congestive) heart failure	I50.32
Acute on chronic diastolic (congestive) heart failure	I50.33
Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	I50.40
Acute combined systolic (congestive) and diastolic (congestive) heart failure	I50.41
Chronic combined systolic (congestive) and diastolic (congestive) heart failure	I50.42
Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	I50.43
Acute right heart failure	I50.811
Acute on chronic right heart failure	I50.813
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
Atherosclerosis of native arteries of extremities with rest pain, right leg	I70.221
Atherosclerosis of native arteries of extremities with rest pain, left leg	I70.222
Atherosclerosis of native arteries of extremities with rest pain, bilateral legs	I70.223
Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, right leg	I70.321
Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, left leg	I70.322

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
Severe persistent asthma, uncomplicated	J45.50
Severe persistent asthma with (acute) exacerbation	J45.51
Severe persistent asthma with status asthmaticus	J45.52
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

Genitourinary Conditions	CODE
Two separate eGFR values are required to change the CKD stage. When both acute kidney failure and CKD are present, code both conditions.	
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

Factors Influencing Health Status	CODE
Body mass index (BMI)	Z68.1-Z68.45
BMI: Reported BMI >40 requires a weight diagnosis to be documented and coded, such as "Morbid Obesity" to rise to an HCC.	
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.-
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. Remember, when coding active cancer, document specific primary sites and metastasis (secondary), if present.	
Personal history of transient ischemic attack (TIA)/cerebrovascular accident (CVA) without residual effects	Z86.73
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.).	
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
Intestine transplant status	Z94.82
Pancreas transplant status	Z94.83
Stem cells transplant status	Z94.84
Presence of heart assist device	Z95.811
Presence of fully implantable artificial heart	Z95.812
When your patient is immunocompromised while taking anti-rejection medication, consider documenting and coding D84.821 "Immunodeficiency due to drugs."	
Dependence on renal dialysis	Z99.2

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).

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