Chapter 18 of ICD-10, ICD-10-CM & ICD-10-AM, *Symptoms, Signs, and Abnormal Clinical and Laboratory Findings* (R00–R99) contains many (but not all) codes for signs and symptoms.

This chapter includes symptoms, signs, and abnormal findings that, without the necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body.

All categories in this chapter could be designated “unknown etiology” or “transient”.

Signs and symptoms should be coded for specific cases to report:

- Cases where no more specific diagnosis can be made
- Symptoms and signs that existed on initial encounter but proved to be transient and whose causes couldn’t be determined.
- Provisional diagnoses for patients who failed to return for further investigation.
- Cases referred elsewhere for further investigation before being diagnosed.
- Cases in which a more definitive diagnosis was not available for other reasons.
The below guidelines apply to all healthcare settings.

When signs and symptoms are reported?

1. Codes for signs and symptoms are acceptable for reporting when the provider has not established a related definitive (confirmed) diagnosis.

2. Signs and symptoms that may not be associated routinely with a disease process should be assigned additional codes. Therefore, understanding of the disease process is crucial for the proper coding; It’s the coder’s responsibility to understand pathophysiology to determine if the signs/symptoms may be separately reported or if they are integral to a definitive diagnosis already reported.

3. List as a additional diagnosis any symptoms, signs, and abnormal findings that are not integral to the principal diagnosis and affect treatment or increase length of stay, monitoring level or care level.

References: ICD-10-AM ACS, ICD-10-CM official coding guidelines, AAPC, AHIMA, HIMAA
When signs and symptoms are not reported?

1. Do not report signs and symptoms with a confirmed diagnosis if the signs or symptoms are integral to a definitive diagnosis, unless otherwise instructed by the classification. Example, nausea and vomiting should not be coded in addition to gastroenteritis, because these symptoms are integral to gastroenteritis.

2. Signs, symptoms and abnormal findings should not be used as “main condition” codes unless the symptom, sign or abnormal finding was clearly the main condition treated or investigated during an episode of care and was unrelated to other conditions recorded by the physician.

3. It is not necessary to code incidental findings documented in physician interpretations of tests. Abnormal findings in test results that are not interpreted by a physician, such as clinical laboratory tests like CBC or urinalysis, should not be coded unless confirmation of a definitive diagnosis is obtained from the patient's physician. In these cases, the presenting symptoms, conditions, or other reasons for the test should be coded.

References: ICD-10-AM ACS, ICD-10-CM official coding guidelines, AAPC, AHIMA, HIMAA
What are the most ICD-10, ICD-10-AM & ICD-10-CM outpatient coding guidelines about signs and symptoms?

The conditions should be coded to the highest degree of certainty, such as symptoms, signs, abnormal test results, or other reason for the visit.

Documentation of "fever and cough, possible pneumonia" at the end of an emergency room visit, only the fever and cough should be coded. However, documentation of "fever and cough, possible pneumonia" on a requisition for an outpatient chest x-ray, and the radiologist’s diagnosis on the radiology report is "pneumonia," code the pneumonia, as it represents the highest degree of certainty for the encounter for the x-ray.

For cases of patients receiving diagnostic services only during an outpatient encounter, sequence first the diagnosis, condition, problem, or other reason for the encounter shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit.

Documentation of "pain and swelling in wrist" on the requisition for an outpatient x-ray of the wrists are coded for the outpatient service rendered. If the radiologist’s report mentions a diagnosis of fractured wrist, then the fracture is the condition representing the highest degree of certainty for this encounter. The pain and swelling would not be coded, even as secondary diagnoses, because they are an integral part of the fracture diagnosis.

References: ICD-10-AM ACS, ICD-10-CM official coding guidelines, AAPC, AHIMA, HIMAA