



2026 ICD-10 Coding Tips

Your Guide to Confident, Accurate Coding in 2026

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As organizational needs change, UASI is here to assist in any capacity, including coding and audit support, consultative solutions and interim management services.

This updated Coding Tips includes information specific to the FY2026 changes impacting coding in every area of healthcare.

*The information present here is not intended to serve as coding or legal advice. Many variables affect code selection and sequencing. All coding must be considered on a case-by-case basis as supported by the documentation presented. Payer-specific rules and regulations must also be taken into consideration in code selection.

The information contained here was accurate at the date of publication and is subject to change based on quarterly Coding Clinic updates from the AMA and yearly code changes as determined by NCHS and CMS with approval from the WHO.



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FY2026 ICD-10-CM Official Coding Guideline (OCG) Updates

OCG I.B.20: Multiple Sites Coding

- **The classification defines “multiple” as involving two or more sites. Follow chapter specific guidelines for assigning codes for “multiple sites.” In the absence of chapter specific guidelines, assign codes describing specified sites individually when documented. When the specified site(s) are not documented, assign the appropriate code for “multiple sites.”**

OCG I.C.1.2.a: HIV Disease

- **If the term “AIDS” or “HIV disease” is documented or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from the patient’s HIV positive status; code B20, Human immunodeficiency virus [HIV], should be assigned.**

OCG I.C.1.2.e: Asymptomatic human immunodeficiency virus

- **When “HIV positive,” “HIV test positive,” or similar terminology is documented, and there is no documentation of symptoms or HIV-related illness, code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, should be assigned.**





OCG I.C.4.1.b: Type 2 diabetes mellitus in remission

- **Code E11.A, Type 2 diabetes mellitus without complications in remission, is assigned based on provider documentation that the diabetes mellitus is in remission. If the documentation is unclear as to whether the Type 2 diabetes mellitus has achieved remission, the provider should be queried. For example, the term “resolved” is not synonymous with remission**

FY2026 Category L98 (Non-pressure chronic ulcer of skin) expanded to include additional sites.

Code	Description
L98.43	Non-pressure chronic ulcer of abdomen
L98.44	Non-pressure chronic ulcer of chest
L98.45	Non-pressure chronic ulcer of neck
L98.46	Non-pressure ulcer of face
L98.47	Non-pressure ulcer of groin
L98.A	Non-pressure ulcer of upper limb





ICD-10-CM Significant Code Updates for FY2026 (not a complete list of ALL ICD-10-CM changes for FY2026)

Chapter 2 - Neoplasms

DX Code	Description	CC/MCC
C50.A0-C50.A2	Malignant Inflammatory neoplasm of breast	N/A

Chapter 4-Endocrine, Nutritional and Metabolic Diseases

DX Code	Description	CC/MCC
E11.A	Type 2 diabetes mellitus without complications in remission	N/A

It is important to note that remission must be clearly documented by the provider. Terms such as “history of type 2 diabetes mellitus (T2DM)” or “resolved T2DM” are not equivalent to T2DM remission. When documentation is unclear regarding whether the patient’s diabetes is in remission, it would be appropriate to query the provider.

If the patient has any diabetic complications, code E11.A cannot be reported. Instead, assign the relevant complication code (E11.0–E11.8).





ICD-10-CM Significant Code Updates for FY2026

Chapter 6-Diseases of the Nervous System

DX Code	Description	CC/MCC
G35.A	Relapsing–remitting multiple sclerosis	N/A
G35.B	Primary progressive multiple sclerosis	N/A
G35.C	Secondary progressive multiple sclerosis	N/A
G35.D	Multiple sclerosis, unspecified	N/A

Chapter 7-Diseases of the Eye and Adnexa

DX Code	Description	CC/MCC
H01.81–H01.8B	Other specified inflammations of eyelid	N/A
H05.83	Thyroid orbitopathy	N/A





ICD-10-CM Significant Code Updates for FY2026

Chapter 9-Diseases of the Circulatory System

DX Code	Description	CC/MCC
I27.840	Fontan –associated liver disease (FALD)	CC
I27.841	Fontan–associated lymphatic dysfunction	N/A
I27.848	Other Fontan–associated condition	N/A
I27.849	Fontan related circulation, unspecified	N/A

Chapter 12-Diseases of the Skin and Subcutaneous Tissue

DX Code	Description	CC/MCC
L02.217	Cutaneous abscess of flank	CC
L03.31A	Cellulitis of flank	CC
L03.32A	Acute lymphangitis of flank	CC





ICD-10-CM Significant Code Updates for FY2026

Chapter 14-Diseases of Genitourinary System

DX Code	Description	CC/MC
N00.B	Acute nephritic syndrome with immune complex membranoproliferative glomerulonephritis (IC-MPGN)	MCC
N04.B	Nephrotic syndrome with immune complex membranoproliferative glomerulonephritis (ICD-MPGN)	CC
N07.B	Hereditary nephropathy, not elsewhere classified with APOL1-mediated kidney disease (AMKD)	N/A

Chapter 18-Symptoms, Signs and Abnormal Findings

DX Code	Description	CC/MC
R10.8A	Flank tenderness	N/A
R10.A	Flank pain	N/A





ICD-10-CM Significant Code Updates for FY2026

Chapter 19-Injury, Poisoning & Other External Causes

DX Code	Description	CC/MCC
T78.07	Anaphylactic reaction due to milk and dairy products	CC
T78.08	Anaphylactic reaction due to eggs	CC
T78.11	Other adverse food reactions due to milk and dairy products	N/A
T78.12	Other adverse food reactions due to eggs	N/A

Chapter 21-Factors Influencing Health Status

DX Code	Description	CC/MCC
Z15.05	Genetic susceptibility to malignant neoplasm of fallopian tube(s)	N/A
Z15.06	Genetic susceptibility to malignant neoplasm of digestive system	N/A
Z15.07	Genetic susceptibility to malignant neoplasm of urinary tract	N/A





ICD-10-CM Significant Code Updates for FY2026

Chapter 21 – Factors Influencing Health Status

DX Code	Description	CC/MCC
Z40.81	Encounter for prophylactic surgery for removal of ovary(s) for persons without known genetic/familial risk factors	N/A
Z40.82	Encounter for prophylactic surgery for removal of fallopian tube(s) for persons without known genetic/familial risk factors	N/A
Z59.861	Financial insecurity, difficulty paying for utilities	N/A
Z80.44	Family history of malignant neoplasm of fallopian tube(s)	N/A
Z85.4A	Personal history of malignant neoplasm of fallopian tube(s)	N/A





FY2026 ICD-10-PCS Official Guideline (OCG) Updates

There are **no updates** to the ICD-10-PCS Official Guidelines for Coding and Reporting for FY2026.

ICD-10-PCS Significant Medical & Surgical Code Updates for FY2026

New Qualifier

Section 0 Medical and Surgical

Body System 0 Central Nervous System and Cranial Nerves

Operation H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	Approach	Device	Qualifier
0 Brain	3 Percutaneous	3 Infusion Device	J Temporary Z No Qualifier

New Device

Section 0 Medical and Surgical

Body System 2 Heart and Great Vessels

Operation U Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

Body Part	Approach	Device	Qualifier
W Thoracic Aorta, Descending	3 Percutaneous	L Intraluminal Device, Endovascular Anchors	Z No Qualifier

New Table

Section O Medical and Surgical
Body System C Mouth and Throat
Operation 1 Bypass: Altering the route of passage of the
contents of a tubular body part

Body Part	Approach	Device	Qualifier
S Larynx	O Open 3 Percutaneous	E Intraluminal Device, Endotracheal Airway F Tracheostomy Device Z No Device	4 Cutaneous



New Qualifier

Section O Medical and Surgical

Body System R Upper Joints

Operation R Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part

Body Part	Approach	Device	Qualifier
J Shoulder Joint, Right K Shoulder Joint Left	O Open	O Synthetic Substitute, Reverse Ball and Socket J Synthetic Substitute	8 Subscapularis-sparing Technique

New Approach

Section 1 Obstetrics

Body System O Pregnancy

Operation D Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force

Body Part	Approach	Device	Qualifier
1 Products of Conception, retained	O Open	Z No Device	Z No Qualifier



New Body Parts

Section O Medical and Surgical

Body System O Central Nervous System and Cranial Nerves

Operation P Removal: Taking out or off a device from a body part

Body Part	Approach	Device	Qualifier
2 Dura Mater T Spinal Meninges	O Open	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

New Row

Section O Medical and Surgical

Body System F Hepatobiliary System and Pancreas

Operation 1 Bypass: Altering the route of passage of the contents of a tubular body part

Body Part	Approach	Device	Qualifier
9 Common Bile Duct	8 Via Natural or Artificial Opening	D Intraluminal Device Z No Device	3 Duodenum





ICD-10-PCS - Coding Conventions

Reminders specific to the ICD-10-PCS Official Guidelines for Coding and Reporting

A. Conventions

- A8: All seven characters must be specified to be a valid code. If the documentation is incomplete for coding purposes, the physician should be queried for the necessary information.
- A11: Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between documentation and the defined PCS terms is clear.
 - Example: When the physician documents 'partial resection' the coder can independently correlate 'partial resection' to the root operation Excision without querying the physician for clarification.
- B3.1a: In order to determine the appropriate root operation, the full definition of the root operation as contained in the PCS Tables must be applied.
- B3.2: Multiple procedures – During the same operative episode, multiple procedures are coded if:
 - A. The same root operation is performed on different body parts as defined by distinct values of the body part character.



- Example: Diagnostic excision of liver and pancreas are coded separately.
- B. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.
 - Example: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.
- C. Multiple root operations with distinct objectives are performed on the same body part.
 - Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.
- D. The intended root operation is attempted using one approach but is converted to a different approach.
 - Example: Lap cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic inspection and open resection.
- B3.4b Biopsy followed by more definitive treatment
 - If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as destruction, Excision, or Resection at the same procedure site, both the biopsy and the more definitive treatment are coded.
 - Example: Biopsy of breast followed by partial mastectomy at the same procedure site, both the biopsy and the partial mastectomy procedure are coded.





Guidelines for Achieving a Compliant Query Practice

The updated Guideline for Achieving a Compliant Query Practice was published December 2022.

“The documentation query process is used for several initiatives which may include reimbursement methodologies, data stewardship and collection, quality measures, medical necessity, denial prevention, and so forth. Regardless of organizational objectives, professionals seeking documentation clarification need to follow this practice brief.”

As diagnoses such as sepsis, severe malnutrition, metabolic encephalopathy and respiratory failure are all on the radar of payers for potential denial, it is more important than ever to make sure the documentation in the patient record is sufficient to support the assignment of these diagnoses and others.

Queries should include the relevant clinical indicators that show why a more complete or accurate diagnosis or procedure is requested.





Guidelines for Achieving a Compliant Query Practice, Continued

“Clinical indicator(s)” is a broad term encompassing documentation that supports a diagnosis as reportable and/or establishes the presence of a condition. Two Examples of clinical indicators include (but are not limited to): provider observations (physical exam and assessment), diagnostic tests, treatments, medications, trends, and consultant documentation authored by providers and ancillary professionals documented throughout the health record. There is no required number of clinical indicator(s) that must accompany a query because what is a “relevant” clinical indicator will vary by diagnosis, patient, and clinical scenario.

It is ultimately up to the providers to make the final determination as to what clinical indicator(s) define a diagnosis.





Clinical Indicators should:

- Be clear and concise
- Directly support the condition requiring clarification
- Allow the provider to clinically determine the most appropriate medical condition or procedure
- Paint the clinical picture of the diagnosis queried to be added or clinically validated
- Be specific or directly related to, but not necessarily from, the current encounter
- Support documentation that will translate to the most accurate code

Clinical indicator(s) may be sourced from the entirety of the patient's health record, including but not limited to:

- Emergency services documentation (e.g., emergency service transport, ED provider, etc.)
- Diagnostic findings (e.g., laboratory, imaging)
- Provider impressions (e.g., H&P, progress notes, consultations)
- Relevant prior visits (if the documentation is clinically pertinent to present encounter)
- Ancillary professional documentation and assessments (e.g., nursing, nutritionist, wound care, physical, occupational, speech, and respiratory therapist)
- Procedure/operative notes
- Care management and social services





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