ICD-10 Rule and Coding Edits: Excludes1

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Official guidelines[1] for coding and reporting are very specific about handling "Excludes1" notes. An Excludes1 note is used when 2 conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. An Excludes1 note indicates that the code excluded should not be used at the same time as the code above the Excludes1 note. You can see the specific guidance here: https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf.

You can also check this link to check ICD-10 Excludes1 edits by specific ICD-10 codes: https://icd10cmtool.cdc.gov/?fy=FY2023.

The following is a list of scenarios common to Excludes1 errors:

Excludes1 Scenarios		
Scenario	**Edit Example**	**Edit Consideration**
Coding for more than one encounter type.	Coding Z01.419, Encounter for gynecological examination (general) (routine) without abnormal findings along with Z00.00 Encounter for general adult medical examination.	Only code for the encounter type that is most appropriate for your patient.
Coding that indicates that the patient is high-risk while also using a code that indicates the patient is low-risk.	Coding for O09.9 Supervision of high risk pregnancy along with Z34.0 Encounter for supervision of normal first pregnancy.	A patient cannot have a high risk pregnancy as well as a low risk pregnancy. Provide the diagnosis code that best represents your patient's condition.
Coding for 2 conditions that cannot exist together.	Coding E10.9 diabetes type 1 along with E11.9 diabetes type 2 on the same order.	A patient cannot have diabetes type 1 as well as type 2. Provide the diagnosis that is correct for your patient.
Coding a specific condition along with a symptom of the same condition.	Coding E10.9 diabetes mellitus type 1 without complications along with R73.9 Hyperglycemia, NOS.	Hyperglycemia is a symptom of diabetes type 1 and should not be coded together. Choose the more specific applicable diagnosis code.

[1] ICD-10-CM Official Guidelines for Coding and Reporting FY 2023, Section 1, Subsection A.12a. https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf.

An ICD-10-CM book should be used as a complete reference. Diagnoses must always be documented in the patient's medical record. The ultimate responsibility belongs to the ordering physician to correctly assign the patient's diagnosis based on the patient's history, symptoms, and medical condition.