Healthicity

Your 2026 ICD-10-CM Update Roadmap

CJ Wolf, MD, CPC, COC, CPB, AAPC Approved Instructor

Presented by

CJ Wolf,

MD, CHC, CCEP, CIA, COC, CPC

cj.wolf@healthicity.com

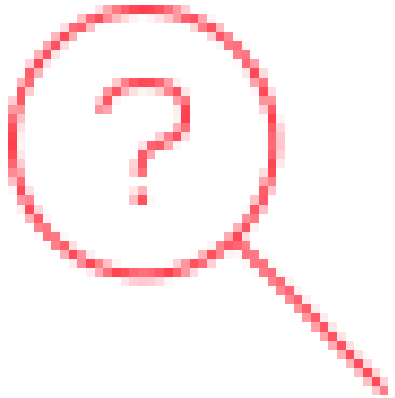
Agenda

01	Enforcement Actions
02	Code Updates
03	Guideline Updates

Polling Question #1

In what capacity do you *primarily* use ICD-10 codes?

a) Auditing
b) Coding
c) Revenue Cycle
d) Compliance
e) Other/NA



01

Enforcement Actions

“…invalid diagnosis codes…”

PRESS RELEASE

Medicare Advantage Provider Independent Health to Pay Up To $98M to Settle False Claims Act Suit

Friday, December 20, 2024

For Immediate Release

Office of Public Affairs

Independent Health Association and its affiliate, Independent Health Corporation (collectively, Independent Health) have agreed to pay up to $98 million to resolve allegations that they violated the False Claims Act by knowingly submitting or causing the submission of invalid diagnosis codes to Medicare for Medicare Advantage Plan enrollees to increase payments that Independent Health received from Medicare. Independent Health is headquartered in Buffalo, New York.

Under Medicare Advantage, also known as the Medicare Part C program, Medicare beneficiaries have the option of enrolling in managed care insurance plans called Medicare Advantage Plans (MA Plans). MA Plans are paid a per-person amount to provide Medicare-covered benefits to beneficiaries who enroll in one of their plans. The Centers for Medicare and Medicaid Services

https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit

“…invalid diagnosis codes…”

“The government expects those who participate in Medicare Advantage to provide accurate information to ensure that proper payments are made for the care received by enrolled beneficiaries.”

--Deputy Assistant Attorney General, Justice Department's Civil Division

Medical Providers Too

Medicare Advantage Provider Seoul Medical Group and Related Parties to Pay Over $62M to Settle False Claims Act Suit

Wednesday, March 26, 2025

Seoul Medical Group Inc. and its subsidiary Advanced Medical Management Inc., headquartered in California, have agreed to pay $58,740,000 and their former president and majority owner, Dr. Min Young Cha, has agreed to pay $1,760,000 for allegedly violating the False Claims Act by causing the submission of false diagnosis codes for two spinal conditions to increase payments from the Medicare Advantage program. Renaissance Imaging Medical Associates Inc., a California-based radiology group that worked with Seoul Medical, has also agreed to pay $2,350,000, for allegedly conspiring with Seoul Medical Group in connection with the false diagnoses for the two spinal conditions.

https://www.justice.gov/opa/pr/medicare-advantage-provider-seoul-medical-group-and-related-parties-pay-over-62m-settle

Medical Providers Too

"Providers who game the Medicare program to increase profit undermine the foundation of care and diminish patient trust in the nation's public health care system."

--Deputy Inspector General for Investigations (HHS-OIG)

02

Code Updates

Polling Question #2

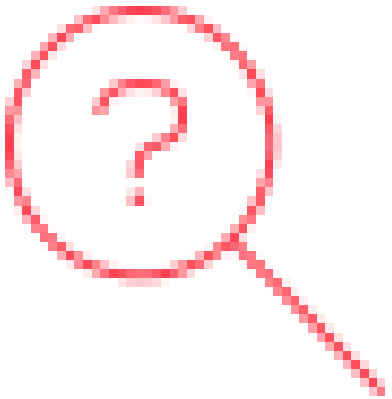
What is the most important tool you use when auditing ICD-10 codes?

a) Auditing software

b) AHA Coding Clinic References

c) Payor Policies

d) Other/NA



2026 ICD-10 Updates

- 487 New codes
- 38 Revised codes
- 12 Deleted codes
- 16 Codes converted-to-parent (thus no longer valid)

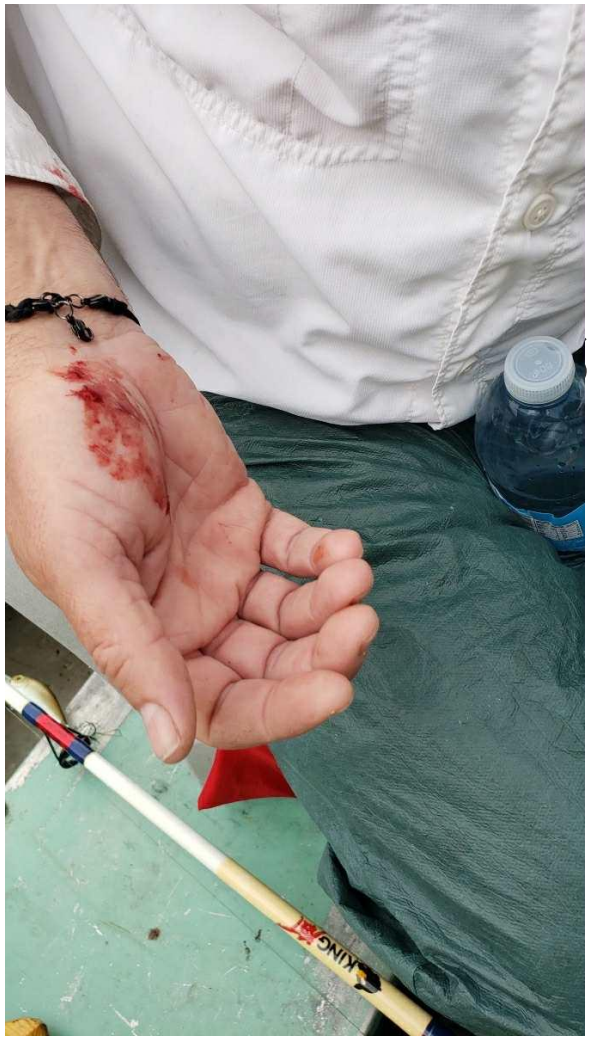
Notable New Code Themes/Topics

- Non-pressure chronic ulcer (numerous locations)
- Abdominal wall (wounds, lacerations, puncture, open bite, unspecified)
- Fluoroquinolone antibiotics (poisoning, accidental, intentional, adverse effects, underdosing, etc.)

Notable New Code Themes/Topics

- Toxic effects, xylazine
- Reactions to egg, milk, dairy
- Blast overpressure (low level, high level)
- Genetic susceptibilities
- Gulf war and other war theater conditions

My Personal Favorite New Codes



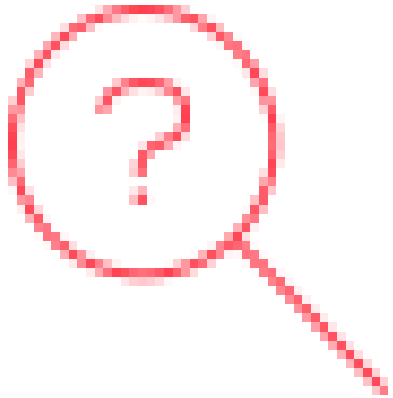
03

Guideline Updates

Polling Question #3

Which topic do you think experienced the most impactful guidelines update for 2026?

a) HIV guidelines
b) Antineoplastic therapy
c) Diabetes in remission
d) Hypertension with heart disease
e) Other or N/A



Select Guideline Changes

, **Commas are used in the Alphabetic Index and have different meanings based on the context of the Index entry, including alternate verbiage, modifier (essential and nonessential), or alternative for “and/or.”**

Documentation by Clinicians Other than the Patient's Provider

- **Firearm injury intent**

Select Guideline Changes

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.”

Select Guideline Changes

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.

Select Guideline Changes

Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. **Code B20 would be reported as a secondary diagnosis. Codes for other documented conditions should also be reported as secondary diagnoses.**

Select Guideline Changes

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.

Select Guideline Changes

Inconclusive HIV serology

Patients with documentation of inconclusive HIV serology, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

Select Guideline Changes

Previously diagnosed HIV-related illness

Patients with documentation of a prior diagnosis of an HIV-related illness should be coded to B20. Once an HIV-related illness has developed, code B20 should always be assigned on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV] or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

Select Guideline Changes

HIV Infection in Pregnancy, Childbirth and the Puerperium

When a patient presents during pregnancy, childbirth or the puerperium with documented symptomatic HIV disease or an HIV related illness, assign a code from subcategory O98.7, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by code B20 and additional code(s) for any HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

When a patient presents during pregnancy, childbirth or the puerperium with documented asymptomatic HIV infection status or is HIV-positive, assign a code from subcategory O98.7 followed by code Z21.

Select Guideline Changes

Encounters for HIV testing

If a patient without signs or symptoms is tested for HIV, assign code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high-risk behavior, if applicable.

If a patient with signs or symptoms of HIV presents for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be assigned if counseling is provided during the encounter for the test. Code Z11.4, Encounter for screening for human immunodeficiency virus [HIV], should not be assigned if HIV signs or symptoms are present.

When a patient presents for follow up regarding their HIV test results and the test result is negative, assign code Z71.7, Human immunodeficiency virus [HIV] counseling.

Select Guideline Changes

HIV disease or HIV positive status managed by antiretroviral medication

If a patient with documented HIV disease, HIV-related illness or AIDS is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease.

If a patient with documented HIV positive status is currently managed on antiretroviral medication, assign code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, in the absence of any additional documentation of HIV disease, HIV-related illness or AIDS.

Select Guideline Changes

Patient admission/encounter chiefly for administration of *antineoplastic* chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is chiefly for the administration of chemotherapy, immunotherapy or external beam radiation therapy **for the treatment of a neoplasm,** assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. **If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and codes from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.**

Select Guideline Changes

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.

Select Guideline Changes

Hypertension with Heart Disease

Hypertension with heart conditions **classified to I50.-, Heart failure, I51.4, Myocarditis, unspecified, I51.89, Other ill-defined heart diseases, and I51.9, Heart disease, unspecified, is assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, or I51, Complications and ill-defined descriptions of heart disease, to identify the heart condition.**

Select Guideline Changes

Hypertension with heart conditions classified to I51.5, Myocardial degeneration, or I51.7, Cardiomegaly, is assigned to a code from category I11, Hypertensive heart disease. No additional code is assigned to identify the specific heart condition.

The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension. **The applicable hypertension code I10, Essential (primary) hypertension, or a code from category I15, Secondary hypertension, should be assigned.** Sequence according to the circumstances of the admission/encounter.

Select Guideline Changes

Z68 Body mass index (BMI)

BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity **or anorexia) documented by the patient's provider.**

Do not assign BMI codes during pregnancy. **When the documentation reflects fluctuating BMI values during the current encounter for an associated reportable condition, assign a code for the most severe value.**

Select Guideline Changes

Prophylactic Organ Removal

For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from subcategory Z40.0, Encounter for prophylactic surgery **for risk factors related to malignant neoplasms, or subcategory Z40.8, Encounter for other prophylactic surgery. If applicable, assign additional code(s) to identify any associated risk factor (such as genetic susceptibility or family history).**

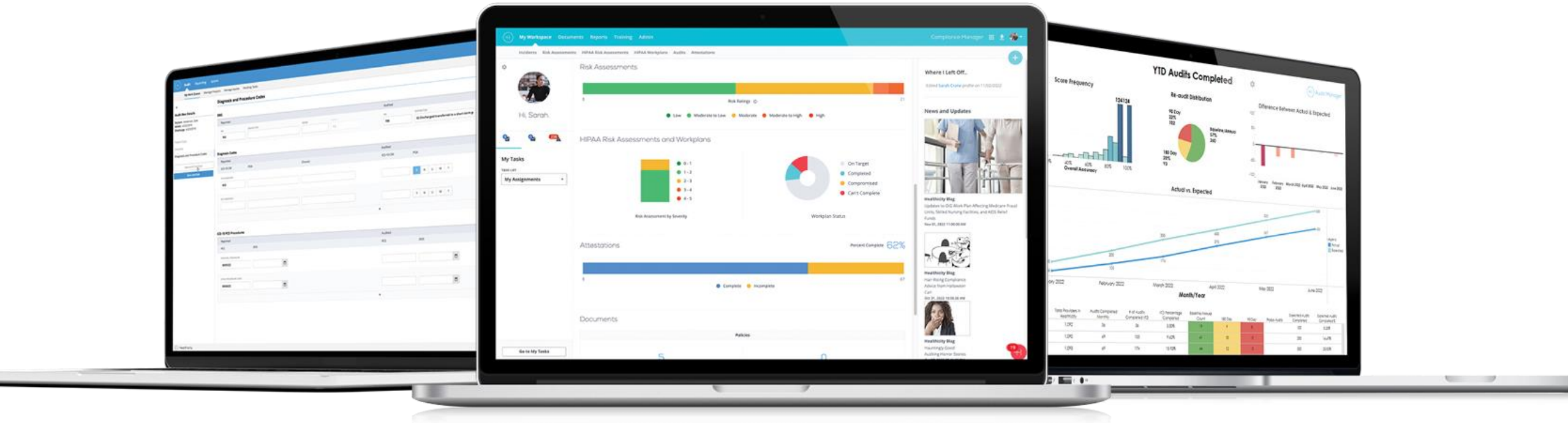
Auditing and Monitoring

"Entities may identify other areas appropriate for routine monitoring based on their risk assessment and their interaction with the Federal health care programs, such as high-value billing codes, medical record documentation, medical necessity of admission, or business-need justifications for contracts with referral so."

--HHS OIG GCPG page 58

Healthicity's Compliance and Auditing Suite

Did you know we offer compliance and auditing software built to help simplify your workflow?



Connect with one of our experts to learn more >>

Thank You!

cj.wolf@healthicity.com

Questions?