



## Top ICD-10 Coding Mistakes That Trigger Denials

A practical guide for skilled nursing facility teams

Accurate ICD-10 coding depends on complete documentation, correct code selection, and consistent application of official guidance. Use this resource to identify common breakdowns before they affect claim submission or audit support.

### **1. The diagnosis is not supported by an authorized provider**

Where claims become vulnerable: A diagnosis appears on the claim or assessment, but the record does not contain documentation from a practitioner legally accountable for establishing it. This can occur when teams rely on a problem list, medication, therapy observation, or documentation from another discipline.

Better practice: Confirm the diagnosis in current provider documentation. When the record is unclear or incomplete, follow the organization's compliant query process before assigning the code.

### **2. The code is not specific enough**

Where claims become vulnerable: An unspecified code is selected even though the record supports details such as site, laterality, condition type, or encounter information.

Better practice: Review the Alphabetic Index, Tabular List, instructional notes, and available clinical documentation. Assign the most specific code supported by the record rather than assuming missing details.

### **3. An inactive or historical condition is treated as current**

Where claims become vulnerable: A diagnosis remains on the active list even though it has resolved or is not affecting the resident's care, treatment, or assessment during the relevant period.

Better practice: Validate that each reported condition is current and meets applicable reporting requirements. Remove or appropriately distinguish resolved and historical conditions.

### **4. The diagnosis does not align with the services billed**

Where claims become vulnerable: The selected diagnosis does not adequately support the medical necessity of the treatment or service reflected on the claim.

Better practice: Confirm that the diagnosis-to-service relationship is supported in the evaluation, plan of care, progress documentation, and claim. Resolve discrepancies before billing.



## 5. Required sequencing or combination-code guidance is missed

Where claims become vulnerable: Codes are reported in the wrong order, an underlying condition is omitted, or tabular instructions such as “code first,” “use additional code,” or Excludes notes are overlooked.

Better practice: Review all applicable tabular instructions and sequencing rules. Do not rely on habit, a facility cheat sheet, or code descriptions alone.

## 6. Documentation conflicts across the record

Where claims become vulnerable: Provider notes, nursing documentation, therapy records, the MDS, and billing information describe the condition differently.

Better practice: Create a review process that brings inconsistencies to the appropriate team member before the claim is submitted. Coding should reflect one clinically supported story.

## 7. Outdated codes or guidance are used

Where claims become vulnerable: The team carries forward an invalid code or relies on an older code set after annual or midyear updates take effect.

Better practice: Use the code set and official guidance that apply to the date of service. Update software, reference materials, education, and internal tools on a defined schedule.

## Pre-Submission Review

- ☐ Provider documentation supports every reported diagnosis.
- ☐ The code reflects the highest specificity available in the record.
- ☐ The condition is current and relevant to the reporting period.
- ☐ Alphabetical Index and Tabular instructions, sequencing rules, and Excludes notes were reviewed.
- ☐ The diagnosis supports the services billed and the documented plan of care.
- ☐ The record presents a consistent clinical picture across disciplines.
- ☐ The current code set and official guidelines were used.

**A stronger process starts before billing.** Routine validation, current references, and clear communication can help teams identify unsupported or inconsistent coding before it becomes a denial issue.