Interventional Radiology ICD-10-CM
Clinical Documentation Guides
OTHER CLINICAL DOCUMENTATION GUIDES

WOMEN’S IMAGING ICD-10-CM
CLINICAL DOCUMENTATION GUIDES

The Women’s Imaging package includes conditions encountered in bone density studies, mammography, breast ultrasound, and other breast studies and procedures. In addition to disorders of the breast and neoplasms of the breast, this package includes a guide that focuses on definition and documentation requirements of active cancer versus history of cancer.

MRI AND CT ICD-10-CM
CLINICAL DOCUMENTATION GUIDES

The MRI/CT package includes a broad range of conditions generally evaluated by these modalities, such as circulatory disorders of the brain, spinal disorders, traumatic brain injury, chest pain, and pneumothorax.

ULTRASOUND ICD-10-CM
CLINICAL DOCUMENTATION GUIDES

The Ultrasound package includes conditions frequently seen in ultrasound studies in the hospital, physician office, and freestanding facility setting. Among the conditions included in this package are ascites, DVT, diverticular disease, abdominal pain, limb pain, and thyroid disorders.

INTERVENTIONAL RADIOLOGY ICD-10-CM
CLINICAL DOCUMENTATION GUIDES

The Interventional Radiology Guide includes topics encountered in both vascular and non-vascular interventions. Some conditions covered in the IR package include circulatory disorders of the brain, DVT, traumatic brain injury, cholelithiasis, pleural effusion, and pneumothorax.
How to use the ICD-10 Documentation Guides

Each documentation guide breaks down the clinical information that needs to be documented into columns and rows. Start with the first row and determine which clinical statement is appropriate for the patient. The additional information that needs to be documented for each condition continues on the following rows.

Some documentation guides are straightforward and follow a single column down the rows. This is the case with the guide for Thyroid Disorders below, once the determination is made that the patient has a non-toxic goiter, the additional information that needs to be documented is provided directly below the non-toxic goiter box.

Physician Documentation Guide for Thyroid Disorders

1. Select a condition and follow the arrows:
   - **Non-toxic Goiter**
   - **Hypothyroidism**
   - **Hyperthyroidism**
   - **Thyrotoxicosis**

2. Be descriptive:
   - **Diffuse**
     - **Simple**
   - **Single thyroid nodule**
     - **Colloid**
     - **Uninodular**
   - **Multinodular**
     - **Cystic**
   - **Congenital with diffuse goiter**
   - **Congenital w/o goiter**
   - **Other**

   - **With diffuse goiter**
     - **Exophthalmic**
     - **Graves’ Disease**
   - **With single thyroid nodule**
   - **With multinodular goiter**
   - **From ectopic thyroid tissue**
   - **Factitia**
   - **Other**

   - **With thyrotoxic storm or crisis**
   - **Without thyrotoxic storm or crisis**
Other documentation guides will be more complex. In these cases, the information in the subsequent rows must be further subdivided to provide the necessary level of detail. Below is the guide for Hypertension. As you can see, more information is necessary to document patients with hypertensive heart and/or kidney disease. Once the determination is made that the patient has hypertensive heart or kidney disease, both the type of heart failure and the stage of kidney disease must be documented.
Physician Documentation Guide for Status, Aftercare & Follow-up

Status vs. Aftercare vs. Follow-up

1. Select status and follow the steps down the column of the same color:

- **Status** – condition is present but is not the reason for the encounter.
- **Aftercare** – condition requiring continued care during the healing & recovery phase
- **Follow-up** – continued surveillance following completed treatment

2. Be specific:

- Presence of device, implant, graft, or documentation of prior surgery
  - Current encounter requested for reason unrelated to the above.
  - Absence of any complications related to the above.
- Document original procedure performed
  - Fracture – see fracture documentation guide
  - Catheter, stent, drainage tube
- Document services provided as routine and directly related to post-surgical state.
- Indicate reason for encounter is follow-up and/or surveillance
- Document the disease, condition, injury with completed course of treatment
Physician Documentation Guide Aftercare vs. Complication

Aftercare vs. Complication

1. Select status and follow the steps down the column of the same color:

- Aftercare – encounter to provide routine services related to the patient’s postsurgical state
  - Patient is not experiencing any complications (ex. pain, fever, etc)

- Complication – encounter due to an unexpected and undesired result of a medical or surgical procedure that affects the patient’s health care

2. Be specific:

- Document original procedure performed
  - Fracture – see fracture documentation guide
  - Catheter, stent, drainage tube

- Document services provided as routine and directly related to post-surgical state

- Document original procedure performed
  - Fracture – see fracture documentation guide
  - Catheter, stent, drainage tube

- Document the type of complication
  - Infection
  - Obstruction
  - Displacement, perforation

- Document relationship between the condition and the procedure
Physician Documentation Guide for Ascites

Patient with Ascites Due to:

1. Select type and follow the arrows:
   - Malignancy
   - Alcoholic Liver Disease
   - Other

2. Be specific:
   - Document malignancy causing ascites
   - Hepatitis with ascites
   - Cirrhosis of liver with ascites

3. Provide context:
   - Document alcohol abuse and/or dependence
   - Ascites
   - Peritoneal effusion

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Physician Documentation Guide for Cholelithiasis

1. Select Location of Calculi:
   - Gallbladder
   - Bile Duct
   - Gallbladder and Bile Duct

2. Be Specific:
   - With Cholecystitis
   - Without Cholecystitis
   - With Cholangitis
   - With Cholecystitis
   - Without Cholangitis or Cholecystitis
   - With Cholecystitis
   - Without Cholecystitis

3. Be descriptive:
   - With Obstruction
   - Without Obstruction

4. Choose severity for the above:
   - Acute
   - Chronic
   - Acute and chronic
   - Unspecified
Physician Documentation Guide for Circulatory Disorders of the Brain (non-traumatic)

Patient with Infarction, Embolism, Thrombosis, Stenosis or Hemorrhage

1. Select a disorder:
   - Infarction
   - Embolism
   - Thrombosis
   - Stenosis

2. Choose the area affected:
   - Subarachnoid
   - Intracerebral
   - Subdural

3. Be Specific:
   - Vertebral
   - Carotid
   - Middle Cerebral
   - Anterior Cerebral
   - Posterior Cerebral
   - Cerebellar
   - Vertebral
   - Carotid
   - Middle Cerebral
   - Anterior Cerebral
   - Posterior Cerebral
   - Cerebellar
   - Subcortical hemisphere
   - Cortical hemisphere
   - Brain stem
   - Cerebellum
   - Intraventricular
   - Multiple localized

Skip Step 2 and move to Step 3.

Acute
Subacute
Chronic
## Physician Documentation Guide for Neoplasms

### Patient Diagnosed with Neoplasm

1. Select status and follow the steps down the column:

   - **History of Cancer** – treatment has ended and no evidence of cancer:
     - Primary site excised or eradicated AND
     - Primary site no longer being treated AND
     - No evidence of remaining malignancy at the primary site

   - **Active Cancer** – disease that is currently causing signs and symptoms and/or is under treatment by any modality:
     - Surgery
     - Chemotherapy
     - Radiation
     - Hormonal Therapy
     - Alternative Medicine

2. Provide context:

   - **Previous treatments**
     - Radiation therapy
     - Chemotherapy

   - **Skip Step 3 and move to Step 4**

3. Specify Location:

   - **Location of Neoplasm** – Specify precise location of neoplasm. See Lung and Breast documentation guides for examples.

4. Reminder:

   All malignancies both primary and secondary should include site specific details – even if no longer active.
### Physician Documentation Guide for Neoplasm of Breast

**Patient Diagnosed with Neoplasm of Breast**

1. Select status and follow the steps down the column of the same color:

   - **History of Cancer:** treatment has ended and no evidence of cancer:
     - Primary site excised or eradicated AND
     - Primary site no longer being treated AND
     - No evidence of remaining malignancy at the primary site

   - **Active Cancer:** disease that is currently causing signs and symptoms and/or is under treatment by any modality:
     - Surgery
     - Chemotherapy
     - Radiation
     - Hormonal Therapy
     - Alternative Medicine

2. Follow the corresponding column

   - **Previous treatments**
     - Radiation therapy
     - Chemotherapy

3. Select Gender:
   - Female
   - Male

4. Select Breast:
   - Right
   - Left

5. Select Area:
   - Nipple and Areola
   - Central Portion
   - Upper-Outer Quadrant
   - Lower-Outer Quadrant
   - Overlapping Sites

6. Reminder:
   - All malignancies both primary and secondary should include site specific details – even if no longer active.
Physician Documentation Guide for Neoplasm of Lung

Patient Diagnosed with Neoplasm of Lung

1. Select status and follow the steps down the column of the same color:

   - **History of Cancer** – treatment has ended and no evidence of cancer:
     - Primary site excised or eradicated AND
     - Primary site no longer being treated AND
     - No evidence of remaining malignancy at the primary site

   - **Active Cancer** – disease that is currently causing signs and symptoms and/or is under treatment by any modality:
     - Surgery
     - Chemotherapy
     - Radiation
     - Hormonal Therapy
     - Alternative Medicine

2. Follow the corresponding column

   - **Previous treatments**
     - Radiation therapy
     - Chemotherapy

3. Select lung

   - Right
   - Left

4. Select Area:

   - Main bronchus
   - Upper lobe, bronchus or lung
   - Middle lobe, bronchus or lung
   - Lower Lobe, bronchus or lung
   - Overlapping site of bronchus or lung

5. Reminder:

   All malignancies both primary and secondary should include site specific details – even if no longer active. Additional code necessary to identify tobacco use.
# Physician Documentation Guide for Pleural Effusion

## Patient with Pleural Effusion

1. Select category and follow the steps down the column of the same color:

- **Pleural effusion, not elsewhere classified**
  - Encysted pleurisy
  - Pleurisy with effusion

- **Malignant pleural effusion**

- **Pleural effusion in other conditions classified elsewhere**

2. Identify the underlying cause:

- **Identify underlying neoplasm.**
  (e.g., lung cancer right main bronchus – see lung cancer documentation sheet)

- **Identify underlying disease.**
  (e.g., influenza, pneumonia, CHF)
Physician Documentation Guide for Pneumothorax

Patient with Pneumothorax and/or Air Leak

1. Select type and follow the arrows:
   - Spontaneous
   - Postprocedural
   - Traumatic

2. Be specific:
   - Primary
   - Secondary (document underlying condition)
   - Chronic
   - Other air leak
   - Other pneumothorax
   - Pneumothorax
   - Air leak
   - Pneumothorax

- Initial encounter
- Subsequent encounter
- Sequela
1. Select a type and follow the arrows:

- **Initial Encounter** (active treatment, may apply to multiple services and/or multiple dates of service)
  - Document as IE if:
    - ED patient (seen in or referred from ED)
    - Surgical treatment including pre- & post-surgical imaging
    - New injury still being evaluated

- **Subsequent Encounter** (routine care during the healing or recovery phase)
  - Document as SE if:
    - Ordered as a “follow-up” or “check status” study
    - Presence of a cast, internal fixation device (beyond initial pre-/post-placement images)

- **Sequela** (residual effect after the acute phase has terminated)
  - Document as a sequela if the current complaint is related to prior accident/injury. Select from the following:
    - Scarring
    - Deformity
    - Post-traumatic arthritis
    - Pain and other conditions

2. Include the following:

- **Remember to include in the patient history details related to the accident/injury.** e.g.:
  - Shoulder pain and bruising after fall from ladder
  - Laceration forehead from MVA

- **For fractures** subsequent encounters must document status as:
  - Routine healing
  - Delayed healing
  - Malunion
  - Non-union

- **Encounters for sequela require that the provider directly link the original injury to the identified residual effect or complication.**

**NOTE:**
Please document Gustilo Class if known.
Physician Documentation Guide for Extremity Venous Embolism & Thrombosis

Venous Embolism and Thrombosis

1. Select one

- [ ] Acute Embolism/Thrombosis
- [ ] Chronic Embolism/Thrombosis

2. Choose the area affected:

- [ ] Upper Extremity
- [ ] Lower Extremity

- [ ] Superficial
  - Antecubital
  - Basilic
  - Cephalic

- [ ] Deep
  - Brachial
  - Radial
  - Ulnar

- [ ] Axillary
- [ ] Subclavian
- [ ] Internal Jugular

- [ ] Femoral
- [ ] Iliac
- [ ] Popliteal
- [ ] Tibial
- [ ] Other

- [ ] Superficial
  - Antecubital
  - Basilic
  - Cephalic

- [ ] Deep
  - Brachial
  - Radial
  - Ulnar

- [ ] Axillary
- [ ] Subclavian
- [ ] Internal Jugular

- [ ] Femoral
- [ ] Iliac
- [ ] Popliteal
- [ ] Tibial
- [ ] Proximal
- [ ] Distal
- [ ] Other

3. Be Specific:

- [ ] Right
- [ ] Left
- [ ] Bilateral
Physician Documentation Guide for Traumatic Intracranial Injury

1. Select a condition and follow the arrows:
   - Concussion
   - Cerebral Edema
   - Diffuse Traumatic Injury
   - Unspecified

   Skip steps 2 and 3 and continue to step 3.

   - Focal Traumatic Injury

   Skip step 2 and continue to step 3.

   - Hemorrhage
   - Other

   - Contusion & Laceration
   - Hemorrhage
   - Contusion, Laceration & Hemorrhage

   Step 2.

   - RT Cerebrum
   - LT Cerebrum
   - Cerebellum
   - Brain Stem

   Step 3.

   - Epidural
   - Subdural
   - Subarachnoid

   - RT Internal Carotid
   - Left Internal Carotid
   - Other

   Step 4. Loss of Consciousness:

   - Without loss of consciousness
   - 30 min or less
   - 31-59 min
   - 1hr – 5hr 59 min
   - 6hrs – 24hrs
   - Greater than 24hrs with return to pre-existing conscious level

   - Greater than 24hrs without return to pre-existing conscious level with patient surviving
   - Any duration with death due to brain injury prior to regaining consciousness
   - Any duration with death due to other causes prior to regaining consciousness
   - Loss of consciousness of unspecified duration
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