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.

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Physician Documentation Guide for Thyroid Disorders

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

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

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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

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
Physician Documentation Guide for Cholelithiasis

Patient with Cholelithiasis

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

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

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

   □ Infarction
   □ Embolism
   □ Thrombosis
   □ Stenosis

Skip Step 2 and move to Step 3

2. Choose level:
   - Subarachnoid
   - Intracerebral
   - Subdural

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

   □ Vertebral
   □ Carotid
   □ Middle Cerebral
   □ Anterior Cerebral
   □ Posterior Cerebral
   □ Cerebellar
   □ Subcortical hemisphere
   □ Cortical hemisphere
   □ Brain stem
   □ Cerebellum
   □ Intraventricular
   □ Multiple localized

   □ Acute
   □ Subacute
   □ Chronic
Physician Documentation Guide for Diverticular Disease of the Intestine

Patient Diagnosed with Diverticular Disease

1. Select location and follow the arrows:
   - Small Intestine
   - Large Intestine
   - Both Small and Large Intestine
   - Unspecified Intestine

2. Select the one that applies and follow the arrow:
   - Diverticulosis only
   - Diverticulitis
     - No complications
     - Bleeding
     - Perforation and/or abscess without bleeding
     - Perforation and/or abscess with bleeding
Physician Documentation Guide for Hypertension

Patient Diagnosed with Hypertension

1. Select type and follow the arrows:

- Essential (default)
- Secondary
- Hypertensive heart and/or kidney disease

- Renovascular
- Other renal disorders
- Hypertensive heart disease
- Hypertensive heart and kidney disease

- Chronic kidney disease
- Hypertensive chronic kidney disease
- Hypertensive heart and kidney disease

- Heart Disease
  - With heart failure
  - Without heart failure

- With stage 1-4 CKD
- With stage 5 or ESRD

- Document both the type of heart failure and the stage of kidney disease
Physician Documentation Guide for Internal Derangement of Knee (Non-traumatic/ Not current Injury)

Patient Diagnosed with Internal Derangement of Knee

1. Select knee:
   - [Right]
   - [Left]

2. Select one of the following paths:
   - Derangement due to old injury to Meniscus
   - Other Meniscus derangement
   - Spontaneous disruption of Ligaments

   - Medial Meniscus
     - [Anterior Horn]
     - [Posterior Horn]
     - [Other]
     - [Unspecified]
   
   OR
   
   - Lateral Meniscus
     - [Anterior Horn]
     - [Posterior Horn]
     - [Other]
     - [Unspecified]

   - Medial Meniscus
     - [Anterior Horn]
     - [Posterior Horn]
     - [Other]
     - [Unspecified]

   OR
   
   - Lateral Meniscus
     - [Anterior Horn]
     - [Posterior Horn]
     - [Other]
     - [Unspecified]

   - Medial Collateral Ligament
   
   - Lateral Collateral Ligament

   - Anterior Cruciate Ligament
   
   - Posterior Cruciate Ligament
   
   - Capsular Ligament
   
   - Other
# 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

- **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. Select Previous Treatments:

- Previous treatments
  - Radiation therapy
  - Chemotherapy

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 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

- **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 correspondent 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.
Patient Diagnosed with Osteoarthritis

1. Select one of the following:
   - Primary (default)
   - Secondary
   - Post Traumatic
   - Other

2. Select location:
   - Right
   - Left
   - Bilateral
   - Unspecified

3. Select area:
   - Shoulder
   - Elbow
   - Wrist
   - Hand
   - First Carpo-metacarpal Joint
   - Hip
   - Hip with Dysplasia
   - Knee
   - Ankle/Foot
Patient Diagnosed with Disorders of the Joint

1. Select condition:
   - Effusion in Joint
   - Pain in Joint
   - Stiffness in Joint

2. Select one of the following Lateralities:
   - Right
   - Left

3. Following the path from step 1, select joint:
   - Joint:
     - Shoulder
     - Elbow
     - Wrist
     - Hip
     - Knee
     - Ankle
     - Foot
### Patient Diagnosed with Abdominal or Pelvic Pain

1. Select type and follow the arrows:

<table>
<thead>
<tr>
<th>Generalized</th>
<th>Localized</th>
<th>Tenderness</th>
<th>Colic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rebound Tenderness</td>
<td>Infantine</td>
</tr>
</tbody>
</table>

2. Be specific:

<table>
<thead>
<tr>
<th>Acute</th>
<th>RUQ</th>
<th>LUQ</th>
<th>Epigastric</th>
<th>Dyspepsia</th>
<th>RLQ</th>
<th>LLQ</th>
<th>Periumbilical</th>
<th>Pelvic/ perineal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-acute</th>
<th>RUQ</th>
<th>LUQ</th>
<th>RLQ</th>
<th>LLQ</th>
<th>Periumbilic</th>
<th>Epigastric</th>
<th>Generalized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Physician Documentation Guide for Chest Pain

Patient Diagnosed with Chest Pain

1. Select type and follow the arrows:

- Pain in Throat
- Pain on breathing
  - Painful respiration
- Preordial pain
- Other or unspecified chest pain

2. Be specific:

- Pleurodynia
- Intercostal pain
- Other chest pain
Physician Documentation Guide for Limb Pain

Patient Diagnosed with Limb Pain

1. Select Limb:
   - [ ] Upper Limb
   - [ ] Lower Limb

2. Select Location
   - [ ] Upper arm
   - [ ] Forearm
   - [ ] Hand
   - [ ] Fingers
   - [ ] Thigh
   - [ ] Lower leg
   - [ ] Foot
   - [ ] Toes

3. Select one:

Laterality:
   - [ ] Right
   - [ ] Left
Physician Documentation Guide for Peptic Ulcer

1. Select Location:
   - [ ] Esophagus
   - [ ] Duodenum
   - [ ] Stomach
   - [ ] Unspecified

   Skip Step 2 and move to Step 3

2. Choose severity of the above:
   - [ ] Acute
   - [ ] Chronic
   - [ ] With hemorrhage
   - [ ] With perforation
   - [ ] With both hemorrhage & perforation
   - [ ] Without hemorrhage or perforation

3. Be specific:
   - [ ] With bleeding
   - [ ] Without bleeding

4. Provide context:
   - If due to drug or toxin, identify drug or toxin
   - If documented, presence of:
     - [ ] Alcohol abuse and dependence
Physician Documentation Guide for Pleural Effusion

Patient with Pleural Effusion

1. Select type and follow the arrows:

- 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
Physician Documentation Guide for Spinal Disc Disorders

Patient Diagnosed with Spinal Disc Disorder

1. Select all that apply:
   - [ ] With Myelopathy
   - [ ] With Radiculopathy
   - [ ] With Disc Displacement
   - [ ] With Disc Degeneration
   - [ ] Other Disc Disorder

2. Identify the Location:
   - [ ] High cervical region
   - [ ] Mid cervical region
   - [ ] Cervicothoracic region
   - [ ] Thoracic region
   - [ ] Thoracolumbar region
   - [ ] Lumbar
   - [ ] Lumbosacral region
Physician Documentation Guide for Spondylosis

Has the Patient been Diagnosed with Spondylosis with Artery Compression Syndrome?

1. Answer the questions and follow the arrows:
   - Yes
   - No

2. Be Specific:
   - Anterior Spinal Artery
   - Vertebral Artery
   - With Myelopathy
   - With Radiculopathy
   - Without Myelopathy or Radiculopathy

3. Select location:
   - Occipito-atlanto-axial region
   - Cervical Region
   - Cervicothoracic Region
   - Thoracic Region
   - Thoracolumbar Region
   - Lumbar Region
   - Sacral and Sacrococcygeal Region
   - Unspecified Site
Physician Documentation Guide for Episodes of Care

Episodes of Care

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:**
Open fractures of the forearm, femur and lower leg are further defined by severity by using the Gustilo Classification. Please document 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
   - Other

3. Be Specific:
   - Right
   - Left
   - Bilateral
Physician Documentation Guide for Pathological Fractures

Pathological Fracture caused by/due to:

1. Select one
   - Neoplasm
     Document neoplasm
   - In other diseases
     Document disease
   - Not elsewhere classified

2. Choose the Location:
   - Shoulder
   - Humerus
   - Radius
   - Ulna
   - Hand
   - Pelvis
   - Femur
   - Tibia
   - Fibula
   - Ankle
   - Foot
   - Verterbra
   - Shoulder
   - Humerus
   - Radius
   - Ulna
   - Hand
   - Fingers
   - Pelvis
   - Femur
   - Tibia
   - Fibula
   - Ankle
   - Foot
   - Toes
   - Verterbra

3. Select a side:
   - Right
   - Left

4. Encounter (Closed):
   - Initial
   - Subsequent routine healing
   - Subsequent delayed healing
   - Subsequent non-union
   - Subsequent malunion
   - Sequela
1. Select a condition and follow the arrows:

- Concussion
- Cerebral Edema
- Diffuse Traumatic Injury
- Unspecified
- Focal Traumatic Injury
- Hemorrhage
- Other

Skip steps 2 and 3 and continue to step 4.

Step 2.

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

Step 3.

- RT Cerebrum
- LT Cerebrum
- Cerebellum
- Brain Stem
- 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 with patient surviving
- 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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Physician Documentation Guide for Traumatic Fractures

Fractures in the upper extremity:
(select one) Shaft of humerus / shaft of ulna / shaft of radius

1. Select one:
- Left
- Right

2. Select the one that applies:
- Displaced (Default)
- Non-displaced

3. Select the type of fracture:
- Spiral
- Oblique
- Comminuted
- Torus
- Transverse
- Segmental
- Monteggia’s (ulna)
- Galeazzi’s
- Bent bone (radius & ulna)

4. Select the one that applies:
- Open
- Closed

5. Document type of encounter:

NOTE: Document severity of open wound.
Other common fractures in the upper extremity

1. Select a side:
   - Right
   - Left

2. Select one:
   - Displaced (default)
   - Non-displaced

3. Select either open or closed:
   - Open
   - Closed (default)

4. Document type of encounter (see guide for Episodes of Care for documentation tips):
   - Initial
   - Subsequent routine healing
   - Subsequent delayed healing
   - Subsequent malunion
   - Subsequent non union
   - Sequela

NOTE: Document severity of the open wound.

5. Select:
   - Radius
   - Ulna
   (select one or both)
   - Styloid process
   - Torus
   - Salter-Harris I
   - Salter-Harris II
   - Salter-Harris III
   - Salter Harris IV
   - Colles’ (radius)
   - Smith’s (radius)
   - Barton’s (radius)
   - Other extraarticular (radius)
   - Other intraarticular (radius)

Wrist
- Scaphoid/Navicular
  - Distal pole
  - Middle third
  - Proximal third
- Other carpal bones
  - Triquetrum/Cuneiform
  - Lunate/Semilunar
  - Capitate/Os Magnum
  - Hamate/Unciform
  - Hook process of Hamate/Unciform
  - Pisiform
  - Trapezium/Larger multangular
  - Trapezoid/Smaller multangular
**Physician Documentation Guide for Traumatic Fractures**

**Fractures of Lower End of Radius**

1. Select one of the following options:
   - [ ] Left
   - [ ] Right

2. Select the one that applies:
   - [ ] Displaced
   - [ ] Non-displaced

3. Select the type of fracture:
   - [ ] Styloid process
   - [ ] Torus
   - [ ] Colles’
   - [ ] Smith’s
   - [ ] Barton’s
   - [ ] Other extraarticular
   - [ ] Other intraarticular
   - [ ] Other

4. Select one of the following options:
   - [ ] Initial
   - [ ] Subsequent routine healing
   - [ ] Subsequent delayed healing
   - [ ] Subsequent non-union
   - [ ] Subsequent malunion
   - [ ] Sequela
Physician Documentation Guide for Traumatic Fractures

Other common fractures in the lower extremity

1. Select a side:
   - [ ] Right
   - [ ] Left

2. Select one:
   - [ ] Displaced (default)
   - [ ] Non-displaced

3. Select either open or closed:
   - [ ] Open
   - [ ] Closed (default)

4. Document type of encounter (see guide for Episodes of Care for documentation tips):
   - [ ] Initial
   - [ ] Subsequent routine healing
   - [ ] Subsequent delayed healing
   - [ ] Subsequent malunion
   - [ ] Subsequent non-union
   - [ ] Sequela

5. Select:

**FEMUR**
- Proximal End
  - Intracapsular
  - Epiphysis
  - Midcervical
  - Base of neck
  - Articular fx head
  - Other head/neck fx
  - Greater trochanter
  - Lesser trochanter
  - Apophyseal
  - Intertrochanteric
  - Subtrochanteric

- Distal End
  - Lateral condyle
  - Medial condyle
  - Lower epiphysis
  - Supracondylar w/o intracondylar extension
  - Supracondylar w/ intracondylar extension
  - Torus
  - Other

**LOWER LEG**
- Proximal Tibia and/or Fibula
  - Tibial spine
  - Lateral condyle fx tibia
  - Medial condyle fx tibia
  - Bicondylar fx tibia
  - Tibial tuberosity
  - Torus fx tibia
  - Torus fx fibula
  - Other fx tibia or fibula

- Distal end
  - Torus fx tibia
  - Torus fx fibula
  - Medial malleolus
  - Lateral malleolus
  - Bimalleolar fx fibula
  - Trimalleolar fx fibula
  - Maisonneuve’s fx fibula
  - Pilon fx fibula
  - Other fx tibia or fibula
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