ICD-10-CM Clinical Documentation Guide

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Chapter	ICD-9-CM	ICD-10-CM Requirements	Notes
Chapter 1: Infections	• Manifestation • Condition	**HIV,** document: • Confirmation doesn't require positive serology; provider's diagnostic statement that the patient is HIV positive or has an HIV related illness is sufficient. **Sepsis,** document: • Specify the underlying systemic infection (specify if post-procedural) or causal organism • Any acute organ dysfunction. **MRSA,** document: • Infection due to MRSA and any causal organism	The word "Certain" in this chapter stresses the fact that localized infections will be located in the pertinent body system (i.e. UTI is classified in Chapter 14).

Chapter 2: Neoplasms	**Anatomical site**
	
	Histologic behavior:
	• Malignant Primary
	• Malignant Secondary
	• In situ
	• Benign
	• Uncertain
	• Unspecified behavior
	
	Skin neoplasms:
	• Basal cell carcinoma
	• Squamous cell carcinoma
	• Specified type NEC
		General Documentation:
		• Anatomical Site
		• **Laterality (left, right)**
		• Histologic behavior:
		  ○ Benign
		  ○ Malignant, **primary and secondary sites if metastatic**
		  ○ In situ
		  ○ Uncertain
		  ○ Unspecified behavior
		• Histologic Type:
		  ○ Carcinoma
		  ○ Basal Cell
		  ○ Squamous Cell
		  ○ Adenoma
		• **Complications or Adverse effects of antineoplastic or immunosuppressive drugs**
		• Previous excision or eradication
		
		Breast, **in-situ, document:**
		• **Lobular**
		• **Intraductal**
		
		Leukemia, **Multiple Myeloma**, **Malignant plasma cell neoplasms**, document:
		• Relapse
			Pathologists may need to work with their referring physician to obtain this information.
			
			When patients have more than one malignant tumor in the same organ document the primary and metastatic disease.

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		• Remission • Not having achieved remission	

Chapter 3: Blood Disorders	Most Intra-operative & Post-procedural complications are included in Chapter 17 – Injury and Poisoning.	**Anemia,** document:
		• Nutritional, specify:
		  ○ Iron deficiency
		  ○ Vitamin B12 deficiency
		  ○ Folate deficiency (dietary or drug-induced)
		  ○ Other (protein, megaloblastic)
		• Hemolytic, specify:
		  ○ Due to enzyme disorders
		  ○ Sickle-cell disorders
		  ○ Other hereditary or acquired
		• Aplastic
		• In other chronic diseases (specify the underlying disease)
		
		Spleen document Intra-operative & Post-procedural complications, specify:
		• **Intra-operative (during) or Post-procedural (following)**
		• **Hemorrhage, hematoma, accidental puncture or accidental laceration of the spleen**
		• **Procedure on the spleen or other procedure**
			Intra-operative & Post-procedural complications are also included in other chapters based on specific site/system documentation.

Chapter 4: Diabetes & Metabolic Disorders	**Diabetes:** Distinguished as "Uncontrolled" or "Not stated as uncontrolled".	**Diabetes,** document: • Type 1 diabetes mellitus • Type 2 diabetes mellitus (default, if not specified) • Drug or chemically induced diabetes mellitus • Secondary diabetes mellitus (specify the cause) • Specify complication(s), when applicable • Specify use of insulin, when applicable **Obesity,** document: • **Due to excess calories** • **Drug-induced** • Identify body mass index	Diabetes: Distinguished as "With complications" or "Without complications". Gestational diabetes (in pregnancy) is reported in Chapter 15.

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Chapter 5: Behavioral Health	Reserved for future expansion (no specific ICD-9-CM direction).	**General Documentation:** • Anatomical Site of pain • Pain that is exclusively related to psychological disorders • Psychological component for a patient with acute or chronic pain • If in remission, document based on provider's clinical judgment and must indicate "in remission" **Psychoactive Substance**, indicate: • "use", "abuse" and/or "dependence" • **If use is associated with a mental or behavioral disorder**	

Chapter 6: Pain Nervous System	• Type
	• Site
		General Documentation:
		• Type of pain:
		  ○ Acute or chronic
		  ○ Post-procedural (specify procedure)
		  ○ Due to trauma
		  ○ Neoplasm related (specify neoplasm and site)
		• Site specificity, when applicable
		• **Laterality (right, left, bilateral), when applicable**
		• Dominant or Non-dominant side, when applicable
		
		Chronic Pain:
		• **Central pain syndrome** and **Chronic pain syndrome** are different than the term 'chronic pain' and will be coded based on your specific documentation.
		
		Migraine, document:
		• With or without aura
		• Intractable or not intractable
		• With or without status migrainosus
		
		Epilepsy, document:
		• Localization related or generalized
		• Intractable or not intractable
		• **With or w/o status epilepticus**
			"Pain" is also included in other chapters based on specific documentation (site, not specified as acute or chronic).

Chapter 7: Eye	**Glaucoma:** • Two codes to identify type & stage.	**General Documentation:** • Specific disorder/disease and external cause, when applicable • **Laterality (right, left, bilateral)**	Moved from Nervous System chapter in ICD-9-CM to its own

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	• Identify the external cause, if applicable, of the eye condition.	**Cataract**, document:
		• Type:
		  ○ Age-related
		  ○ Traumatic
		  ○ Complicated
		  ○ Drug-induced
		  ○ Other
		
		Glaucoma, document:
		• Type:
		  ○ Suspect
		  ○ Open-angle
		  ○ Primary angle-closure
		  ○ Secondary due to (specify: trauma, inflammation, drugs)
		• Stage:
		  ○ Mild
		  ○ Moderate
		  ○ Severe
		  ○ Indeterminate (cannot be clinically determined)
			chapter in ICD-10-CM.
			
			Glaucoma type & stage combined into one code.

Chapter 8: Ear		**General Documentation:**
		• Specific disorder/disease
		• **Laterality (right, left, bilateral)**
		
		Otitis media, document:
		• Acute or chronic
		• Suppurative or nonsuppurative
		
		Perforation tympanic membrane, document:
		• Type:
		  ○ Central
		  ○ Attic
		  ○ Other marginal
		  ○ Multiple
		  ○ Total
		
		Hearing loss (deafness), document:
			Moved from Nervous System chapter in ICD-9-CM to its own chapter in ICD-10-CM.

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		• Type:
		  ○ Conductive
		  ○ Sensorineural
		  ○ Mixed
		  ○ Other	

Chapter 9: Circulatory	Hypertension (HTN):
	• Benign
	• Malignant
	• Unspecified
	
	Coronary Artery Disease (CAD) (Atherosclerosis/Ischemia):
	• Native Coronary Artery
	• Graft type
	• Nonautologous
	
	Acute Myocardial Infarction (AMI) defined as duration of 8 weeks or less.
	
	Cerebral Infarction / Cerebrovascular Accident (CVA):
	• Occlusion
	• Thrombosis
	• Embolism
		General Documentation:
		• Site specificity, when applicable
		• **Laterality (right, left, bilateral), when applicable**
		
		HTN (no distinction of status/type), document if:
		• With heart involvement (and with heart failure, if applicable)
		• With kidney involvement, specify:
		  ○ Stage 1 thru 5, or ESRD
		• Secondary
		
		CAD, document:
		• Specific artery (default is native artery)
		• With angina (specify: stable or unstable) or without angina
		
		AMI (redefined as duration of 4 weeks {28 days} or less), document:
		• Location:
		  ○ Anterior wall (left main, left anterior descending or other coronary artery)
		  ○ Inferior wall (right or other coronary artery)
		  ○ Other sites (left circumflex coronary artery or other site)
		• ST elevation (STEMI) or Non-ST elevation (NSTEMI)
		
		CVA, document:
		• **Location:**
		• **Precerebral artery**
		  ○ **(vertebral, basilar, carotid)**
		• **Cerebral artery**
		  ○ **(right/left…middle, anterior, posterior, cerebellar)**
		• Due to:
		  ○ Thrombosis, embolism, occlusion or stenosis
		
		Heart Failure/CHF, document:
			No distinction of HTN status/type.
			
			CAD with or without angina inclusive in one code.
			
			AMI redefined as duration of 4 weeks (28 days) or less.

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		• Left ventricle, systolic, diastolic, combined • Acute, chronic, acute on chronic (decompensated) **Cardiomyopathy**, document: • Dilated • Hypertrophic (obstructive, other) • Endomyocardial • Endocardial fibroelastosis • Other restrictive • Due to: alcohol, drug or external agent **Atrial fibrillation**, document: • Paroxysmal, persistent or chronic **Atrial flutter**, document: • Typical or atypica	

Chapter 10: Respiratory	• Severity	**General Documentation:**
		• Document causal organism
		
		Asthma, document:
		• Severity:
		  ○ Mild intermittent
		  ○ Mild persistent
		  ○ Moderate persistent
		  ○ Severe persistent
		  ○ Other
		• Complication:
		  ○ With acute exacerbation
		  ○ With status asthmaticus
		  ○ Uncomplicated
		
		Bronchitis, document:
		• Acute, and document causal organism
		• Chronic, and document if simple, mucopurulent or mixed
		
		Allergic rhinitis, document:
			No documentation changes from ICD-9-CM to ICD-10-CM. Column to the left are common documentation pitfalls that may have been missed while documenting I-9. Emphasizing the importance of documenting for I-10.

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		• Pollen
		• Other seasonal
		• Food
		• Animal (cat)(dog) hair and dander
		• Other
		
		Sinusitis, document:
		• Acute (and if recurrent) or chronic
		• Site:
		  ○ Maxillary
		  ○ Frontal
		  ○ Ethmoidal
		  ○ Sphenoidal
		  ○ Pansinusitis	

Chapter 11: GI		**Crohn's** disease and **Diverticular** disease, document:
		• Site:
		  ○ Small intestine
		  ○ Large intestine
		  ○ Both small & large intestine
		• Complication (specify) or w/o complication
		
		Ulcerative Colitis, document:
		• Type:
		  ○ Pancolitis
		  ○ Proctitis
		  ○ Rectosigmoiditis
		  ○ Left sided
		  ○ Other
		• Complication (specify) or w/o complication
		
		Hemorrhoids, document:
		• Internal
		  ○ Specify degree, grade, state
		• External
		
		Hernia, document:
			No documentation changes from ICD-9-CM to ICD-10-CM. Column to the left are common documentation pitfalls that may have been missed while documenting I-9. Emphasizing the importance of documenting for I-10.

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		• Site:
		  ○ Inguinal
		  ○ Femoral
		  ○ Ventral (specify: incisional, parastomal)
		  ○ Diaphragmatic
		  ○ Other/unspecified abdominal
		• Unilateral or bilateral (applicable to inguinal & femoral)
		• Recurrent or not specified as recurrent (applicable to inguinal & femoral)
		• With obstruction and/or gangrene or w/o obstruction and/or gangrene	

Chapter 12: Skin	**Anatomical** site
	
	Specimen type i.e., cyst, tag, abscess, ulcer, scar, etc.
	
	Neoplasm skin and subcutaneous tissues see Chapter 2 guidelines.
	
	Dermatitis, document if:
	• Atopic
	• Seborrheic
	• Diaper
	• Exfoliative
	• Contact (due to…)
	  ○ Irritant contact (due to…)
	  ○ Unspecified contact (due to…)
	
	Pressure Ulcer
		General Documentation:
		• Anatomical site
		• **Laterality**
		
		Pressure ulcer, document:
		• **Site**
		• **Laterality**
		• **Specify stage:**
		  ○ **Unstageable (can't be clinically determined)**
		  ○ **Stage 1**
		  ○ **Stage 2**
		  ○ **Stage 3**
		  ○ **Stage 4**
		
		Dermatitis, document:
		• Atopic
		• Seborrheic
		• Diaper
		• Exfoliative
		• Contact
		  ○ Allergic (specify: due to…)
		  ○ Irritant (specify: due to….)
		
		Non-pressure ulcer, document:
		• Site
		• **Laterality (left or right)**
		• **Severity:**
			Neoplasm skin and subcutaneous tissue are included in Chapter 2.
			
			Pressure ulcer staging is generally identified by the clinician.
			
			As with ICD-9-CM, Pathologists may need to work with their referring physician to obtain this information.
			
			Non-pressure ulcers are included in Chapter 19.

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		○ **Limited to breakdown of skin** ○ **With fat layer exposed** ○ **With necrosis of muscle** ○ **With necrosis of bone**	
Chapter 13: M/S Fracture	• Site • Late Effect	**General Documentation:** • Anatomical Site, when applicable (bone, join or muscle involved) • **Laterality (left, right, bilateral), when applicable** • Chronic, recurrent or healed musculoskeletal conditions **Fracture,** document: • Location (specify site of the fracture, e.g. hip fracture – subtrochanteric fracture of right femur) • Late Effect • **Type of** fracture**:** ○ Fatigue ○ Stress ○ Pathological • **Laterality** • **Encounter type:** ○ **Initial** ○ **Subsequent (specify routine or delayed healing, non-union, malunion)** ○ **Sequela** **Osteoarthritis,** document: • **Type:** ○ **Primary (wear and tear)** ○ **Secondary (caused by other condition)** ○ **Post-traumatic** **Gout**, document: • Acute or chronic (with or without tophus) • Idiopathic • Lead-induced • Drug-induced • Due to renal impairment (specify renal disease) • Other secondary gout (specify associated condition)	**Fatigue fractures and collapsed vertebra will require a 7th** character**:** • A – Initial encounter • D – Subsequent with routine healing • G – Subsequent with delayed healing • S – Sequela (complications, or conditions – i.e. scars) **Stress and Pathological fractures will require a 7th** character**:** • A – Initial encounter • D – Subsequent with routine healing • G – Subsequent with delayed healing • K – Subsequent with non-union • P – Subsequent with malunion • S – Sequela (complications, or conditions – i.e. scars)

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Chapter 14: GU Kidney Disease	• Chronic • Stage	**Chronic Kidney Disease**, document: • Stage 1 • Stage 2 (mild) • Stage 3 (moderate) • Stage 4 (severe) • Stage 5 • Co-morbidities (e.g. DM, HTN) • **Specify any associated kidney failure** **Urinary Incontinence**, document: • Stress • Urge • Without sensory awareness • Post-void dribbling • Nocturnal enuresis • Continuous leakage • Mixed • Overflow **Hematuria**, document: • Recurrent • Persistent • Any applicable underlying condition(s) **Neurogenic bladder**, document: • Uninhibited • Reflex • Flaccid • Any associated urinary incontinence **Prolapse**, document: • Site • Complete (3rd degree) or incomplete (1st/2nd degree)	Codes from Chapter 14 may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly.
Chapter 15: Obstetrics & Gynecology	• Pregnancy specified as episode of care. • Missed abortion defined as fetal	**General Documentation:** • **Episode of Care**, document: ○ **Trimester of pregnancy, for the current encounter**	Trimester**:** • 1st trimester – less than 14

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	death (before **22** weeks). • Weeks of pregnancy (not reported). • Abortions • Current conditions complicating pregnancy. • Diabetes mellitus in pregnancy	○ **Number weeks gestation** • If pregnancy is Incidental, i.e. not the reason for encounter • Pre-existing conditions versus conditions due to the pregnancy • Condition that resulted in the performance of a cesarean delivery • **Number of fetus'** • Outcome of delivery **Termination of pregnancy and Spontaneous Abortions**, document: • Type of termination • Type of abortion and completion status incomplete/complete • Retained products of conception following abortion • Complications leading to abortion **Premature Rupture of Membranes**, document: • **Onset of labor within 24 hours of rupture** • **Onset of labor more than 24 hours of rupture** **Gestational diabetes**, document: • **Diet controlled** • **Insulin controlled** **Pre-eclampsia**, document: • Mild to moderate • Severe • HELLP **Malposition**, document: • Disproportion • Maternal condition	weeks 0 days • 2nd trimester – 14 weeks 0 days to less than 28 weeks 0 days • 3rd trimester – 28 weeks 0 days until delivery Several categories require a 7th character code for single gestations and multiple gestations: 0 – not applicable or unspecified 1 – fetus 1 2 – fetus 2 3 – fetus 3 4 – fetus 4 5 – fetus 5 9 – other fetus Missed abortion defined as fetal death (before **20** weeks)

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Chapter 16: Perinatal		**General Documentation:** • Conditions that have their origin in the fetal or perinatal period (defined as before birth through the 28th day following birth). • Documentation of the listed maternal conditions is specified as the cause of confirmed morbidity or potential morbidity.	Conditions listed in Chapter 16 are never for use on the maternal record. Conditions listed in Chapter 16 may be used throughout the life of the patient if the condition is still present.

Chapter 17: Congenital/ Chromosomal	• Unilateral, Bilateral
	• Type
		General Documentation:
		• **Laterality (right, left,** unilateral, bilateral)
		• Specify distinction between existing malformation or deformity vs. personal history.
		
		Cleft palate, document:
		• Hard
		• Soft
		• Hard w/soft
		
		Cleft lip, document:
		• Bilateral
		• Median
		• Unilateral
		
		Hypospadias, document:
		• Site of the urethral opening:
		  ○ Balanic
		  ○ Penile
		  ○ Penoscrotal
		  ○ Perineal
		  ○ Congenital chordae
		  ○ Other specified
			Malformation, deformation or chromosomal abnormality may be the principal / first-listed diagnosis or a secondary diagnosis.
			
			Although present at birth malformation, deformation or chromosomal abnormality may not be identified until later in life.
			
			Conditions listed in Chapter 17 may be used throughout the life of the patient.

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Chapter 18: Signs / Symptoms
Clinical Lab Findings
	This section includes symptoms, signs, abnormal results of laboratory or other investigative procedures and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.	**General Documentation:**
		• **Repeated falls**
		• **Coma scale,**
		  ○ **Glasgow coma scale, total score, must be documented in the medical record, not the individual score, in order to assign diagnosis codes.**
		• **Functional quadriplegia must be specifically documented in the medical record in order to assign R53.2.**
		• **SIRS due to non-infectious process**
		  ○ **Documentation must clearly indicate that SIRS was due to a non-infectious process (i.e., trauma, malignant neoplasm or pancreatitis).**
			Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditional regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point to a specific diagnosis have been assigned to a category in other chapters of the classification.

Chapter 19: Injury Burns/ Wounds Poisoning	• Location/site
	• Injury
	• Type
	• Depth
	• Percentage
		General Documentation:
		• Location/site
		• Laterality
		• Sequence most serious injury as determined by the provider
		• Superficial injury/abrasions or contusions should be specified if associated with more severe injuries of the same site.
		• Injury with damage to nerve/blood vessels: document primary injury, followed by nerves and/or blood vessels. (If the primary injury is to the nerve/blood vessel code as primary.)
		
		Fractures, document:
		• Location (specify site of the fracture, e.g. hip fracture – subtrochanteric fracture of right femur)
		• Open or Closed
		• Late Effect
		• **Type:**
		  ○ **Displaced or non-displaced**
		• **Laterality**
		• **Gustilo classification system (specify classification) of open fractures**
		• **Encounter type:**
		  ○ **Initial (during active treatment)**
		  ○ **Subsequent (i.e. specify routine or delayed healing, non-union, malunion)**
		  ○ **Sequela**
			Most codes may require a 7th character for encounter type.
			Burns:
			• Sequence code to highest degree of burn(s).
			• Non-healing burns coded as Acute Burn (Necrosis of non-healed burn coded as non-healed burn).
			• Infected burn site, use additional code for infection.
			• Burns are classified by degree/depth, extent and agent.

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		Burns, document:
		• Distinguish between 'burns' and 'corrosions'
		• If thermal burn, specify heat source (i.e. electricity or radiation)
		• Specify if due to chemicals.
		
		Wounds, document:
		• Location/site
		• Depth
		• Type:
		  ○ Bite
		  ○ Laceration
		  ○ Puncture
		• With or without foreign body
		
		Poisoning:
		• Identify define Drug or Chemical
		• Specify: Adverse effect, Poisoning, Under-dosing or Toxic effects	

Chapter 20: External Causes	The use of E codes are supplemental to the application of ICD-9-CM diagnosis codes. E codes are never to be recorded as principal diagnoses (first-listed in non-inpatient setting) and are not required for reporting to CMS.	**General Documentation:** • Identify the external cause, the intent, the place of occurrence (when applicable).	There is no national requirement for mandatory ICD-10-CM external cause code reporting.

Chapter 21: Factors Influencing Health	**ICD-9 V-codes:**
	• Screening
	• History of
	• Contact/Exposure
	• Follow-up
	• Pre-Operative
		General Documentation:
		• Specific purpose for receiving services
		• Circumstance that affects the patient's health status but is not a current illness or injury. Key Terms include:
		  ○ Examination, History, Fitting, Status, Screening, etc…
		
		• **Contact/Exposure:** document if with or suspected to communicable disease.
		• **Inoculations and vaccinations** document if:
		  ○ Prophylactic inoculation against disease, or
		  ○ Screening for patient without sign or symptom (e.g. encounter of screening mammogram for malignant neoplasm of breast)
			ICD-9-CM V-codes are now Z-codes, which may be used as primary or secondary.
			
			May be used in any healthcare setting.

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		• **Documenting "History of"** indicates the condition no longer exists but is being monitored) (e.g. personal history of malignant neoplasm of breast) • **Documenting "Follow-up"** indicates continued surveillance following completed treatment (e.g. Encounter for routine postpartum follow-up) • **Pre-operative** for patients receiving preoperative evaluation only (e.g. Encounter for pre-procedural exam [Specify – Cardio/ Resp./lab /other]) • **Aftercare; Follow-up; Donor; Counseling and Obstetrical services**. ○ Specify as applicable.	

