ICD-10 Basic Documentation Concepts

When applicable, documentation should include the following concepts:

- **Type** – Type I or Type II diabetes, suppurative, allergic, hyper, hypo, systolic
- **Location** – lower back, upper lip, proximal, distal
- **Site** – cerebrum, radius, left ventricle
- **Laterality** – right, left, unilateral, bilateral
- **Severity** – mild, moderate, severe, stage 1, exacerbations
- **Time Parameters**
    - Intermittent/Paraxysmal
    - Acute, Chronic, Acute on Chronic
    - Post-op, post-delivery, number of weeks gestation
- **Associate with** – hypertensive heart disease, diabetic retinopathy
- **Caused by/Contributing factors** – irritant, allergy, trauma, exertion, drug induced
    - Example: Contact dermatitis due to food handling
- **Healing Level** – non-union, malunion, routine, delayed
- **Episode/Encounter**
    - Initial, Subsequent, Sequela (used for complications or conditions that arise as a direct result of an injury. Example:. a scar formation after a burn)
    - Single, Recurrent, in remission
- **Substance** – insulin dependence, alcohol, tobacco
- **Findings/Symptoms/Manifestations** – fever, hypoglycemia, wheezing, renal, ulcers, paralysis, loss of consciousness

ICD-10 Basic Documentation Concepts

Tips

- Only code definitive diagnoses
  - When you do not have a definitive diagnosis, code the signs and symptoms
  - Codes for signs and symptoms may be reported in addition to a definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis
  - Do not code for likely, differential, probable, or rule out diagnoses
- "History of" means there is no evidence of the disease. Do not say "history of" if it is a current diagnosis
- Combination code: a single code used to classify two diagnoses that are "associated with" each other
  - Examples:
    - Diabetes associated with retinopathy (E11.4*)
    - Rheumatoid myopathy with rheumatoid arthritis of right shoulder (M05.411)

Asthma and COPD

Components of Severity		Intermittent			Persistent								
					Mild			Moderate			Severe		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week			>2 days/week but not daily			Daily			Throughout the day		
	Nighttime awakenings	0	≤2x/month		1–2x/month	3–4x/month		3–4x/month	>1x/week but not nightly		>1x/week	Often 7x/week	
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week but not daily	>2 days/week but not daily and not more than once on any day		Daily			Several times per day		
	Interference with normal activity	None			Minor limitation			Some limitation			Extremely limited		
	Lung function												
	➔ FEV_1* (% predicted)	Not applicable	>80%	>80%	Not applicable	>80%	>80%	Not applicable	60–80%	60–80%	Not applicable	<60%	<60%
	➔ FEV_1/FVC*		>85%	Normal†		>80%	Normal†		75–80%	Reduced 5%†		<75%	Reduced >5%†
Risk	Asthma exacerbations requiring oral systemic corticosteroids‡	0–1/year			≥2 exacerb. in 6 months, or wheezing ≥4x per year lasting >1 day AND risk factors for persistent asthma	≥2/year		*Generally, more frequent and intense events indicate greater severity.*			*Generally, more frequent and intense events indicate greater severity.*		
		*Consider severity and interval since last asthma exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV_1.**											

* www.nhlbi.nih.gov

Asthma and COPD

Documentation should include:

- **Severity** – Mild / Moderate / Severe
- **Time Parameters** – Intermittent / Persistent
- **Level of Exacerbation** – Uncomplicated / Acute / Status Asthmaticus
- **Type** – Allergic / Atopic / Idiosyncratic / Exercise-Induced Bronchospasm / Cough Variant / Childhood

When documenting **COPD** include:

- Episodes of exacerbation should be indicated
- COPD must be documented separately from any asthmatic conditions the patient may have

Description	Severity		ICD-10	4th, 5th or 6th Digit Description
Asthma	Mild	Intermittent	J45.2■	■ 0 = Uncomplicated 1 = w/ (acute) Exacerbation 2 = w/ Status Asthmaticus
		Persistent	J45.3■	
	Moderate	Persistent	J45.4■	
	Severe	Persistent	J45.5■	
	Other & Unspecified	Unspecified	J45.9■	◆ 0 = Exercise induced bronchospasm, 1 = Cough variant asthma, 8 = Other asthma
		Other	J45.99◆	
COPD			J44.●	● 0 = w/ acute lower respiratory infection, 1 = w/ (acute) exacerbation, 9 = unspecified
Emphysema			J43.▲	▲ 0 = Unilateral pulmonary, 1 = Panlobular, 2 = Centrilobular, 8 = Other, 9 = Unspecified

Acute URI, Bronchitis & Bronchiolitis

ICD-10	Acute URI
J00	Acute Nasopharyngitis (Common Cold)
J06.0	Acute Laryngopharyngitis
J06.9	Acute URI, Unspecified (includes upper respiratory disease, acute & upper respiratory disease infection NOS)
J22	Acute Respiratory Infection NOS (includes lower respiratory infection)

* = 4th Digit Bronchitis
0: Mycoplasma Pneumoniae
1: Hemophilus Influenza
2: Streptococcus
3: Coxsackievirus
4: Parainfluenza Virus
5: Respiratory Syncytial Virus
6: Rhinovirus
7: Echovirus
8: Other Specified Organisms
9: Unspecified

^ =4th Digit Bronchiolitis
0: Respiratory Syncytial Virus
1: Human Metapneumovirus
8: Other Specified Organisms
9: Unspecified

ICD-10	Bronchitis & Bronchiolitis
J20. *	Acute Bronchitis due to
J21. ^	Acute Bronchiolitis due to
J40	Bronchitis NOS
J84.115	Respiratory Bronchiolitis Interstitial Lung Disease

Acute URI, Bronchitis & Bronchiolitis

When documenting and coding **Acute URI,** include the following coding concept:

- **Type** – Laryngopharyngitis / Unspecified
- **Other Types Include** – Laryngitis / Obstructive Laryngitis / Epiglottis with or w/o Obstruction / Laryngotracheitis / Streptopharyngitis or Tonsillitis / Pharyngitis or Tonsillitis due to Other Organism

When documenting and coding **Acute Bronchitis / Acute Bronchiolitis**, include the following coding concept:

- **Cause** – Identify the causal organism or underlying cause to determine code selection if known (Example: Streptococcus, Rhinovirus, Respiratory Syncytial Virus)

ICD-10 Tips:

- *Document and code associated tobacco exposure or dependence [Example: Exposure to environmental tobacco smoke, Z72.220]*
- *Document and code for infectious organism, if known*

Abdominal Pain or Tenderness

ICD-10	Description
R10.0	Acute Abdomen (severe pain w/ rigidity)
R10.1 *	Upper Abdominal Pain
R10.13	Epigastric Pain
R10.3 *	Lower Abdominal Pain
R10.33	Periumbilical Pain
R10.2	Pelvic and Perineal Pain
ICD-10	Description
R10.81 ^	Abdominal Tenderness
R10.82 ^	Abdominal Rebound Tenderness
R10.83	Colic (Age 0-12 month)
R10.84	Generalized Abdominal Pain
R10.9	Unspecified Abdominal Pain

* = 5th Digit
0: Unspecified
1: Right Quadrant
2: Left Quadrant

^ = 6th Digit
1: RUQ
2: LUQ
3: RLQ
4: LLQ
5: Periumbilic
6: Epigastric
7: Generalized
9: Unspecified

Abdominal Pain or Tenderness

Documentation should include:

- **Type** – Acute Abdomen / Pain / Tenderness / Rebound Tenderness / Colic
- **Location** – RUQ / LUQ / RLQ / LLQ / Epigastric / Periumbilic / Pelvic and Perineal / Generalized / Unspecified

Type Definitions:

- **Acute Abdomen** – Sudden, severe pain, accompanied by rigidity (Example: Appendicitis, Duodenal Ulcer, etc.)
- **Pain** – Pain reported by the patient in the abdominal region
- **Tenderness** – Pain that occurs when the examiner presses on the abdomen and there is an observable reaction
- **Rebound Tenderness** – Pain that occurs when the examiner releases pressure on the abdomen
- **Colic** – Pain that comes in waves, associated with contractions of smooth muscles

ICD-10 Tips:

- *Abdominal pain is considered a symptom. See basic concept card tips on coding symptoms.*

Pneumonia

ICD-10	Description
J12.0	Adenoviral Pneumonia
J12.1	Respiratory Syncytial Virus Pneumonia
J12.2	Parainfluenza Virus Pneumonia
J12.3	Human Metapneumovirus
J12.81	Pneumonia d/t SARS-associated
J12.89	Other Viral Pneumonia
J12.9	Viral Pneumonia, Unspecified
J13	Pneumonia d/t Streptococcus
J14	Pneumonia d/t Hemophilus
J15.0	Pneumonia d/t Klebsiella
J15.1	Pneumonia d/t Pseudomonas
J15.20	Pneumonia d/t Staphylococcus
J15.211	Pneumonia d/t Methicillin Susceptible Staphylococcus Aureus
J15.212	Pneumonia d/t Methicillin Resistant Staphylococcus Aureus
J15.29	Pneumonia d/t Other Staphylococcus

ICD-10	Description
J15.3	Pneumonia d/t Streptococcus, Group B
J15.4	Pneumonia d/t Other Streptococcus
J15.5	Pneumonia d/t Escherichia Coli
J15.6	Pneumonia d/t Other Aerobic Gram-Negative Bacteria
J15.7	Pneumonia d/t Mycoplasma
J15.9	Unspecified Bacterial Pneumonia
J16.0	Chlamydial Pneumonia
J16.8	Pneumonia d/t Other Specified
J17	Pneumonia in Disease Classified Elsewhere
J18.0	Bronchopneumonia, Unspecified
J18.1	Lobar Pneumonia, Unspecified Organism
J18.2	Hypostatic Pneumonia, Unspecified
J18.8	Other Pneumonia, Unspecified Organism
J18.9	Pneumonia, Unspecified Organism

Pneumonia

Documentation should include:

- **Type** (if known) – Viral / Bacterial / Fungal / Hypostatic / Drug-Induced / Ventilator-Induced / Radiation-Induced / Etc
- **Infectious Agent** (if known) – Adenovirus / RSV / Staphylococcus Aureus / E. Coli / Etc
    - If the infectious agent is not known, also document location (if known) – Lobe / Bronchus

ICD-10 Tips:

- *Code first associated influenza, if applicable (J09.X1, J10.00, J10.01, J10.08, J11.00, J11.08)*
- *Code also associated abscess, if applicable (J85.1)*
- *Code also any underlying disease, if applicable (Example: Respiratory Failure, Sepsis, Neoplasm, etc)*