Top Ten ICD-10-CM Tips

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Medical record documentation and coding tips

ICD-10-CM (ICD-10) provides a greater level of specificity with over 71,000 diagnosis codes to select from. This requires medical record documentation to be more specific to ensure the most appropriate code is selected. To assist with accurate diagnosis coding and billing compliance for Medicare risk adjustment, below are ten ICD-10-CM documentation and coding tips. These tips are based on the CMS requirements for Medicare Advantage plans, *Official ICD-10-CM Guidelines for Coding and Reporting* and American Hospital Association Coding Clinic™ guidelines.

Tip 1: Document all coexisting conditions related to the patient's health status

Per ICD-10 Guidelines, "code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management." All coexisting conditions have to be documented and reported each year, including chronic and status conditions. Status codes are used to report when a patient is a carrier of a disease, has the sequelae, residual of a past disease or condition, including such things as the presence of a prosthetic or mechanical device resulting from previous treatment.

Status conditions that impact risk adjustment include:

- Transplant status (Z94.--)
- Renal dialysis dependence (Z99.2) or encounter for care involving renal dialysis (Z49.--)
- Ventilator status (Z99.1-)
- Current ostomies (Z93.- or Z43.-)
- Lower limb amputations (Z89.---)
- Asymptomatic HIV infection (Z21)
- Long term (current) insulin use (Z79.4)
- Adult body mass index, when clinically relevant (Z68.-)

In terms of risk adjustment, if the chronic and/or status condition is not documented and reported annually, it indicates the condition has resolved or no longer exists. This can lead to an inaccurate depiction of the member's current health status and a decrease in risk adjusted reimbursement to provide appropriate medical care.

Tip 2: Document current status of the condition

Document details regarding the current status of a condition such as acute, recurrent, chronic, acute on chronic, in remission, etc. including the date of onset. Coders cannot make assumptions regarding the acuity of a condition; it has to be explicitly stated in the medical record documentation by the provider who is legally accountable for establishing the diagnosis.

Note: Avoid using terms such as "history of" when documenting a current condition that a patient has had for an extended period of time. From a coding perspective, "history of" means that the condition no longer exists and is not receiving treatment. When appropriate, there are personal and family history Z-codes to use.

Tip 3: Document the anatomical site/location

Approximately 25 percent of ICD-10 codes are related to fractures. The location of the fracture is more specific identifying sites such as the shaft, head, neck, distal, proximal, styloid, etc. With this increase in specificity, documentation needs to identify the specific anatomical site/location in order to code appropriately.

Tip 4: Document laterality (side of the body affected)

Over one-third of the expansion in ICD-10 codes are due to the addition of laterality (left, right or bilateral). Ensure documentation specifies the side(s) of the body affected. In cases where a bilateral code is not provided, it is appropriate to assign a code for both the right and left side when bilateral is documented.

Tip 5: Document etiology (origin of disease)

ICD-10 contains coding instructional notes to use additional code at an etiology code and a code first note at the manifestation code. Be sure to include the underlying etiology/cause such as infectious agent, physical agent, internal failure, congenital, etc.

Tip 6: Document manifestation/ complication

ICD-10 also contains combination codes in which a single code classifies two diagnoses, a diagnosis with an associated secondary process (manifestation) or complication. Documentation should show a clear, causal relationship between any condition and its respective manifestation/complication with linking verbiage such as: due to, caused by, secondary to, etc.

Tip 7: Document severity of illness

Documentation needs to provide the extra level of detail for severity of an illness in order to assign the most appropriate ICD-10 code such as mild, moderate or severe. For instance, identify the stage for conditions such as pressure ulcers and chronic kidney disease (CKD). This is important as certain stages of pressure ulcers and CKD can impact risk adjustment.

Tip 8: Document the episode of care (initial, subsequent, sequela)

Documentation needs to specify the episode of care as this impacts the 7th character for ICD-10 code assignment of most categories in chapter 19 “Injury, Poisoning, and Certain Other Consequences of External Causes.”

The three most common 7th character values are:

- **A:** initial encounter (for use when the patient is receiving active treatment)
- **D:** subsequent encounter (for use after active treatment, receiving routine care during healing or recovery phase)
- **S:** sequela (for use of complications or conditions arising as a direct result of a condition)

Tip 9: Sign/symptom and unspecified codes may be appropriate to code

Per ICD-10 Guidelines, “while specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each health care encounter should be coded to the level of certainty known for that encounter.” When a definitive diagnosis is not established, it’s appropriate to code for sign(s) and/or symptom(s).

Tip 10: Reference the ICD-10-CM code book

Always reference the ICD-10-CM codebook as it contains the *Official Guidelines for Coding and Reporting* and the complete listing of valid diagnosis codes. Reliance on coding software, electronic health record systems and cheat sheets alone can lead to coding errors.

Documentation should be clear, concise, consistent and complete!