Clinical Documentation Improvement Desk Reference for ICD-10-CM and Procedure Coding

The Clinician's Checklist for ICD-10-CM
Your copy of this manual includes The Clinician's Checklist for ICD-10-CM, a trifold card with documentation tips for the most common chronic and acute medical conditions. Use this card to help clinicians understand the documentation needed for accurate ICD-10-CM coding.
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### Acute Myocardial Infarction (AMI)

#### Code Axes

<table>
<thead>
<tr>
<th>Description</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST elevation (STEMI) myocardial infarction of anterior wall</td>
<td>I21.01, I21.02, I21.09</td>
</tr>
<tr>
<td>ST elevation (STEMI) myocardial infarction of inferior wall</td>
<td>I21.11, I21.19</td>
</tr>
<tr>
<td>ST elevation (STEMI) myocardial infarction of other and unspecified sites</td>
<td>I21.21, I21.29, I21.3</td>
</tr>
<tr>
<td>Non-ST elevation (NSTEMI) myocardial infarction</td>
<td>I21.4</td>
</tr>
<tr>
<td>Acute myocardial infarction, unspecified</td>
<td>I21.9</td>
</tr>
<tr>
<td>Myocardial infarction type 2</td>
<td>I21A1</td>
</tr>
<tr>
<td>Other myocardial infarction type</td>
<td>I21A9</td>
</tr>
<tr>
<td>Subsequent ST elevation (STEMI) myocardial infarction of anterior/inferior walls</td>
<td>I22.0, I22.1</td>
</tr>
<tr>
<td>Subsequent non-ST elevation (NSTEMI) myocardial infarction</td>
<td>I22.2</td>
</tr>
<tr>
<td>Subsequent ST elevation (STEMI) myocardial infarction of other/unspecified site</td>
<td>I22.8, I22.9</td>
</tr>
<tr>
<td>Old myocardial infarction</td>
<td>I25.2</td>
</tr>
<tr>
<td>Intraoperative acute myocardial infarction, during cardiac surgery</td>
<td>I97.790</td>
</tr>
<tr>
<td>Intraoperative acute myocardial infarction, during other surgery</td>
<td>I97.791</td>
</tr>
<tr>
<td>Postprocedural acute myocardial infarction, following cardiac surgery</td>
<td>I97.190</td>
</tr>
<tr>
<td>Postprocedural acute myocardial infarction, following other surgery</td>
<td>I97.191</td>
</tr>
</tbody>
</table>

#### Description of Condition

Acute myocardial infarction (MI) is a leading cause of morbidity and death worldwide. Myocardial infarction occurs when reduced blood supply to the heart (myocardial ischemia) results in irreversible myocardial heart damage. Myocardial can be categorized as:

- **Common Clinical Diagnosis**
  - STEMI  ST elevation myocardial infarction
  - NSTEMI  No ST elevation myocardial infarction

---

The ICD-10-CM definition of initial acute myocardial infarction (category I21) is that with a stated duration of four weeks (28 days) or less from onset. A subsequent AMI is defined as one occurring within four weeks (28 days) of a previous AMI. If a patient is still receiving treatment for the myocardial infarction after the four week time frame, an appropriate aftercare code should be reported.
Classified by Clinical Scenario

Type 1  Spontaneous MI related to ischemia
Type 2  Secondary to Ischemia from supply and demand mismatch
Type 3  MI resulting in sudden cardiac death
Type 4a  MI associated with percutaneous coronary intervention
Type 4b  MI associated with in-stent thrombosis
Type 4c  MI associated with a rise and/or fall of cTn values in patients with ≥50% stenosis
Type 5  MI associated with coronary artery bypass

ST elevation (STEMI) myocardial infarction (I21.0-, I21.1-, I21.2-, I21.3)
An ST elevation myocardial infarction (STEMI) involves electrocardiogram (ECG) evidence of the ST-segment elevation, meaning that there is active and ongoing transmural myocardial damage due to the coronary artery being totally blocked. Patients with STEMI can develop Q-waves, which indicate an area of dead myocardium and irreversible damage. STEMI AMIs reflect a higher severity level than non-STEMI AMIs.

Clinical Tip
AMIs may affect the anterior wall, which includes the following:

- Left main coronary artery
- Left anterior descending coronary artery
- Diagonal coronary artery
- Anteroapical, anterolateral, or anteroseptal AMIs

The inferior wall AMIs include the following:

- Right coronary artery
- Inferolateral AMI

Other areas where AMIs may occur include:

- Left circumflex coronary artery
- Apical-lateral, basal-lateral, high lateral, posterobasal, posterolateral, posteroseptal

Key Terms
Key terms found in the documentation may include:

AMI with ST elevation
Coronary artery embolism, occlusion, rupture, or thrombosis
Infarction of heart, myocardium, or ventricle
ST AMI
Transmural Q-wave infarction
Endoscopy — Lower GI

Code Axes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>45378–45398</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>45330–45350</td>
</tr>
</tbody>
</table>

Description of Procedure

These codes represent the examination of the colon by flexible fiberoptic endoscope. Since code selection is based upon the portion of the intestine being examined as well as any other services and procedures performed during the surgical encounter, it is critical that the documentation be clear and complete. As with any other endoscopic procedures, this procedure can be performed for either diagnostic or therapeutic purposes.

A flexible sigmoidoscopy is reported when the documentation indicates that the provider examined only the lower one third of the intestine and documentation does not include notation that the splenic flexure was examined. Report a colonoscopy when the entire colon, including the cecum is examined according to the documentation. When the documentation does not indicate that the cecum is examined, report the appropriate colonoscopy code with modifier 52 Reduced services.

Clinical Tip

Control of bleeding that is the result of a biopsy or polypectomy is considered part of the main service and is not reported separately; however, it should be clearly documented.

Key Terms

Key terms found in the documentation may include:

- Colo
- Colo with bx
- Colo w/polypectomy
- Flex sig
- Flex sig w/bx
- Flex sig w/polypectomy

Clinician Documentation Checklist

Clinician documentation should indicate the following:

- Type of sedation provided
- Quality of bowel preparation
- Clearly indicate the anatomical structures examined
  - colonoscopy
    - examination of cecum or terminal ileum (or small bowel proximal to an anastomosis)
- sigmoidoscopy
  - examination of sigmoid colon (may include a portion of descending colon)

- The medical condition being treated

- Flexible sigmoidoscopy
  - biopsy
  - removal of foreign body
  - removal of tumor
  - control of bleeding
  - submucosal injection
  - decompression
  - snare technique used
  - ablation
  - balloon dilation
  - ultrasound examination
  - fine needle aspiration
  - placement of stent
  - band ligation

- Colonoscopy
  - removal of foreign body
  - biopsy
  - mucosal injection
  - control of bleeding
  - ablation
  - removal of tumor-hot biopsy forceps
  - removal of tumor-snare technique
  - balloon dilation
  - stent placement
  - ultrasound
  - fine needle aspiration
  - decompression
  - band ligation

- Summary of findings and recommendations
Ulcer — Pressure

Code Axes

- Pressure ulcer of elbow  L89.0- MDC
- Pressure ulcer of back    L89.1- MDC
- Pressure ulcer of hip     L89.2- MDC
- Pressure ulcer of buttock L89.3- MDC
- Pressure ulcer of contiguous sites of back, buttock and hip L89.4- MDC
- Pressure ulcer of ankle   L89.5- MDC
- Pressure ulcer of heel    L89.6- MDC
- Pressure ulcer of other site L89.8- MDC
- Pressure ulcer of unspecified site L89.9- MDC

Description of Condition

Clinical Tip
Pressure ulcers initially affect superficial tissues and, depending on the state of the patient’s health and other circumstances, may progress to affect muscle and bone. Patients at risk for development of pressure ulcers include the bedridden, unconscious, or immobile such as stroke patients or those with paralysis and limited motion. Intrinsic loss of pain and pressure sensations, disuse atrophy, malnutrition, anemia, and infection contribute to the formation and progression of decubitus ulcers. In the early stages, the condition is reversible, but left untended, the decubitus ulcer can become extensively infected, necrotic, and ultimately, irreversible.

The National Pressure Ulcer Advisor Panel (NPUAP) has recently updated the definition and staging of pressure ulcers. A pressure ulcer is now defined as a "localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction."

Pressure ulcers are classified by location, shape, depth, and healing status. The depth of the lesion or stage of ulcer is the most important element in clinical measurement:

- Unstageable/unspecified stage: lesion inaccessible for evaluation due to nonremovable dressings, eschar, sterile blister, and suspected deep injury in evolution. Deep tissue injury may be difficult to detect in individuals with dark skin tones and, as such, evolution of the wound may progress rapidly. Suspected deep tissue injury may be characterized by purple or maroon discoloration of the skin with or without blistering. Affected tissue may be painful and variant in temperature and texture from surrounding normal tissue.
Stage 1 (I): Non-blanching erythema (a reddened area on the skin).
Stage 2 (II): Abrasion, blister, shallow open crater, or other partial thickness skin loss.
Stage 3 (III): Full thickness skin loss involving damage or necrosis into subcutaneous soft tissues.
Stage 4 (IV): Full thickness skin loss with necrosis of soft tissues through to the muscle, tendons, or tissues around underlying bone.

Key Terms
Key terms found in the documentation include:
- Bed sore
- Decubitus ulcer
- Plaster ulcer
- Pressure area
- Pressure sore

Clinician Note
Specify the ulcer stage accurately in the diagnosis. Document the specific anatomic site and laterality. For example, the back is separated into upper and lower, right and left quadrants. For paired anatomic sites, specify laterality (right or left).

For example:

L89.131 Pressure ulcer of the right lower back, stage 1
L89.141 Pressure ulcer of the left lower back, stage 1

Document contiguous, overlapping ulcer sites if present.

Clinicians (physicians and other qualified health care practitioners) should document the pressure ulcer stage as clearly and thoroughly as possible in the record, including any changes in ulcer status or complications associated with the healing process. Although the physician is responsible for documenting the associated diagnoses, nonprovider clinicians should document the stage of ulcer, and any changes in healing status for each ulcer, by anatomic site.

Clinician Documentation Checklist
Clinician documentation should indicate the following:

- Includes
  - bed sore
  - decubitus ulcer
  - plaster ulcer
  - pressure area
  - pressure sore
• Identification of
  – pressure ulcer described as healing
  – any associated gangrene
  – site
    — elbow
    — back
      • upper
        □ shoulder blade
      • lower
      • unspecified
    — sacral region
      • coccyx
      • tailbone
    — hip
    — buttock
    — contiguous site of back, buttock and hip
    — ankle
    — heel
    — other sites
      • head
        □ face
      • other site
    — unspecified site
  – laterality of elbow, hip, buttock, back, ankle and heel
    — right
    — left
  – stage
    — stage 1: pressure pre-ulcer changes limited to persistent focal edema
    — stage 2: pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
    — stage 3: pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissues
    — stage 4: pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
    — unspecified stage
    — unstageable: pressure ulcers whose stage cannot be clinically determined
      • ulcer covered by eschar or treated with skin or muscle graft
      • pressure ulcers documented as deep tissue injury and not due to trauma
To use the table below, find the term used in the medical record documentation in column one. Column two indicates the term(s) used in the ICD-10-CM system for that condition.

<table>
<thead>
<tr>
<th>Medical Record Terminology</th>
<th>ICD-10-CM Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess of lung</td>
<td>Gangrene and necrosis of lung</td>
</tr>
<tr>
<td>Achalasia and cardiospasm</td>
<td>Achalasia of cardia</td>
</tr>
<tr>
<td>Acute coronary occlusion without MI</td>
<td>Acute coronary thrombosis not resulting in MI</td>
</tr>
<tr>
<td>Acute pyelonephritis w/ or w/o lesion of medullary necrosis</td>
<td>Acute tubulo-interstitial nephritis</td>
</tr>
<tr>
<td>Acute respiratory failure following trauma and surgery</td>
<td>Postprocedural respiratory failure</td>
</tr>
<tr>
<td>Adenocarcinoma of intrahepatic bile duct</td>
<td>Intrahepatic bile duct carcinoma</td>
</tr>
<tr>
<td>After-cataract</td>
<td>Other secondary cataract</td>
</tr>
<tr>
<td>Allergic alveolitis and pneumonitis</td>
<td>Hypersensitivity pneumonitis (due to: cause)</td>
</tr>
<tr>
<td>Allergic rhinitis cause unspecified</td>
<td>Vasomotor rhinitis</td>
</tr>
<tr>
<td>Angina decubitus</td>
<td>Other forms of angina pectoris</td>
</tr>
<tr>
<td>Asbestos</td>
<td>Pneumoconiosis due to asbestos and other mineral fibers</td>
</tr>
<tr>
<td>Asiderotic anemia</td>
<td>Anemia secondary to blood loss</td>
</tr>
<tr>
<td>Atrial flutter</td>
<td>Persistent/Atypical/Typical atrial flutter</td>
</tr>
<tr>
<td>Atrophic gastritis</td>
<td>Chronic superficial gastritis</td>
</tr>
<tr>
<td>Attacks without alteration of consciousness</td>
<td>Localization-related epilepsy</td>
</tr>
<tr>
<td>Autoimmune/Non-autoimmune hemolytic anemias</td>
<td>Drug-induced autoimmune hemolytic anemia</td>
</tr>
<tr>
<td>Avian Influenza virus (pneumonia, other resp infection)</td>
<td>Identified novel influenza A virus (with manifestation: pneumonia, other respiratory)</td>
</tr>
<tr>
<td>Backwash ileitis</td>
<td>Ulcerative colitis</td>
</tr>
<tr>
<td>Bacterial colitis</td>
<td>Bacterial intestinal infection, unspecified</td>
</tr>
<tr>
<td>Basilar migraine</td>
<td>Juvenile myoclonic epilepsy</td>
</tr>
<tr>
<td>Bed sore</td>
<td>Pressure ulcer</td>
</tr>
<tr>
<td>Benign childhood epilepsy with centrot temporal EEG spikes</td>
<td>Localization-related epilepsy</td>
</tr>
<tr>
<td>Biliary cirrhosis</td>
<td>Primary biliary cirrhosis</td>
</tr>
<tr>
<td>Blood in stool</td>
<td>Secondary biliary cirrhosis</td>
</tr>
<tr>
<td>Bloodstream infection [although necessary to differentiate from bacteremia]</td>
<td>Septicemia due to (organism)</td>
</tr>
<tr>
<td>Bowen's disease</td>
<td>Carcinoma in situ site unspecified</td>
</tr>
</tbody>
</table>
Appendix 1: Physician Query Samples

The major purpose of queries is to obtain clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. As noted earlier in this manual, queries should not be leading by eliciting a specific response, introduce new information not documented elsewhere, be “yes/no” in format, or appear to question a provider’s clinical judgment.

The query examples that follow here are intended to provide those actively working with physicians in clinical documentation improvement activities, to encourage accurate and appropriate documentation.

Pressure Ulcer Clarification

Dr. Walker:

You documented a diagnosis of sacral pressure ulcer for this patient, but did not specify the stage of pressure ulcer. A dressing change was performed on 7/5. The nurse noted “breakdown of skin with clean, circumscribed edges.” Nursing documentation is unclear whether this indicates a partial (Stage II) or full (Stage III) thickness skin ulcer.

Can this patient’s pressure ulcer be specified to The National Pressure Ulcer Advisor Panel (NPUAP) stage as:

• Unstageable/unspecified stage
• Stage I: non-blanching erythema (a reddened area on the skin).
• Stage II: abrasion, blister, shallow open crater, or other partial thickness skin loss.
• Stage III: full thickness skin loss involving damage or necrosis into subcutaneous soft tissues.
• Stage IV: full thickness skin loss with necrosis of soft tissues through to the muscle, tendons, or tissues around underlying bone.

Undetermined or Unknown: __________________________________________________________________________

If so, please document the ulcer stage in the progress notes.

Signature ________________________________________________________________________________________

Date ____________________________________________________________________________________________

Thank you!

Cathy Coder

X 5437
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CMS-HCC Model Category</th>
<th>QPP Individual Measures–Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>33251</td>
<td>Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>33256</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>33261</td>
<td>Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>33320</td>
<td>Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>33321</td>
<td>Suture repair of aorta or great vessels; with shunt bypass</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>33322</td>
<td>Suture repair of aorta or great vessels; with cardiopulmonary bypass</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>44120</td>
<td>Enterectomy, resection of small intestine; single resection and anastomosis</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>44140</td>
<td>Colectomy, partial; with anastomosis</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>44150</td>
<td>Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>44155</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileostomy</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>44160</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileostomy</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>45378</td>
<td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>185, 320, 425</td>
<td></td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy, flexible; with biopsy, single or multiple</td>
<td>185, 425</td>
<td></td>
</tr>
<tr>
<td>45381</td>
<td>Colonoscopy, flexible; with directed submucosal injection(s), any substance</td>
<td>185, 425</td>
<td></td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
<td>185, 425</td>
<td></td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
<td>185, 425</td>
<td></td>
</tr>
<tr>
<td>45395</td>
<td>Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>45397</td>
<td>Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed</td>
<td>21, 23</td>
<td></td>
</tr>
<tr>
<td>93453</td>
<td>Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>44150</td>
<td>Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>44160</td>
<td>Colectomy, partial, with removal of terminal ileum with ileocolostomy</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>99291</td>
<td>Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes</td>
<td>1, 47, 254, 255, 407</td>
<td></td>
</tr>
<tr>
<td>A40.0</td>
<td>Sepsis due to streptococcus, group A</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A40.1</td>
<td>Sepsis due to streptococcus, group B</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A40.3</td>
<td>Sepsis due to Streptococcus pneumoniae</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A40.8</td>
<td>Other streptococcal sepsis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A40.9</td>
<td>Streptococcal sepsis, unspecified</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A41.01</td>
<td>Sepsis due to Methicillin susceptible Staphylococcus aureus</td>
<td>2</td>
<td>407</td>
</tr>
<tr>
<td>A41.02</td>
<td>Sepsis due to Methicillin resistant Staphylococcus aureus</td>
<td>2</td>
<td>407</td>
</tr>
<tr>
<td>A41.1</td>
<td>Sepsis due to other specified staphylococcus</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A41.2</td>
<td>Sepsis due to unspecified staphylococcus</td>
<td>2</td>
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</tr>
<tr>
<td>A41.3</td>
<td>Sepsis due to Hemophilus influenzae</td>
<td>2</td>
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</tr>
<tr>
<td>A41.4</td>
<td>Sepsis due to anaerobes</td>
<td>2</td>
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</tr>
<tr>
<td>A41.50</td>
<td>Gram-negative sepsis, unspecified</td>
<td>2</td>
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</tbody>
</table>