



ICD-10 Documentation Tips

Neurology Services

The following are important documentation tips and strategies for ICD-10 compliance:

General:

- Document diagnosis that were “present on admission” as POA.
- Include diagnoses monitored, treated, evaluated on discharge summary.
- Laterality should be specified for all body parts and sites.

Condition/Concept	ICD-10 Documentation Tips
Alzheimer’s Disease	Onset: Early or Late If with dementia, document as: With behavioral disturbance, for example – combative and/or aggressive
AMS	Associated: Encephalopathy, Acute confusion, Drug delirium, Dementia (type)
Attention Disorder	Site: Predominantly inattentive, Predominantly hyperactive, Combined type
Cognitive Signs & Symptoms	Identify when signs and symptoms are related to a known mental disorder. Associated Conditions: Current injuries, Late effects of past events. Type of mental disturbances: Altered mental status, Age-related mental decline, Confusion, Dementia

Condition/Concept	ICD-10 Documentation Tips
CVA (hemorrhagic)	Specify: Traumatic or non-traumatic Location of Bleed: epidural, subdural, intra-cerebral, subarachnoid, extra-dural, other Specify artery involved Laterality Note residuals: dysphasia, aphasia, hemi paresis, hemiplegic
CVA (infarct)	Etiology: Due to (Occlusion, stenosis, embolism, thrombus, hemorrhagic, other) Laterality: Right, Left Specific Artery Affected: Precerebral (vertebral, basilar or carotid), Cerebral (middle, anterior, posterior), Cerebellar arteries Specify: Intraoperative or postoperative complication, if applicable Related deficits: dysphasia, aphasia, hemi-paresis, hemiplegia Document: TPA administration
Delirium	Drug induced, Acute, Alcoholic, ETOH withdrawal, other
Dementia	Type: Alzheimer, Vascular, HIV, Senile, etc Note all behavior manifestations: aggression, combative, wandering, violent
Diabetic Neuropathy	Specify Type if known or suspected: Diabetic mononeuropathy, Diabetic polyneuropathy, Diabetic autonomic neuropathy, Diabetic amyotrophy, Other neurological condition. Insulin control status: Inadequately controlled, Out of control or Poorly controlled.
Dysphagia	Type: Cervical, oral phase, functional, or pharyngeal, pharyngeal, other
Encephalopathy	Type: Hypertensive, Metabolic, Toxic, Hepatic, etc

Condition/Concept	ICD-10 Documentation Tips
Epilepsy	Document: Intractable or Not Intractable AND With or Without status epilepticus Type: Localization-related idiopathic or symptomatic, Simple partial or complex partial seizures, Generalized idiopathic Specify special epileptic syndromes: Seizures related to alcohol, drug, sleep deprivation, etc. Include descriptions of poorly controlled pharmacoresistant, treatment resistant and refractory
Gait Disturbance	Document if: Ataxic, Spastic, Paralytic, Staggering, Falling, Unsteadiness, Difficult walking
Headache	Type: Cluster, Vascular, Tension-type, Post-traumatic, Drug-induced (specify drug), Other Specify: Intractable, Not Intractable Timing: Episodic, Chronic, Episodic paroxysmal hemicrania, Chronic paroxysmal hemicranias, Short lasting unilateral
Hemiparesis/Hemiplegia	Hemiplegia Type: Flaccid or spastic. Note if dominant or non-dominant side
Major Depressive Disorder	Episode: Single, Recurrent Severity: Mild, Moderate, Severe w/o psychotic symptoms, Severe w/ psychotic symptoms Status: Full remission, Partial remission
Malnutrition	Type: Protein calorie, Protein energy Severity: Mild or 1 st degree, Moderate or 2 nd degree, Severe or 3 rd degree. Document BMI
Memory Loss	Specify if known: Disoriented Anterograde Amnesia, Retrograde Amnesia, Age related, Altered mental status

Condition/Concept	ICD-10 Documentation Tips
Migraine	Type: Migraine w/ aura, Migraine w/o aura, Hemiplegic migraine, Persistent migraine aura w/o cerebral infarction, Persistent migraine aura w/ cerebral infarction, Chronic migraine If Drug Induced: Due to specified drug Document: With status migrainosus, Without status migrainosus, Intractable, Not Intractable Identify when migraine is associated with seizures or cerebral infarction
MRI and edema/mass	Under A/P include diagnoses. Ex. Brain mass with cerebral edema
Myalgia	Specific Location: Shoulder, Upper arm, Forearm , Hand, Fingers, Thigh, Ankle Detail when paralysis or burns accompany the calcification or ossification of muscles. Document any underlying disease. Laterality: Right, Left , Bilateral Document any rupture: Non-traumatic ischemic, Infarction, Wasting, Contracture of muscle
Obtunded	Utilize Glasgow Coma Scale to further describe
Pathological Vertebral Fractures	Etiology: Age related, Disuse osteopenia, Neoplastic, Some other disease
Pressure Ulcers	Must document diagnosis of pressure ulcer. Site Stage Note: Stage of pressure ulcer can be taken from nursing notes
Pulmonary Embolism	Type: Saddle, Septic Cor pulmonalae if present and if: Acute, Chronic Specify if: Chronic (still present) Versus: Healed/old, Note that ‘History of PE’ is ambiguous

Condition/Concept	ICD-10 Documentation Tips
Respiratory Failure	Acuity: Acute, Chronic, Acute on Chronic If Acute: Hypoxemic, Hypercapnic or Both
Seizure	Type: Grand mal, Petit Mal, post-traumatic, febrile, due to old stroke, etc Seizures not diagnosed as a disorder or recurrent (i.e., nonepileptic) should specify the condition as being: Febrile – specify simple or complex, New onset, Single seizure or convulsion, Post traumatic or hysterical, Autonomic Described as: Localized onset, Simple partial, Complex partial, Intractable, Not Intractable, With status epilepticus, Without status epilepticus
Sequelae of Cerebrovascular Disease	‘Due to’ or ‘Secondary to’: Cognitive, Speech (Aphasia, Dysphasia, Dysarthria, Fluency Disorder), Monoplegia, Hemiplegia Sequelae when present.
Skin Disturbance	Laterality: Right, Left, Bilateral Detail any associated condition or disease (e.g., easy bruising, Specific sensory disturbances: Hypoesthesia, Paresthesia, Hyperesthesia Underlying cause of any sign or symptom if known.
Spinal Column Injury	Site affected as: Occipito-atlanto-axial, Cervical or cervical-thoracic, Thoracic or thoracolumbar, Lumbar or lumbosacral, Sacral or sacrococcygeal Site of injury: Cervical – identify each vertebral segment; Thoracic – identify as T1, T2-T6, T7-T10, or T11-T12; Lumbar – identify each vertebral segment; Sacral – no additional specificity needed.

Condition/Concept	ICD-10 Documentation Tips
Transient Ischemic Attack (TIA)	If known or suspected, rather than ‘TIA’: Vertebro-basilar artery syndrome, Carotid artery syndrome, Precerebral artery syndrome, Amaurosis fugax, Transient global anemia, Other cerebral ischemic attacks and syndromes Diagnosis of ‘TIA’ = “unspecified code”
Traumatic Brain Hemorrhage	Site: Left or right cerebrum, Cerebellum, Brainstem, Epidural, Subdural, Subarachnoid Specify if with LOC and how long.
Traumatic Vertebral Fractures	Document: Level of vertebral column, example – L1, Displaced versus nondisplaced, Part of vertebra fractured, example – posterior arch. Type: Type II dens fracture of the 2 nd cervical vertebra, Type III spondylolisthesis of the 2 nd cervical vertebra, Stable versus unstable burst fracture, Zone I-III or Type 1-4 sacral fracture.
Tremors	Document: Abnormal head movements, tremor, Cramp/spasm, Fasciculations (twitching)
Underdosing	Type: Intentional, Unintentional Reason: Financial hardship or Age related dementia
Unresponsive	Etiology of: progression of dementia, late effect of stroke (hemiparesis), exacerbation of MS, etc
Weakness	Etiology of: progression of dementia, late effect of stroke (hemiparesis), exacerbation of MS etc
NOTE	Diagnoses noted on X-rays, CT, MRI can not be captured unless re-documented in the progress notes under the A/P
PROCEDURES	

Condition/Concept	ICD-10 Documentation Tips
Arterial Catheterization	Site of Artery: Abdominal aorta, Anterior tibial, External iliac, Renal, Common carotid, Hand, etc. Laterality: Right, Left, Bilateral Approach: Open, Percutaneous, Percutaneous endoscopic
Arteriogram	Done with: Plain radiography, Fluoroscopy Site: Abdominal aorta, Hepatic artery, Lumbar arteries, Lower arteries, other Type of Contrast: None, Low Osmolar, High Osmolar, Other
Central Venous Catheter Placement	Site: Artium, Interior vena cava, Innominate vein, Subclavian vein, Superior vena cava. Substance Administered: No substance, Antibiotics, Antineoplastic, Dialysis, Nutritional substance, Other substance Approach: Open, Percutaneous, Percutaneous endoscopic
Excision of Intervertebral Disc	Differentiate between removal of a portion or All of an intervertebral disc
Injection/Infusion	Substance Administered: Analgesic, anti-infective, sedative, anti-inflammatory, Recombinant Human-activated Protein C, Other thrombolytic Approach: Open, Percutaneous
Insertion Vascular Stent	Site: Olfactory, Optic, Facial, Vagus, Femoral, Sciatic, Sacral, etc. Approach: Open, Percutaneous, Percutaneous endoscopic

Condition/Concept	ICD-10 Documentation Tips
Transfusion	Product: FFP, RBC, Albumin, etc, AND Autologous or nonautologous When blood was collected if autologous: Prior to surgery, Intraoperative/perioperative/post-operative (24 hr surrounding surgery), Previously collected, Salvage (24 hr period surrounding surgery) Site of Administration: Central artery or vein, Periphery artery or vein Approach: Open, Percutaneous
Spinal Fusion	Document level of spinal column involved and number of vertebral joints fused Operative Approach: Anterior approach, anterior column, Posterior approach, posterior column OR Posterior approach, anterior column

This ICD-10 Tipsheet is meant to assist providers for the transition from ICD-9-CM to ICD-10-CM. Content provided is informal guidance, and any definitive guidance is issued from CMS.