As the implementation date of October 1st is starting to loom large, providers are starting to ask how their documentation needs to change in order to utilize the most specific code available. Below are some examples of areas where documentation should be improved so the most specific code can be selected.

**Acute Myocardial Infarction (AMI)**
Both ICD-9 and ICD-10 required documentation of whether the MI was a STEMI or non-STEMI. ICD-10 documentation guidelines look to the number of days (equal to or less than 28 days) as to whether the MI is acute or not. This is a change from ICD-9 where the MI was categorized as initial or subsequent episode of care. The site of the MI needs to be documented if it is known as there are codes for both coronary artery or wall location. Other elements that need to be captured include:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco use (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Status post administration of tPA in a different facility within the last 24 hours prior to admission to current facility (Z92.82)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

**Strokes**
Stroke documentation will need to include the vessel in which the stroke occurred if known. Unless otherwise specified, the dominant side will be assumed to be the right side.

**Diabetes**
There are many new manifestation codes that should be documented if applicable. For example, in ICD-9 there is a code for diabetes with renal manifestations. A secondary code would be chosen to indicate what that renal manifestation is. In ICD-10, one code will describe diabetes with diabetic nephropathy (E08.21), diabetic chronic kidney disease (E08.22) or other diabetic kidney complication (E08.29). There is also greater specificity regarding secondary diabetes (E09.-) and other specified diabetes mellitus (E13.-).

**Open Fractures**
Severity of the fracture is based on the Gustilo classification which should be documented as well as laterality. The fracture codes were expanded exponentially and make up a significant portion of the 69,000 ICD-10 codes. Good documentation regarding which bone, which part of the bone (the upper end, head, neck, shaft, etc), laterality, healing, nonunion, malunion as well as whether the visit is initial or subsequent are all required to select the most accurate code.

**Cardiac Catheterizations**
Cardiac catheterizations will require documentation of whether low osmolar or high osmolar contrast was used as well as the function or device used (i.e., sampling and pressure).

Starting to improve documentation now will ease the transition from ICD-9 to ICD-10. This will reduce the number of hospital and clinic queries received from coders and reduce claims rejected for lack of specificity.