Background:

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems. It codes for diseases, signs, symptoms, abnormal findings, associated conditions and external causes of injuries. It is used by CMS to determine medical necessity.

The deadline for the implementation of ICD-10 in the United States is 10/1/2015. After this date, CMS and most other payers have currently indicated they will no longer accept ICD-9 codes. For the first year of implementation, CMS will process and not deny claims if they fall within the correct “family” of codes. Commercial payers may not follow this policy and they may still choose to deny claims if they are coded incorrectly. Every effort should be made to ensure that claims are coded to the correct level of specificity beginning 10/1/2015.

Additional documentation requirements are stated within applicable Medicare Local Coverage Determinations or National Coverage Determinations, and CMS may still deny claims if these requirements are not met. Specific documentation is also required to support appropriate CPT/HCPCS billing codes. Failure to document the procedure performed, the use of sedation or the administration of contrast to the correct level of specificity can impact coding and the level of reimbursement, and may result in penalties in the event of an audit by the payer.

Documentation Requirements:

The radiology report is the single most important document to support medical necessity and billing. If clinical or diagnostic information is missing, incomplete, nonspecific or vague there is an increased risk of denial and nonpayment. Similarly, if the procedure, use of sedation, or administration of contrast is not documented to the correct level of specificity in the radiology report, the exam or procedure cannot be billed at the appropriate level or in some cases cannot be billed at all resulting in no or decreased reimbursement.

Clinical Information:

This section outlines the clinical information necessary to determine specific codes with ICD-10. This information should be sufficient to support medical necessity irrespective of findings in the radiology report. Clinical information is requested on the order form, within our electronic order entry systems, within provider EMR systems, and on the patient information forms. This information should be dictated by the radiologist into the patient information section of the radiology report. Failure to document clinical information increases the risk of denial and nonpayment.

This is not a complete list of the clinical information determinants within ICD-10. Rather it represents a subset of parameters most relevant to radiology outpatient practices, and may be
updated as we gain more experience with ICD-10. This summary will also be available in the auto text section of the Nuance Powerscribe 360 system under the “ICD10 radiologist” and is also available on the S: sharedrive under CDI Quality Institute Guidelines.

**Injury or fracture:**
- Injury including contusion, foreign body, laceration, open wound, sprain, subluxation, dislocation, strain, laceration
  - History of injury, if known
  - Initial encounter, subsequent encounter or sequela*
  - Specific anatomic site or area
  - Laterality

- Traumatic Extremity Fractures (Pathologic fractures coded separately)
  - History of injury, if known
  - Encounter
    - Initial
    - subsequent (with routine healing, delayed healing, nonunion or malunion)
    - sequela (symptoms or conditions secondary to an old fracture)
  - Location
  - Laterality
  - open v. closed

- Spine Fractures
  - History of injury or trauma, if known
  - Encounter*
    - Initial
    - subsequent with routine healing, delayed healing v. nonunion
    - sequela
  - Specific level
  - Pathologic, if known (fragility secondary to osteoporosis, primary neoplasm or metastatic disease)

*Episodes of care are defined as:

**Initial encounter** is used while the patient is receiving active treatment for the condition. This would include x-ray, CT or MRI examinations to characterize the initial injury.

**Subsequent encounter** is used after the patient has completed active treatment for the condition and is receiving routine care during the healing or recovery phase. Examples might include follow-up x-rays or CT examinations to evaluate healing.

**Sequela** is used for complications arising directly from the injury. Examples might include a CT or MRI to evaluate for a sequestrum, osteomyelitis or post-traumatic osteoarthritis.

**Chest/Lung:**
- Pain
Location (throat, anterior, precordial, intercostal)

- Character (pleuritic, ischemic, atypical, musculoskeletal)
- Cause if appropriate (Post-traumatic, postoperative or post-procedural)

- Bleeding (Hemoptysis or Epistaxis)
- Breathing difficulties (dyspnea, wheezing, respiratory arrest)
- Abnormal sputum
- Pulmonary nodule or mass on x-ray
- Emphysema (panlobular, centrilobular or unilateral if known)
- Asthma (Mild, moderate, severe, intermittent or persistent, if known)
- Bronchiectasis, pneumoconiosis, hypersensitivity pneumonitis, pulmonary fibrosis or interstitial pulmonary disease, if known.
- Smoking history

Abdominal/Pelvic:
- Pain, tenderness, swelling, rigidity
  - Location – periumbilical, epigastric, pelvic, perineal or generalized
  - Laterality – RUQ, LUQ, RLQ, LLQ
  - With or without tenderness, rebound or rigidity
- Nausea and vomiting
- Change in bowel habits, diarrhea
- Ascites
- Hepatomegaly
- Swelling, mass or lump
- Hematuria (Gross, microscopic or benign essential, if known) or occult fecal blood
- Iron deficiency anemia
- Abnormal cytology, liver enzymes or other laboratory tests
- Abnormal finding on diagnostic imaging (ultrasound, CT or MRI)
- Cause if known (due to trauma, neoplasm related or post-procedural)

Female pelvis:
- Pregnancy
  - First versus subsequent gestation
  - Trimester
- Encounter for fertility testing (fallopian tube patency)
- Infertility (fallopian tube, uterine or other origin)
- Dysmenorrhea (primary or secondary)
- Postmenopausal bleeding
- Abnormal finding on diagnostic imaging (enlarged endometrial canal or ovarian cyst)
MSK/Joints:
- Pain, effusion, hemarthrosis, loose body, stiffness, chronic instability, or mass
- Dislocation, acute or recurrent, or instability
- Tendinitis/bursitis
- Known diagnosis of osteoarthritis
- Specific joint, tendon or bursal structure involved
- Laterality

Spine:
- Pain (Neck, mid back, low back pain, sacral or sacroiliac)
- Arm or leg pain, sciatica or radiculopathy with laterality
- Difficulty walking, frequent falling or gait abnormalities
- Bowel or bladder incontinence
- Scoliosis with specific subtype, if known:
  - Congenital versus idiopathic
  - Infantile (beginning before the age of 3 years)
  - Juvenile (beginning between 3 and 9 years of age)
  - Adolescent (begins between the age of 10 and young adult)
  - Thoracogenic (secondary to disease or operative trauma in or on the thoracic cage)
  - Neuromuscular (e.g. with spina bifida, cerebral palsy or Chiari malformation)

Osteoporosis:
- Cause, if known (Chronic steroid use, age-related, post-menopausal or disuse)
- With or without fragility fracture (with minor or no trauma)

Head and neck:
- **Headaches** - Intractable v. not intractable. (Other terms considered equivalent for intractable are pharmacoresistant, treatment resistant, refractory (medically) and poorly controlled. (from G43 2105 ICD-10-CM))
  - Headache, NOS
  - Migraine
    - with or w/o status migrainosus (lasting more than 72 hours)
    - with or w/o aura,
    - with or w/o hemiplegia,
    - with or w/o persistent migraine aura (>1 week)
    - with or w/o cerebral infarction
    - (also chronic, ophthalmoplegic, periodic, abdominal, and other migraine)
  - Cluster headaches
    - episodic v. chronic v. unspecified
    - with or w/o paroxysmal hemicranias
- Tension headaches
  - Episodic v. chronic v. unspecified
- Post-traumatic headaches
  - Acute v. chronic v. unspecified
- Drug-induced headaches
- Facial pain (excluding atypical or paroxysmal facial pain arising from the trigeminal nerve)

- Seizures
  - Generalized v. Focal
  - Intractable or not intractable
  - With or without status epilepticus
  - Absence
  - Secondary to external causes

- Cerebral Ischemia
  - Vertebral-basilar syndrome
  - Carotid-artery syndrome (hemispheric)
  - Amaurosis fugax
  - Transient global ischemia
  - Multiple
  - Other

- Neurologic symptoms
  - Laterality if appropriate
  - Dominant v. non-dominant

- Hearing loss
  - Laterality
  - Conductive
  - Sensorineural
  - Mixed

- Tinnitus with laterality

- Thyroid
  - Diffuse goiter
  - Solitary nodule
  - Multinodular goiter
  - With or without thyrotoxicosis
Neoplasm:
- Type of encounter
  - Screening
  - Evaluation of a mass of lump
  - Primary treatment of a current cancer
  - Treatment of a secondary (metastatic) neoplasm
  - Surveillance after treatment of a cancer or neoplasm
  - Personal history of cancer (post treatment)
- Location of mass of lump
- Known cancer diagnosis
  - Laterality if appropriate (e.g. breast, renal etc.)
  - Specific histologic type if known for lymphoma and leukemia
  - Anatomic site for lymphoma (e.g. intrathoracic, intra-abdominal, spleen, intrapelvic, axial and upper limb, inguinal region and lower limb or head, face and neck.)
- First degree family history (Mother, sister or maternal aunt) of breast and ovarian cancer particular important to identify patients at high risk scheduled for mammography or breast MRI

Vascular, Arterial:
- Pain
  - Upper versus lower extremity
  - Laterality
  - Intermittent claudication (bilateral leg pain worse with walking and better with sitting)
  - Resting pain
- Atherosclerosis/peripheral vascular disease, if known
  - Aorta
  - Renal arteries
  - Lower extremities with laterality and specific anatomic area (e.g. thigh, calf, ankle, heel, midfoot)
  - By-pass graft with laterality, specific anatomic area and type of graft, if known (autologous, nonautologous, nonbiological)
  - With or without ulceration or gangrene
- Embolism and thrombosis, if known
  - Aorta (thoracic, abdominal or saddle)
  - Iliac artery with laterality
  - Upper or lower extremity with laterality
  - Pulmonary
    - With or w/o cor pulmonale
    - Acute v. chronic
    - Saddle or septic if known
• Aneurysm or dissection, if known
  o Aorta (thoracic, thoracoabdominal or abdominal)
  o Carotid, renal or iliac with laterality
  o Upper or lower extremity with laterality
  o With or without rupture

Vascular, venous:
• Lower extremity edema (chronic venous hypertension) or post-thrombotic syndrome of the lower extremities
  o Laterality
  o With or without ulcer, inflammation or other complications
• Varicose veins
  o Upper v. lower extremities
  o Laterality
  o With or without ulcer or inflammation
• Embolism, thrombosis, blood clot or thrombophlebitis, if known
  o Acute v. chronic
  o SVC or IVC
  o Lower extremities
    ▪ Deep v. superficial veins, if known
    ▪ Iliac, femoral, popliteal or tibia veins, if known
    ▪ Laterality
• Pulmonary embolism (acute v. chronic, if known)
**Technical Information:**

The documentation of technical factors is also a requirement for reimbursement. The ACR states that a radiology report should include a description of the studies/procedures performed and should detail administered activities such as sedation (including medications administered), contrast administration (including type, volume and concentration), catheters or devices (pulse oximetry) used. This information needs to be documented in the radiology report to support CPT/HCPCS coding and to justify billing at the appropriate level. Incomplete documentation may result in a denial of payment, decrease of payment or fines if an audit is performed.

The following list the most common documentation deficiencies.

**Number and type of x-ray views**
- Document in the exam title and technical section.

**Contrast**
- Document in the exam title and technical section.
- Must have type, strength and amount injected.
- Must note if diluted with saline with ratio specified.

**Sedation/Medication/Pulse Oximetry**
- Must include type of medication, strength and dose administered in the technical section.
- If the medicine was mixed, need to document the exact ratio.
- If pulse oximetry used and billed, this needs to be documented.

**Ultrasound**
- Must document if transabdominal and/or transvaginal used.

**Mammography**
- Must document if screening v. diagnostic.

**Doppler**
- Documentation must support color and spectral imaging and include reference to arterial inflow and venous outflow.
**Radiological Findings and Diagnoses:**

These diagnostic points need to be documented in the body and summarized in the conclusion sections of the radiology report. Conclusions should be listed in order of severity, with the most severe or relevant findings first. Again, failure to do this will increase the risk of denial and nonpayment.

This is not a complete list of findings and diagnoses within ICD-10. Rather, it represents a subset of parameters most relevant to radiology outpatient practices and may be updated as we gain more experience with ICD-10. This summary will also be available in the auto text section of the Nuance Powerscribe 360 system under the “ICD10 radiologist” and on the S: sharedrive under CDI Quality Institute Guidelines.

**MSK/Joint imaging:**

**Extremity Fractures, traumatic** (Pathologic fractures coded separately)

- **Encounter**
  - Initial (open v. closed) v.
  - subsequent with routine healing, delayed healing v. nonunion
  - sequelae*
- **Specific location**
- **Fracture type, if appropriate** - Greenstick, Torus, oblique, spiral, transverse, complex, or segmental; impacted, depressed or simple; apophyseal, physeal or osteochondral; pilon, bimalleolar or trimalleolar; or stress
- **Fracture eponym if appropriate** – Colles’, Smith’s
- **Fracture eponym with associated dislocation or ligamentous injury**– Barton’s, Monteggia, Galeazzi, Maisonneuve’s
- **Displaced v. nondisplaced**
- **Open v. Closed**
- **With or without intraarticular extension**
- **Salter type for physeal fractures**
- **Gustilo classification for initial encounters with open fractures**
  - I and II – Open fracture with limited or without extensive soft tissue injury
  - IIIA – Extensive soft tissue injury but intact periosteal sleeve
  - IIIB – Extensive soft tissue injury with periosteal stripping and bone damage
  - IIIC – Associated with arterial injury requiring repair

**Pelvic fractures**

- **Encounter**
  - Initial (open v. closed) v.
  - subsequent with routine healing, delayed healing, nonunion or malunion
  - sequelae
- **Displaced v. nondisplaced**
• Acetabular fractures
  o Dome
  o Anterior wall
  o Posterior wall
  o Anterior (iliopubic) column
  o Posterior (ilioischial) column
  o Transverse
  o Medial wall
• Pubic fractures
  o Right v. left
  o Superior rim
  o Displaced v. nondisplaced avulsion
• Ischium
  o Laterality
  o Displaced v. nondisplaced avulsion
• Ilium
  o Laterality
  o Displaced v. nondisplaced avulsion
• Multiple fractures of the pelvis with disruption of the pelvic rim
  o Stable v. unstable

**Tendon/bursa abnormalities** including tenosynovitis, synovial hypertrophy, tendinitis or bursitis

• Specific tendon or bursa involved
• Tenosynovitis/synovitis/bursitis
  o Infectious, calcific or other
• Overuse disorder/Impingement syndrome
• Tendon strain or rupture
  o Type of encounter (Initial, subsequent or sequela)
  o Specific structure involved
  o Indicate whether spontaneous (normal forces) or secondary to injury
  o for Rotator cuff tear indicate Complete or Incomplete
• Laterality
• Ganglion cyst
• Calcium deposition
• Enthesopathy

**Internal Derangement of the joints**

• Anatomic site and structure with laterality
• Hemarthrosis, Effusions
• Acute subluxations
  o Type of encounter (Initial, subsequent or sequela)
  o Anatomic structure (e.g. patella, proximal tibia or proximal fibula, radial head)
  o Direction (anterior, posterior, lateral, medial as appropriate)
- Strains/Tendon injuries and Sprains/ligament injury –
  - Type of encounter (Initial, subsequent or sequela)
  - Specific structure involved
  - Indicate whether spontaneous (normal forces) or secondary to injury
    - for Rotator cuff tear indicate Complete or Incomplete
- Meniscal tear type or abnormality- Bucket handle, peripheral, complex tear or cystic meniscus
- Chronic subluxation and/or recurrent dislocations
- Adhesive capsulitis

**Osteoarthritis (Degenerative Joint Disease)**
- Specific joint with laterality
- Laterality
- Primary, secondary or post-traumatic

**Inflammatory Arthritis**
- Rheumatoid arthritis
  - Specific joint with laterality
  - With or without other organ involvement
  - With or without rheumatoid factor
  - Felty’s syndrome (with splenomegaly and leukopenia)
  - Rheumatoid lung disease, heart disease or other organ
  - Rheumatoid vasculitis, myopathy, polyneuropathy
- Reiter’s disease, enteropathic or reactive
- Juvenile rheumatoid arthritis (pauciarticular, with systemic onset or other)
- Crystal or deposition arthropathy
  - Specific joint with laterality
  - Gout (drug induced, due to renal impairment, lead induced, idiopathic)
  - Hydroxyapatite, chondrocalcinosis,
- Chronic postrheumatic arthropathy (Jaccoud)
- Villonodular synovitis

**Osteonecrosis (AVN)**
- Specific location
- Laterality
- Cause - Idiopathic, secondary to drugs (cortisone therapy) or secondary to trauma, other
Spine Imaging:

Fractures
- Specific level
- Vertebral type - wedge compression, stable burst, unstable burst, fatigue or other
- Specific structure involved lateral mass, posterior arch, type II dens
- Sacral fractures
  - Zone 1 – vertical fracture lateral to the sacral neural foramina
  - Zone 2 – vertical fracture involving the sacral foramina
  - Zone 3 – medial to the foramina and involving the spinal canal
  - Nondisplaced, minimally displaced v. severely displaced
  - Fracture type if appropriate
    - Type 1 – transverse w/o displacement
    - Type 2 – transverse with posterior displacement
    - Type 3 – transverse with anterior displacement
    - Type 4 – transverse with segmental comminution

Spondylosis, myelopathy, radiculopathy, spinal stenosis, spondyloysis, spondylolisthesis, ankylosing spondylitis, inflammatory spondyloarthropathy, discitis, disc disorders, osteomyelitis with specific level or region involved (cervical, cervicothoracic, thoracic, thoracolumbar, lumbar, lumbosacral or sacral)

Scoliosis with specific subtype, if known:
- Congenital versus idiopathic
- Infantile (beginning before the age of 3 years)
- Juvenile (beginning between 3 and 9 years of age)
- Adolescent (begins between the age of 10 and young adult)
- Thoracogenic (secondary to disease or operative trauma in or on the thoracic cage)
- Neuromuscular (e.g. with spina bifida, cerebral palsy or Chiari malformation)

Osteoporosis:
- Must indicate if patient is symptomatic (diagnostic) or screening
- Must indicate if patient is estrogen deficient and at clinical risk for osteoporosis
- Must indicate if currently taking FDA-approved osteoporosis drug or current long-term use of steroids
- Must indicate whether the osteoporosis (if known) is age related or post-menopausal, disuse, localized, or other (drug induced, disuse, postoophrectomy or postsurgical malabsorption)
- Must indicate whether with or w/o a pathologic fracture
- If pathologic fracture, must indicate
  - The history of the fracture
  - The location of the fracture
- Laterality initial encounter, for subsequent encounter or sequel
- Type of healing, routine, delayed or nonunion, for subsequent encounters
• Indicate if history of a healed osteoporotic fracture

**Head and Neck Imaging:**

**Subarachnoid hemorrhage**
• Traumatic v. non-traumatic
• Laterality, if appropriate
  o Origin
  o Carotid siphon
  o Cerebral artery
  o ACA or PCA
  o Basilar or vertebral artery
  o Other

**Cerebral Infarctions**
• Etiology (embolism, thrombosis, unspecified occlusion/stenosis)
• Vertebral, carotid, cerebral (anterior, middle or posterior) artery or cerebellar artery
• Laterality

**Thyroid**
• Diffuse goiter
• Solitary nodule
• Multinodular goiter
• With or without thyrotoxicosis

**Ear**
• Otosclerosis
  o Laterality
  o Involving the oval window, obliterator v. nonobliterator
  o Cochlear
• Abnormalities of the ear ossicles
  o Laterality
  o Discontinuity and dislocation
  o Ankylosis
  o Partial loss
• Cholesteatoma
  o Laterality
  o Attic, tympanum or Mastoid
  o Diffuse

**Chest:**
• Pulmonary nodule or mass
• Pulmonary edema
• Pneumonia (with specific infectious agent, e.g. influenza, viral, streptococcus pneumonia, if known) or pulmonary abscess
• Emphysema (panlobular, centrilobular or unilateral, if known)
• Bronchiectasis, pneumoconiosis, hypersensitivity pneumonitis, pulmonary fibrosis or specific interstitial pulmonary disease, if known.
• Pleural effusion (malignant or benign), pneumothorax, hemothorax or abscess

Renal:
• Renal failure
  o Acute
  o Chronic (and whether related to diabetes and/or hypertension)
• Hydronephrosis/hydroureter
  o Laterality
  o Cause – calculus, ureteral stricture, UPJ, congenital
  o With or w/o infection
  o TB
• Document whether you are adjusting, removing or replacing urinary devices or tubes

Neoplasm:
All neoplasms are classified primarily by topography (site) with broad groupings for behavior (benign, in situ or malignant). The histologic type is used for selected neoplasms (malignant melanoma and certain neuroendocrine types). Additional codes are also used to indicate whether or not the neoplasm is functional. It is very important from a coding perspective to indicate if the imaging is being performed as part of current treatment vs. personal history of malignancy. Coding guidelines indicate that when a primary malignancy has been previously excised or eradicated from its site, there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, code as personal history.

Screening. Indicate if an examination is being performed for screening or for observation until a given condition or finding is ruled out (e.g. lung screening or f/u incidental findings)

Mass or lump, diagnosis unknown.
• Specific location
• Laterality

Malignancy. Specify whether the imaging or treatment is for treatment of the primary malignancy, a metastatic lesion (secondary malignancy), or a complication arising from the treatment of the neoplasm.
• Indicate current malignancy v. personal history of malignancy (once treatment is complete).
If current malignancy,
  o Is treatment being directed at the primary tumor or at a secondary tumor (metastatic site), complications associated with the malignancy or the treatment thereof, or a pathologic fracture (coding directed to the fracture)
  o Specific location of the neoplasm being treated
    ▪ Pancreas – head, body or tail of the pancreas;
    ▪ Breast – upper outer quadrant, upper inner quadrant, lower inner quadrant, or lower outer quadrant;
    ▪ Brain – parietal lobe, temporal lobe, etc.
  o Laterality, if appropriate (extremity, ovary, testis, breast, kidney, eye, etc.)
  o Specific type of neoplasm
    ▪ Skin;
    ▪ Lymphoma and leukemia - Large B-cell v. peripheral T-cell lymphoma;
    ▪ Benign bone - fibrous dysplasia v. aneurysm bone cyst v. simple bone cyst)
  o Gender, if breast
  o Behavior (breast, skin, respiratory, GI, GU, genital organs)
    ▪ Benign,
    ▪ In situ,
    ▪ Malignant or
    ▪ Uncertain behavior

For certain malignancies (larynx, trachea/bronchus, lung) additional codes are used to indicate if the neoplasm is associated with
  o Exposure to environmental tobacco smoke
  o Occupational exposure to tobacco smoke
  o Tobacco dependence
  o History of Tobacco use
  o Alcohol abuse and dependence
  o Hepatitis B or C
Pathologic Fractures:
- Timing of the encounter (Initial encounter, subsequent encounter, or sequelae)
- Specific structure
- Laterality, if appropriate
- Type of pathologic fracture (neoplastic, osteoporotic, stress/fatigue)
- Type of healing, routine, delayed or nonunion, for subsequent encounters
- Active treatment or subsequent treatment

Pain Management or Pain Control:
- Pain Severity (numerical scale)
- Acute v. chronic
- Specific site of pain
- Underlying condition or significant MRI or CT findings related to the current symptoms
  - Disc herniation
  - Stenosis
  - Moderate or severe disc degeneration (w/ or w/o moderate or marked discogenic marrow edema)
- Cause
  - Due to trauma,
  - Post-thoracotomy
  - Postprocedural
  - Neoplasm related
    ▪ Document whether the malignancy is a primary or metastatic lesion.
- Specific pain syndrome, if appropriate
  - Central pain syndrome
    ▪ Dejerine-Roussy syndrome
    ▪ Myelopathic pain syndrome
    ▪ Thalamic pain syndrome (hyperesthetic)
  - Chronic pain syndrome (associated with significant psychosocial dysfunction)
- Known conservative treatment if injection procedure
- Response to previous injections
**Vascular:**

**Arterial**
- Atherosclerosis including peripheral vascular disease
  - Aorta
  - Renal arteries
  - Lower extremities with laterality and specific anatomic area (e.g. thigh, calf, ankle, heel, midfoot)
  - Involving a by-pass graft with laterality, specific anatomic area and type of graft, if known (autologous, nonautologous, nonbiological)
  - With or without ulceration or gangrene
- Embolism and thrombosis
  - Aorta (thoracic, abdominal or saddle)
  - Iliac artery with laterality
  - Upper or lower extremity with laterality
- Aneurysm or dissection
  - Aorta (thoracic, thoracoabdominal or abdominal)
  - Carotid, renal or iliac artery with laterality
  - Upper or lower extremity with laterality
  - With or without rupture

**Venous**
- Varicose veins
  - Upper v. lower extremities
  - Laterality
  - With or without ulcer, inflammation or other complications
- Embolism, thrombosis, blood clot or thrombophlebitis
  - Acute v. chronic
  - SVC or IVC
  - Lower extremities
    - Deep v. superficial veins
    - Iliac, femoral, popliteal or tibia veins, if known
    - Laterality

This is a guideline, not a policy. It is a summary and distillation of relevant literature and subspecialty guidelines. The purpose of the CDI Quality Institute guidelines is to promote quality and continuity, where appropriate for medical practices within the CDI/Insight enterprise, and to provide relevant and up to date background information to support the development of policies within each individual practice. Guidelines should be adjusted for local standards of care, associated hospital or network policies, hospital versus outpatient settings, different patient populations and your own risk tolerance. Guidelines should also be modified to account for new information or publications that become available between revisions.