



Reimagine Healthcare.

ICD-10 for ENT

UConn Health



Just himagine what we can accomplish together.

Introduction

Dr. Frank Turner

ICD-10 Implementation Physician Advisor

Agenda

- After attending this session participants will be able to:
 - Describe the challenges associated with ICD-10 implementation
 - Identify documentation standards necessary for complete and accurate code assignment for the most frequent diagnoses used by physicians and hospitalists
 - Identify the importance of physician documentation and coding
 - Discuss the importance of the query writing process and physician response

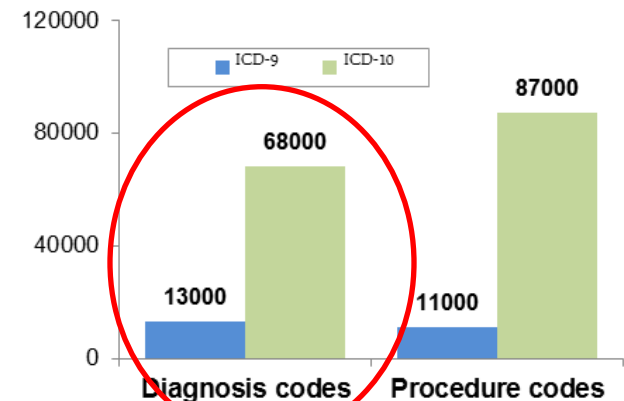
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

Considerations

- ***ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:***
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions



Challenges

- **Documentation by the physician** of specific components of a particular classification (diagnosis code) **is required**:
 - Test results, labs, x-rays, EKGs, echo reports, path reports, studies performed for diagnosis ***are not sufficient documentation*** for classifying (coding) a disease/injury
 - ***Coders are only allowed to use physician documentation to classify a disease/injury or procedure***

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Sigmoid colon, wrist, upper forearm
Laterality	Right, left, bilateral
Specific type of condition	Acute blood loss anemia, type 2 diabetes with hyperglycemia
Etiology of diagnosis	Chest pain due to gastroesophageal reflux, anxiety due to alcohol abuse
Link must be established between manifestations and underlying diseases	Hypertension due to cardiovascular disease, vascular insufficiency secondary to diabetic PVD
Complications of care	Intraoperative, postoperative, mechanical malfunctions, infections
Degree of severity	Mild, moderate, severe, e.g., malnutrition: mild, moderate, severe

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses

Stages (I, II, III, IV)	Stage IV decubitus ulcer
Injury details	Place of occurrence, activity causing the injury
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Cerebral and myocardial infarctions	Site and artery specificity
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement



Reimagine Healthcare.

ENT Diagnosis Documentation Examples



Otitis Media

- In ICD-10-CM for otitis media the physician should specify:
 - Characteristics (i.e. effusion, suppurative, allergic, postmeasles, rupture, serous)
 - Laterality (R, L, bilateral)
 - Acuity (acute, chronic)

There are more than 90 distinct codes for otitis media in ICD-10-CM

Otitis Media ICD-10

- H66 Suppurative and unspecified otitis media
 - H66.0 Acute suppurative
 - H66.00 without spontaneous rupture of ear drum
 - H66.001 right ear
 - H66.002 left ear
 - H66.003 bilateral
 - H66.004 recurrent, right ear
 - H66.005 recurrent, left ear
 - H66.006 recurrent, bilateral
 - H66.007 recurrent, unspecified ear
 - H66.009 unspecified ear
 - H66.01 with spontaneous rupture of ear drum
 - H66.011 right ear
 - H66.012 left ear
 - H66.013 bilateral
 - H66.014 recurrent, right ear
 - H66.015 recurrent, left ear
 - H66.016 recurrent, bilateral
 - H66.017 recurrent, unspecified ear
 - H66.019 unspecified ear

Otitis Externa

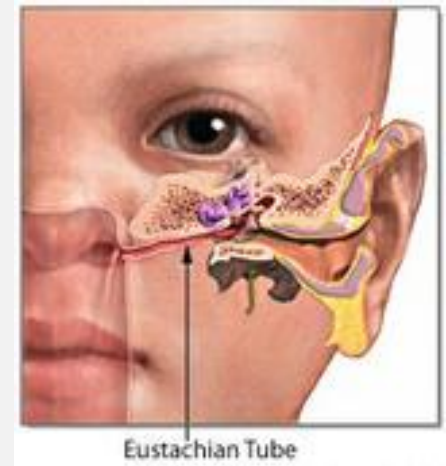
Otitis externa in ICD-10-CM specifically delineates codes for cellulitis and abscess of outer ear whereas ICD-9 generally classifies “infection” of outer ear

- H60.00 Abscess of external ear, unspecified ear
- H60.01 Abscess of right external ear
- H60.02 Abscess of left external ear
- H60.03 Abscess of external ear, bilateral
- H60.10 Cellulitis of external ear, unspecified ear
- H60.11 Cellulitis of right external ear
- H60.12 Cellulitis of left external ear
- H60.13 Cellulitis of external ear, bilateral



Clinical Example: Documentation Improvement

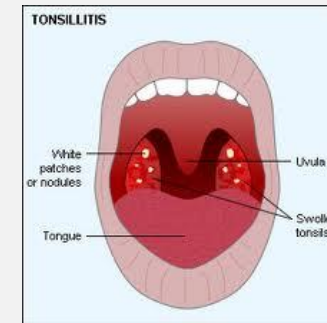
- **Disorders of the Eustachian Tube**
- To properly classify Disorders of the Eustachian Tube in ICD-10-CM, physicians must specify the following about the condition:
 - *Specific disorder*
 - such as type of infection or obstruction
 - *Osseous obstruction or cartilaginous obstruction.*
 - Cartilaginous obstruction
 - intrinsic
 - extrinsic.
 - *Acuity*
 - *Laterality*
 - *Infective or viral organism*



Tonsillitis

Documentation terms to remember for ICD-10:

- Acuity
- Recurrent
- Specified organism



Tonsillitis - Example

A patient was seen by his family physician and diagnosed with acute tonsillitis. The patient had a previous acute bout of tonsillitis six months ago and this is the second occurrence in six months.

- Acute recurrent tonsillitis

Currently, in ICD-9-CM there is not a code to report recurrent tonsillitis.

Sinusitis

Documentation should include:

- **Specific** anatomy involved
- Laterality
- Infectious Agent (if known)

Documentation of Causal Relationship

The provider's documentation of the relationship between the complication and the procedure.

- Intraoperative hemorrhage and hematoma of ear and mastoid process *complicating a procedure on the ear and mastoid process*
- Intraoperative hemorrhage and hematoma of ear and mastoid process *complicating other procedure*
- Document **where the hemorrhage occurred**, but also **what kind of procedure the bleed complicated.**

Infections Resistant to Antibiotics

- Many bacterial infections are resistant to current antibiotics. ***It is necessary to identify all infections documented as antibiotic resistant.*** The infection must also be identified.
- For example – Resistance to antimicrobial drugs



Debility ICD-9

799 Other ill-defined and unknown causes of morbidity and mortality

799.0 Asphyxia and hypoxemia

799.1 Respiratory arrest

799.2 Signs and symptoms involving emotional state

799.3 Debility, unspecified

799.4 Cachexia

799.8 Other ill-defined conditions

799.9 Other unknown and unspecified cause

Debility ICD-10

R53 Malaise and fatigue

R53.0 Neoplastic (malignant) related fatigue

R53.1 Weakness

R53.2 Functional quadriplegia

R53.8 Other malaise and fatigue

R53.81 Other malaise

- Includes debility NOS, chronic debility, general physical deterioration, malaise NOS, nervous debility

R53.82 Chronic fatigue, unspecified

R53.83 Other fatigue

R54 Age-related physical debility

Includes frailty, old age, senescence, senile asthenia, senile debility

Fatigue ICD-9

780.7 Malaise and fatigue

780.71 Chronic fatigue syndrome

780.72 Functional quadriplegia

780.79 Other malaise and fatigue

Fatigue ICD-10

R53 Malaise and fatigue

R53.0 Neoplastic (malignant) related fatigue

R53.1 Weakness

R53.2 Functional quadriplegia

R53.8 Other malaise and fatigue

R53.81 Other malaise

R53.82 Chronic fatigue, unspecified

R53.83 Other fatigue

- fatigue NOS, lack of energy, lethargy, tiredness

Smoking ICD-9

- 305 Nondependent abuse of drugs

Note: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative to the detriment of his health or social functioning.

- 305.0 Alcohol abuse
- **305.1 Tobacco use disorder**
- 305.2 Cannabis abuse.....

Smoking ICD-10

- Z72 Problems related to lifestyle
 - Z72.0 Tobacco use
 - Excludes hx tobacco dependence, use in pregnancy
- F17.2 Nicotine dependence
 - F17.21 Nicotine dependence, cigarettes

Smoking ICD-10

- **F17.2 Nicotine dependence**
 - **F17.20 Nicotine dependence, Unspecified**
 - F17.200 – Uncomplicated
 - F17.201 – In remission
 - F17.203 – With withdrawal
 - F17.208 – With other nicotine-induced disorders
 - F17.209 – With unspecified nicotine-induced disorders
 - **F17.21 Nicotine dependence, cigarettes**
 - F17.210 – Uncomplicated
 - F17.211 – In remission
 - F17.213 – With withdrawal
 - F17.218 – With other nicotine-induced disorders
 - F17.219 – With unspecified nicotine-induced disorders
 - **F17.29 Nicotine dependence, other tobacco products**
 - F17.290 – Uncomplicated
 - F17.291 – In remission
 - F17.293 – With withdrawal
 - F17.298 – With other nicotine-induced disorders
 - F17.299 – With unspecified nicotine-induced disorders

Underdosing

New concept in ICD-10- Document if:

- Intentional underdosing
 - Due to financial hardship
 - Other reasons
- Unintentional underdosing
 - Age-related debility
 - Other reasons
- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

Separate “Z” code is submitted alongside the code for underdosing.

ICD-10 Procedure Documentation Requirements



Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System**.
- It is a multi-axial system with a 7 character alphanumeric code classification providing a **unique code** for all substantially different procedures and with **easy expandability**, incorporating new procedures, technologies and devices utilized in medical/surgical procedures.
- The classification for the general surgery procedures has undergone significant revision focusing primarily on **section, body system, root operation, body part, approach, device and qualifier**.

ICD-10-PCS

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

The ICD-10-PCS code structure tells a story

ICD-10-PCS Laryngoscopy

Patient presents for Laryngoscopy

ICD-10-PCS

- Inspection of Larynx, Via Natural or Artificial Opening Endoscopic



ICD-10-PCS Table

Section	0 Medical and Surgical		
Body System	C Mouth and Throat		
Operation	J Inspection: Visually and/or manually exploring a body part		
Body Part	Approach	Device	Qualifier
A Salivary Gland	0 Open 3 Percutaneous X External	Z No Device	Z No Qualifier
S Larynx Y Mouth and Throat	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic X External	Z No Device	Z No Qualifier

ICD-10-PCS Nasal Polyp Biopsy

Patient presents for nasal polyp biopsy of the left ethmoid sinus

ICD-10-PCS

- Excision of Left Ethmoid Sinus, Percutaneous Endoscopic Approach, Diagnostic



ICD-10-PCS Table

Section	0 Medical and Surgical		
Body System	9 Ear, Nose, Sinus		
Operation	B Excision: Cutting out or off, without replacement, a portion of a body part		
Body Part	Approach	Device	Qualifier
0 External Ear, Right	0 Open		
1 External Ear, Left	3 Percutaneous	Z No Device	X Diagnostic
K Nose	4 Percutaneous Endoscopic X External		Z No Qualifier
3 External Auditory Canal, Right	0 Open		
4 External Auditory Canal, Left	3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic X External	Z No Device	X Diagnostic Z No Qualifier
5 Middle Ear, Right			
6 Middle Ear, Left			
9 Auditory Ossicle, Right	0 Open	Z No Device	X Diagnostic
A Auditory Ossicle, Left			Z No Qualifier
D Inner Ear, Right			
E Inner Ear, Left			
7 Tympanic Membrane, Right	0 Open		
8 Tympanic Membrane, Left	3 Percutaneous	Z No Device	X Diagnostic
F Eustachian Tube, Right	4 Percutaneous Endoscopic		Z No Qualifier
G Eustachian Tube, Left	7 Via Natural or Artificial Opening		
L Nasal Turbinate	8 Via Natural or Artificial Opening Endoscopic		
N Nasopharynx			
B Mastoid Sinus, Right			
C Mastoid Sinus, Left			
M Nasal Septum			
P Accessory Sinus			
Q Maxillary Sinus, Right	0 Open	Z No Device	X Diagnostic
R Maxillary Sinus, Left	3 Percutaneous		Z No Qualifier
S Frontal Sinus, Right	4 Percutaneous Endoscopic		
T Frontal Sinus, Left			
U Ethmoid Sinus, Right			
V Ethmoid Sinus, Left			
W Sphenoid Sinus, Right			
X Sphenoid Sinus, Left			

ICD-10-PCS Pharyngoplasty

Patient presents for lysis of pharyngeal adhesions

ICD-10-PCS

- Release Pharynx, Via Natural or Artificial Opening Endoscopic



ICD-10-PCS Table

Section 0 Medical and Surgical Body System C Mouth and Throat Operation N Release: Freeing a body part from an abnormal physical constraint by cutting or by the use of force			
Body Part	Approach	Device	Qualifier
0 Upper Lip 1 Lower Lip 2 Hard Palate 3 Soft Palate 4 Buccal Mucosa 5 Upper Gingiva 6 Lower Gingiva 7 Tongue N Uvula P Tonsils Q Adenoids	0 Open 3 Percutaneous X External	Z No Device	Z No Qualifier
8 Parotid Gland, Right 9 Parotid Gland, Left B Parotid Duct, Right C Parotid Duct, Left D Sublingual Gland, Right F Sublingual Gland, Left G Submaxillary Gland, Right H Submaxillary Gland, Left J Minor Salivary Gland	0 Open 3 Percutaneous	Z No Device	Z No Qualifier
M Pharynx R Epiglottis S Larynx T Vocal Cord, Right V Vocal Cord, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier
W Upper Tooth X Lower Tooth	0 Open X External	Z No Device	0 Single 1 Multiple 2 All

Physician Queries



Query...why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.



The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
 - Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
 - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
 - Provides a diagnosis without underlying clinical validation
 - Is unclear for present on admission indicator assignment
- “A proper query process ensures that appropriate documentation appears in the health record”**

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

“A proper query process ensures that appropriate documentation appears in the health record”



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Query...answer?

- Coding data is incorporated into the information used by insurance companies to determine which physicians they are going to contract.
- *Coded information is made available to consumers on various platforms, such as HealthGrades, which uses coding data as well as other information to 'rate' facility and provider service*



Query...answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.



- ***A. signature alone on a generated query does not fulfill this requirement***

Query...answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
 - Requesting provider to freehand a response
- *Multiple Choice* format
 - Requesting provider select one of the offered responses



Please sign, date and time Queries!

Query...answer how?

A Physician response, 'see notes' does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- *Although the response may seem 'obvious' coders are only 'reporters' of the word and **cannot code a diagnosis that is not documented by the Provider.***



Summary

- The transition to ICD-10 classification systems on October 1, 201 will have a significant impact on physician documentation requirements.
- Please let us know areas or items that you would like to see further addressed in more detail.



Questions?

