ICD-10 Documentation for Endocrinology
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized endocrinology diagnoses and the ICD-10 changes associated with them
• Define documentation recommendations for each diagnosis
• Document the clinical findings/indicators to support the diagnosis documented
Overview

While the actual number of diagnosis codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of patients with respiratory illness.

Standard ICD-10 Documentation Requirements

- Document causal agents as clearly as possible.
- Document the condition as acute or chronic
- Document location with as much specificity as possible
- Document the clinical findings/indicators to support the diagnosis documented
- Document related, secondary or causal illness whenever appropriate

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis
Assessment

• **Question:** What resource is available to help ensure proper ICD-10 documentation with complicated, hard to code cases?
Assessment

• **Answer:** Guidance on tips and recommendations for proper documentation from a Clinical Documentation Improvement Specialist is available.
Helpful Hint

To determine how to calculate the new ICD-10 code documentation requirements, think of the acronym “CALCS” (See below). While not all 5 types of documentation will be needed in each case, remembering this acronym will help you to think through the new specifications required and document the case appropriately.

- **C** - Document causal agents as clearly as possible
- **A** - Document the condition as acute or chronic
- **L** - Document location with as much specificity as possible
- **C** - Document the clinical findings/indicators to support the diagnosis documented
- **S** - Document related, secondary or causal illness whenever appropriate
Assessment

- **Question:** To remember what information is required for proper ICD-10 documentation, recall what the 5 letters in “CALCS” stand for.
Assessment

- **Answer:** Cause, Acuity, Location, Clinical Findings, Secondary Illnesses
Specifications Unique to Documentation

Endocrinology

Important Note:

• **Cause:**
  • Within endocrinology, the cause of the condition will also specify the type.
  • Document a clear LINK between underlying condition and related, secondary or causal illness whenever appropriate

• **Secondary Illnesses:**
  • Proper documentation will also list the complications, which can be remembered by thinking of “CALCS” with the “S” representing secondary illnesses and complications.
  • Document comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
Section 1: ICD-10 Diagnostic Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Endocrinology providers are responsible for a wide array of diagnoses and procedures. By identifying those used most frequently and those with high ICD-10 impact, this module will

- Provide specific knowledge for a common core of diagnoses
- Identify concepts of ICD-10 specificity to apply to any diagnoses

**Endocrinology diagnoses included in the module are:**

- Diabetes Mellitus
- Disorders of the Thyroid
- Fluid & Electrolyte Imbalances
- Gout
- Overweight/Obesity/
  Hyperalimentation
- Malnutrition
- Hyperlipidemia
- General Documentation for Endocrine and Metabolic Disorders
Documenting Post-Operative Complications

Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Diabetes Mellitus

- Biggest changes for diabetes documentation → elimination of controlled/uncontrolled
- Documenting the patient presentation allows coder to capture the necessary information to fully code the patient’s condition
- IMPORTANT: Document a LINK between DM and manifestations or complications
- Think of the diabetes codes in building blocks, building from one block to the next for complete documentation:

### Cause or Type
- Secondary to Underlying Condition
- Drug or Chemical Induced
- Type 1
- Type 2
- Other

### Presence of Manifestations or Complications
Examples:
- Kidney
- Neuro
- Circulatory

### Specific Complications
Examples:
- Polyneuropathy
- Hyperglycemia with coma
- Cataract

### Insulin Dependence
- NIDDM
- IDDM

Note: Document if insulin overdosing or underdosing is related to an insulin pump malfunction

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• If there are complications/manifestations of the diabetes, additional details may be necessary for the following conditions:

- Arthropathy
- Site of ulcer
- Severity of retinopathy
- With/without macular edema
- Stage of CKD
- Gangrene
- Hyperglycemia
DKA/NKHHC/Coma

Documenting *ketoacidosis, nonketotic hyperglycemic hyperosmolar coma and coma* follow the same building blocks as other diabetic complications:

**Cause:** specify the type or cause

**Acuity:**

**Location:**

**Clinical Findings:**

**Secondary Illnesses/complications:** document the presence of complications

Examples:

*Type 1 diabetes mellitus with ketoacidosis without coma*

*Type 2 diabetes mellitus with hyperosmolarity with coma*

*Diabetes mellitus due to underlying condition with hyperosmolarity without NKHHC*
Diagnoses of the Thyroid

Documentation of thyroid disorders requires:

- **Cause:**
  - Identify the problem: thyrotoxicosis, thyroiditis, goiter, hypothyroidism
  - Detail the type of hypothyroidism (e.g., congenital, acquired, subclinical, due to medicine or other substances, post-infectious, atrophy, etc.)

- **Acuity:** Designate the problem as acute or chronic

- **Clinical Findings:**
  - Indicate any iodine deficiencies
  - Detail the type of congenital iodine-deficiency syndrome (e.g., neurological, myxedematous, mixed)
  - List the presence or absence of a diffuse goiter
  - List the acuity of thyroiditis (e.g., acute, subacute, chronic)

- **Secondary Illnesses:**
  - Identify associated complications: thyrotoxic crisis/storm, transient thyrotoxicosis, myxedema.
  - Report any post-surgical hypothyroidism
  - Specify the presence or absence of a thyrotoxic crisis, storm, or goiter with hyperthyroidism
  - State the type of goiter associated with iodine-deficiency thyroid disorders (e.g., diffuse, multinodular)

Examples:
- Drug-induced thyroiditis
- Congenital hypothyroidism without goiter
- Iodine-deficiency related diffuse goiter
- Thyrotoxicosis with toxic multinodular goiter with toxic storm

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Gout

Documentation of gout includes these primary building blocks:

- **Cause:** idiopathic, drug-induced, secondary to renal impairment or other causes
- **Acuity/Episode:** chronic, acute, attack, flare
- **Location:** ankle, right foot, left hand, right elbow
- **Secondary Illnesses: If adverse effect, document mindset:** Intentional, unintentional, assault,
- **Secondary Illnesses: Tophi:** Indicate presence or absent of tophi

**Examples:**
- Drug-induced, chronic gout of the right knee
- Idiopathic gout attack of the right hip
- Gout attack due to renal impairment of the vertebrae

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Assessment

- **Question:** The documentation of what specific clinical finding and secondary illness are necessary to accurately code a case of gout?
Assessment

• **Answer:** The patient’s mindset as it relates to the cause of the event and the presence of Tophi need to be documented.
Fluid & Electrolyte Imbalances

There is little ICD-10 impact for fluid and electrolyte imbalances:

- Differentiate *volume depletion* between dehydration vs. hypovolemia
- Identify electrolyte imbalance by:
  - Identification of **variance**: hypo/hyper
  - Identification of **electrolyte**: potassium, calcium, magnesium, etc.
  - Identify **specific metabolic syndromes** when appropriate: tumor lysis syndrome, Tay-Sachs disease, Wilson’s Disease, Barth syndrome
Malnutrition

Examples and Specifications

- **Cause:** Identify the type or degree of malnutrition (i.e. kwafhiorkor, nutrition marasmus)
- **Clinical Findings:**
  - Specify any vitamin and/or mineral deficiency or disorder
  - Specify any nutritional anemia (e.g., EFA deficiency with secondary thrombocytopenia)
- **Secondary Illnesses:**
  - Specify any condition resulting from malnutrition (e.g., nutritional short stature)
  - Document information regarding any adverse effects of a vitamin, mineral, or fatty acid deficiency (e.g. Bitots spot)
General Documentation for Endocrine and Metabolic Disorders

Examples and Specifications

- **Cause:**
  - Identify any underlying condition (e.g., feeding difficulties)
  - Specify the disorder, disease, defect, deficiency, or syndrome

- **Clinical Findings:** Specify any significance of abnormal lab findings (e.g., low TSH due to graves)

- **Secondary Illnesses:** document any related complications
Body Mass Index

Many quality measures as well as ICD-10 diagnoses require documentation of weight status

BMI categories include:

\[ \leq 19 \]

20-40 (each whole number)

40-44

45-49

50-60

\[ \geq 70 \]

**Important Note:**

**Who can Document BMI?**

- Coding guidelines allow any clinician to capture and record a patient’s BMI
- However, the provider is ultimately responsible for the completeness of diagnosis documentation
- Find where BMI is routinely captured at your facility and partner with other clinicians to ensure this is properly documented

**NOTE:** In pediatric patients, document their weight percentile
Overweight/Obesity

Overweight \(\rightarrow\) should be accompanied by documentation of BMI

Obesity \(\rightarrow\) Is further subdivided into three groups:

- **From Excess Calorie Intake**
  - Severe
  - Morbid

- **Drug Induced**
  - Identify causal agent

- **With Alveolar**
  - Hypoventilation
Assessment

• **Question:** When documenting obesity, it is important to further describe the case as a result of specific causes and as associated with a specific conditions or complications. What are the three major specifications associated with obesity that need to be documented?
Assessment

• **Answer:** ICD-10 requires the documentation of obesity with 1 or more of the following descriptors:
  • From excess calorie intake (cause)
  • Drug-induced (cause)
  • With Aveolar (secondary illness/complication)
Hyperlipidemia

- Coding for hyperlipidemia has changed slightly with ICD-10
- Documentation for hyperlipidemia has not changed
- Document if there is a relationship between other conditions and hyperlipidemia e.g. CAD, DM
- **Document the type:**
  - Group A- Pure Hypercholesterolemia
  - Group B- Pure Hyperglyceridemia
  - Group C- Mixed Hyperlipidemia
  - Group D- Hyperchylomicronemia
  - Group E - Familial combined Hyperlipidemia
  - Group F - Unspecified Hyperlipidemia

**Restructure** of codes will provide a better picture of patients that have “other specified” hyperglycemias instead of combining “other specified” with “unspecified”

**Documentation Requirements:**
- Providers must continue to document specifically:
  - Triglycerides
  - Lipids
  - Cholesterol

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**Assessment**

- **Question:** What three attributes of hyperlipidemia should providers continue to document?
Assessment

• **Answer:** Providers should continue documenting patients’ triglycerides, lipids, and cholesterol.
Section 2: ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple characters
- Each character captures an increased amount of provider documentation in respect to the service or procedure provided
**Section: Starting point for coding procedures.**

Provides the coder with the initial criteria to class information and narrows available codes.

Endocrinology Procedures are categorized in the following highlighted sections:

<table>
<thead>
<tr>
<th>Medical and Surgical</th>
<th>Other Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>Placement</td>
<td>Imaging</td>
</tr>
<tr>
<td>Administration</td>
<td><strong>Nuclear Medicine</strong></td>
</tr>
<tr>
<td>Measurement and Monitoring</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Extracorporeal Assistance and Performance</td>
<td>Diagnostic Audiology</td>
</tr>
<tr>
<td>Extracorporeal Therapies</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Osteopathic</td>
<td>Substance Abuse Treatment</td>
</tr>
</tbody>
</table>

Endocrinology Examples of Section:

- Medical and surgical- Partial removal of the pituitary gland
- Nuclear Medicine- injection of radioisotopes
Body System: is the next character to understand for ICD-10 coding. As the characters increase so does the specificity of documentation AND coding.

Depending on the section identified the character may be:

- Body System
- Physiologic System
- Anatomic Region
- Endocrine System

Endocrinology Examples of Body System:
- Heart and Great Vessels
- Upper Veins
- Lower Veins
- Upper Arteries
- Lower Arteries
- Central Nervous System
- Upper Extremities
- Lower Extremities
Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/put back** or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** - can be performed only on tubular body parts
6. Procedures that always involve a **device**
7. Procedures involving **examination only**
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**
Documenting for Root Operations:

- Don’t attempt to memorize the coding verbiage for each root operation
- Ensure documentation of the procedure has a clear objective/purpose
- Ensure one of the 9 groupings of operations can be identified

Endocrinology Examples of Root Operations:

- Resection- Parathyroidectomy
- Drainage- Incision of the adrenal gland
**Body Part:** Very specific and detailed, procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or on a body part
- Conduction mechanism (brain or heart)

**Endocrinology Examples of Body Part:**

- Thyroid gland lobe, left
- Thyroid gland lobe, right
- Pituitary gland
- Adrenal gland
- Thyroid gland
- Parathyroid gland
Documenting for Body Part:

- Be as specific as the body part and procedure allow
- If there is laterality capture right, left or bilateral
- If there is distance capture proximal and distal
- Multiple procedures in the same organ or vessel need to have clear documentation
Approach: Defined based on access location, method and types of instrumentation used:

- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
Assessment

- **Question:** What are the 3 determinants for coding an “approach”?
Assessment

- **Answer**: Location, method, and instrumentation.
Device: Devices left in place at the completion of a procedure require a code.

Device Placement for Procedures:

- It is important to document specifically what type of device is placed, and also how it is placed
- Qualifying codes will often capture additional details about a device placement

Example Devices:

- Monitoring device
- Infusion device
Assessment

• **Question:** What devices require documentation to accurately code the surgical procedure under ICD-10
Assessment

- **Answer:** Devices that are left in place after the procedure require documentation.
Qualifier: Defines a “qualifier” or an additional attribute of the procedure when appropriate.

- Not all procedure codes require qualifiers
- Data adds specific, clarifying information that is not contained in another character

**Examples of Qualifiers:**
- Procedures including biopsy for diagnostic purposes
- Identifies source of tissue if placed during a procedure: autologous, non-autologous
- Identifies source of blood product: frozen vs. fresh
Putting It All Together:

**Excision, left thyroid gland lobe, open approach 0GBG0ZZ**

- 0GBG0ZZ- Excision of Left Thyroid Gland Lobe, Open Approach, No Qualifier, No Device
- 0GBG3ZZ- Excision of Left Thyroid Gland Lobe, Percutaneous Approach No Qualifier, No Device
- 0GBG4ZZ- Excision of Left Thyroid Gland Lobe, Percutaneous Endoscopic Approach No Qualifier, No Device
- 0GBG0ZX- Excision of Left Thyroid Gland Lobe, Open Approach, Diagnostic, No Device
- 0GBG3ZX- Excision of Left Thyroid Gland Lobe, Percutaneous Approach, Diagnostic, No Device
- 0GBG4ZX- Excision of Left Thyroid Gland Lobe, Percutaneous Endoscopic Approach, Diagnostic, No Device
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non- Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Biopsy

- Document the root operation e.g. excision, resection, etc.
- Document specific site and laterality (if applicable)
- Document approach e.g. open, percutaneous endoscopic, etc.
Documentation and coding of endocrine diagnoses have greater alignment with ICD-10.

Following these documentation recommendations will assist in meeting the greater specificity demands of ICD-10:

- Document **causal** agents as clearly as possible. This includes the type and a LINK to the underlying condition.
- Document the condition as **acute or chronic**
- Document **location** with as much specificity as possible
- Document the **clinical findings/indicators** to support the diagnosis documented
- Document **related, secondary or causal illness** whenever appropriate. This include a clear LINK to the cause and documenting comorbidities with detail that will show their impact on patient condition even if it is not the primary problem.

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