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
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
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:

**Diabetes Mellitus**

- **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 under dosing is related to an insulin pump malfunction
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
DKA/NKHHC/Coma

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

**Type or Cause**
- 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 contains the following:

1. Designate the problem as acute or chronic
2. Identify the problem: thyrotoxicosis, thyroiditis, goiter, hypothyroidism
3. Identify associated complications: thyrotoxic crisis/storm, transient thyrotoxicosis, myxedema
4. Indicate any iodine deficiencies
5. Detail the type of congenital iodine-deficiency syndrome (e.g., neurological, myxedematous, mixed)
6. State the type of goiter associated with iodine-deficiency thyroid disorders (e.g., diffuse, multinodular)
7. Detail the type of hypothyroidism (e.g., congenital, due to medicine or other substances, post-infectious, atrophy, etc.)
8. List the presence or absence of a diffuse goiter
9. Report any post-surgical hypothyroidism
10. Specify the presence or absence of a thyrotoxic crisis, storm, or goiter with hyperthyroidism
11. List the acuity of thyroiditis (e.g., acute, subacute, chronic)

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

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

- Differentiate *volume depletion* between dehydration vs. hypovolemic

- 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
Gout

Documentation of gout includes three primary building blocks:

**Cause:**
- idiopathic,
- drug-induced,
- secondary to renal impairment or other causes

**Episode:**
- chronic,
- acute,
- attack,
- flare

**Location:**
- ankle,
- right foot,
- left hand,
- right elbow

**Mindset:**
- Intentional,
- unintentional,
- assault,
- undetermined

**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
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
\[ \geq 70 \]

**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 → should be accompanied by documentation of BMI

Obesity → Is further subdivided into three groups:

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

- **Drug Induced**
  - Identify causal agent

- **With Alveolar**
  - Hypoventilation
Malnutrition

- Identify the type or degree of malnutrition
- Specify any condition resulting from malnutrition (e.g., nutritional short stature)
- Specify any vitamin and/or mineral deficiency or disorder
- Document information regarding any adverse effects of a vitamin, mineral, or fatty acid deficiency (e.g., Bitots spot)
- Specify any nutritional anemia (e.g., EFA deficiency with secondary thrombocytopenia)
Hyperlipidemia

The coding for hyperlipidemia has changed slightly with ICD-10 but the documentation for hyperlipidemia has not changed. The restructure of codes will provide a better picture of patients that have “other specified” hyperglycemias instead of combining “other specified” with “unspecified”

**ICD-9-CM Codes:**
- 272.0, *Pure hypercholesterolemia*
- 272.1, *Pure hyperglyceridemia*
- 272.2, *Mixed hyperlipidemia*
- 272.4, *Other and unspecified hyperlipidemia*

**ICD-10 Codes:**
- E78.0, *Pure hypercholesterolemia*
- E78.1, *Pure hyperglyceridemia*
- E78.2, *Mixed hyperlipidemia*
- E78.4, *Other hyperlipidemia*
- E78.5, *Hyperlipidemia, unspecified*

**Documentation Requirements:**
Providers must continue to document specifically:
- Triglycerides
- Lipids
- Cholesterol
General Documentation for Endocrine and Metabolic Disorders

• Specify the disorder, disease, defect, deficiency, or syndrome
• Identify any underlying condition (e.g., feeding difficulties)
• Specify any significance of abnormal lab findings (e.g., low TSH due to graves)
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 axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
Axis 1: Starting point for coding procedures.
Provides the coder with the initial criteria to class information and narrows available codes

Endocrinology examples include:
• Medical and surgical- Partial removal of the pituitary gland
• Nuclear Medicine- injection of radioisotopes

<table>
<thead>
<tr>
<th>Medical and Surgical</th>
<th>Chiropractic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td>Imaging</td>
</tr>
<tr>
<td>Placement</td>
<td><strong>Nuclear Medicine</strong></td>
</tr>
<tr>
<td>Administration</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Measurement and Monitoring</td>
<td>Physical Rehabilitation and Diagnostic</td>
</tr>
<tr>
<td>Extracorporeal Assistance and Performance</td>
<td>Audiology</td>
</tr>
<tr>
<td>Extracorporeal Therapies</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Osteopathic</td>
<td>Substance Abuse Treatment</td>
</tr>
<tr>
<td>Other Procedures</td>
<td></td>
</tr>
</tbody>
</table>
Axis 2: Body System

**Body System:** is the next axis for understand ICD-10 coding. As the Axes increase so does the specificity of documentation AND coding.

**Depending on the section identified the axis may be:**

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

**Examples of Axis 2:**
- 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**
Axis 3: Root Operation

Endocrinology Examples of Axis 3-Root Operation:

Resection- Parathyroidectomy
Drainage- Incision of the adrenal gland

Documenting for Axis 3:

• 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
Axis 4: Body Part

Axis 4: 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 Axis 4:

- Thyroid gland lobe, left
- Thyroid gland lobe, right
- Pituitary gland
- Adrenal gland
- Thyroid gland
- Parathyroid gland
Axis 4: Body Part

Documenting for Axis 4:

• 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
Axis 5: Approach

Axis 5: 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
Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:
• Monitoring device
• Infusion device

**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
Axis 7: Qualifier

Axis 7: Defines “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 axis

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 comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
- Document a clear LINK between underlying condition and 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