ICD-10-CM IS HERE: ARE YOU READY?!

Sponsored by
SOHN’s 39th Annual Congress and Nursing Symposium
“ORL Nursing: The New Frontier”
Dallas, Texas
Tuesday, September 29, 2015

Presented by:
Kim Pollock
RN, MBA, CPC, CMDP

DISCLOSURE

Kim Pollock, RN, MBA, CPC, CMDP

• Employee of KarenZupko & Associates, Inc., a physician practice management consulting company that helps physicians with practice management issues including improving revenue, decreasing expenses, streamlining processes and reducing risk.

• Does not receive compensation for sales of KZA products or any recommended products/services.

CONNECT WITH US AT
WWW.KARENZUPKO.COM

We thought ICD-10 would be pushed back.
**WHEN TO USE WHICH CODES**

- Do not **BILL** ICD-10 Codes for a date of service prior to October 1, 2015.
- Do **PRECERT** ICD-10 codes for a date of service October 1, 2015 and later.
- Do not **BILL** ICD-9 codes for a date of service after September 30, 2015 (unless payer does not accept ICD-10).
- **ALERT:** Claims cannot contain both ICD-9 codes and ICD-10 codes.
- **E/M inpatient care** crossing September 30-October 1? Split the claims so the services prior to October 1, 2015 are billed with ICD-9 codes are on a separate claim.

---

**WHAT IS ICD-10-CM?**

- International Classification of Diseases, 10th Revision, Clinical Modification.
- We are currently using ICD-9-CM.
- Codes are used to calculate MS-DRG payments.
- Compile statistics.
- Already being used in 138 countries for mortality reporting, 99 countries for morbidity. US implemented for mortality on 1/1/99.
- Other countries use ICD-10 for reimbursement or case mix: UK, Denmark, Finland, Iceland, Norway, Sweden, France, Australia, Belgium, Germany, Canada.

---

**WHY ARE WE CHANGING?**

- ICD-9-CM is out of date and running out of space for new codes.
- ICD-10-CM is the international standard to report and monitor disease and mortality – USA must adopt for reporting and surveillance.
- ICD codes are core elements of many health information technology systems making the conversion to ICD-10-CM necessary to fully realize benefits of HIT adoption.
- It’s mandated by CMS for all HIPAA-covered entities!!
POPULAR IN 1979...

- Sony introduced the Sony Walkman costing $200.
- Atari 400, one of the earliest home computer systems, was high tech.
- Record players were all the rage.
- Gloria Gaynor topped the charts with “I Will Survive”.

Sources: http://www.thepeoplehistory.com/1979.html

FORMAT OF ICD-9-CM VS. ICD-10-CM

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Structure</td>
<td>Code Structure</td>
</tr>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td>1st digit may be alpha, but is usually numeric; 2nd-5th is numeric</td>
<td>Character 1 is alpha; character 2 is always numeric; characters 3-7 can be either alpha or numeric</td>
</tr>
<tr>
<td>Approximately 14,000 codes</td>
<td>Approximately 69,000 codes</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
</tbody>
</table>

Major Differences between ICD-9-CM and ICD-10-CM

- Laterality (right, left, bilateral) for many diagnoses
- Combination codes for certain conditions, common associated symptoms, poisonings and associated external cause
- Character “x” is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character).
- Inclusion of clinical concepts that did not exist in ICD-9-CM.
- Codes expanded (e.g., injuries, postoperative complications).
- Injuries grouped by anatomical site rather than type of injury.
ICD-10: 3 VOLUMES

ICD-10 has Three Volumes (but two types of codes)

I: Tabular List of ICD-10-CM is a structured list of codes divided into chapters based on body system or condition.

II: Alphabetic Index of ICD-10-CM is an alphabetical list of terms and their corresponding code. This volume is actually listed first in the book.

III: Procedures (ICD-10-PCS)

- Physicians will not use this code set for professional claims; hospitals and facilities use these codes to describe procedures performed.

PLACEHOLDER “X” FOR FUTURE EXPANSION

- H66.3X - Other chronic suppurrative otitis media
  - H66.3X1 Right ear
  - H66.3X2 Left ear
  - H66.3X3 Bilateral
  - H66.3X9 Unspecified ear

PLACEHOLDER “X”

“X” placeholder is used to provide room for future expansion.

“X” placeholder is used to keep applicable 7th character in the 7th position when the code is less than 6 characters long.
Some codes require a 7th character to be added for a complete, valid code.

Some codes require a 7th character to be added for a complete, valid code. Remember not all codes are seven characters. There are valid three, four, five and six character codes.

Pertinent codes for otolaryngology that require a seventh character mainly fall into injury categories including: open wounds, fractures, foreign bodies and certain complications.

However, fractures (S02.-) have 6 options for the 7th character.

The Tabular List will note how many characters are required for a code to be valid.

The Tabular List will note how many characters are required for a code to be valid.

When seeing this character notation, the applicable seventh character options will be at the code category level and must be appended to report a valid code.

Seventh character extensions are not the same for all code categories as noted by the two examples below.

The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.
7TH CHARACTER EXTENSION: INITIAL-SUBSEQUENT-SEQUELA

- The healing process guides the extension selection, not chronology of the visits.
- While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

7TH CHARACTER DEFINITIONS

**Initial Encounter = A, B**

The 7th character for an initial encounter is used while the patient is receiving active treatment for the condition.

*Examples include:* Surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician. This extension is used when the patient is receiving active treatment for the condition.

**Subsequent Encounter = D, G, K**

The 7th character for a subsequent encounter, is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

*Examples include:* Cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury.

Subsequent encounter does not equal established patient (E/M code 9921x).

**Sequela = S**

- ICD-10-CM no longer has late effect codes.
- To indicate a condition is the result of a previous injury, the 7th character extension “S” is used on the active injury code. A code for the current condition is also used.
- The 7th character “S” sequela is used when there is a residual effect (condition produced) after the acute phase of an illness or injury has terminated.
- There is no time limit on when a sequela code can be used.

*Examples include:* Scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis.
### 7th Character Definitions

**Sequela = S**

Example: Scar resulting from a previous laceration. The scar is the “late effect” or “sequela” of the laceration.

When using this extension it is necessary to use both the injury code that is the cause of the sequela and the code for the sequela itself.

*Example:* L91.0 Hypertrophic scar  
S01.415 Laceration without foreign body of right cheek and temporomandibular area, sequela

---

### Other Coding Conventions and Guidelines

#### "Other" Codes

"Other" and "other specified" are used when the medical record gives detail for a condition or illness, but a specific code does not exist.

<table>
<thead>
<tr>
<th>ICD-10-CM “unspecified”</th>
</tr>
</thead>
<tbody>
<tr>
<td>C34.9 Malignant neoplasm of floor of mouth, unspecified</td>
</tr>
<tr>
<td>H68.029 Chronic Eustachian salpingitis, unspecified ear</td>
</tr>
<tr>
<td>J32.9 Chronic sinusitis, unspecified</td>
</tr>
<tr>
<td>J34.9 Unspecified disorder of nose and nasal sinuses</td>
</tr>
<tr>
<td>S02.609 Fracture of mandible, unspecified (7th character required)</td>
</tr>
<tr>
<td>S02.9 Unspecified fracture of facial bones</td>
</tr>
</tbody>
</table>

*Although the record may have the following information, ICD-10-CM does not provide specific codes for the conditions listed here. All conditions would be assigned to the same code.*

#### "Unspecified" Codes

Codes that have "unspecified" in the title are used when information in the medical record is not sufficient or detailed enough to assign a more specific code.

- H83.3- Noise effects on inner ear
- H83.3X1 Noise effects on right inner ear

---

**Dash -**

Used after a subcategory to indicate code requires further characters to be valid.
OTHER CODING CONVENTIONS AND GUIDELINES

**Excludes Notes**

Two types of excludes notes.

**Excludes 1**

Different definitions, but similar because they indicate that codes excluded from each other are independent of each other.

- **Excludes 1** “NOT CODED HERE”
  - The code excluded should never be used at the same time as the code above the Excludes 1 note.
  - Used when two conditions can’t occur together.

  - C00 Malignant neoplasm of lip
    - **Excludes 1** Malignant melanoma of lip (C43.0)
    - Merkel cell carcinoma of lip (C4A.0)
    - Other and unspecified malignant neoplasm of skin of lip (C44.0)

**Excludes 2**

“NOT INCLUDED HERE”

- The condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time.
- It is acceptable to use both the code and the excluded code together, when appropriate.

  - R07.0 Pain in throat
    - **Excludes 2** Dysphagia (R13.1)
    - Pain in neck (M54.2)

**A Few More Terms...**

**“And”**

- Means either “and” or “or” when it appears in a code title.

  - S01.411A Laceration without foreign body of right cheek and temporomandibular area, initial encounter

**“With”**

- Interpreted to mean “associated with” or “due to” when it appears in a code title.
OTHER CODING CONVENTIONS AND GUIDELINES

A Few More Terms...

“See” and “See Also”

- In the Alphabetic Index
  - “See” instruction following a main term indicates another term should be referenced to locate the proper code.
  - “See Also” instruction following a main term indicates there is another term that may be referenced, but it is not necessary to follow the instruction if the original main term provides necessary detail.

A Few More Terms...

“Code also”

- Indicates two codes may be required to fully describe the condition.
- Does not provide sequencing direction.

OTHER CODING CONVENTIONS AND GUIDELINES

Acute and Chronic Conditions

If separate entries exist in the Alphabetic Index at the same indentation level:

1. Code both.
2. Sequence the acute condition first.

OTHER CODING CONVENTIONS AND GUIDELINES

Laterality

Laterality is a prominent concept in ICD-10-CM. Some code series reflect right, left and bilateral conditions.

If a bilateral code does not exist, assign separate codes for both the right and left side.

If the side is not documented, assign the code for unspecified side.
CHAPTER 2: NEOPLASMS

Chapter Organization

C00-D49

CHAPTER 2: NEOPLASMS (C00-D49)

- **Malignant** – Cancerous and capable of invading normal tissue and spreading to other sites.
  - C09.0 – Malignant neoplasm of tonsillar fossa
- **Benign** – Does not invade normal tissue and remains localized at the original site.
  - D22.12 – Melanocytic nevi of left eyelid, including canthus
- **In situ** – Is a malignancy which has not yet invaded the basement membrane.
  - D03.21 – Melanoma in situ of right ear and external auricular canal
- **Uncertain behavior** – Histologic confirmation whether the neoplasm is malignant or benign can not be made. There is a specific pathologic diagnosis.
  - D37.05 – Neoplasm uncertain behavior of pharynx
- **Unspecified behavior** – Is an appropriate category only if neither the behavior nor the morphology is known by the provider.
  - D49.0 – Neoplasm of behavior of digestive system unspecified
CHAPTER 2: NEOPLASMS (C00-D49)

Overlapping sites should be classified to .8 (overlapping lesion) codes unless a combination code exists.

Example: C02.8 Overlapping malignant lesion of the tongue

Multiple neoplasms that are not contiguous should be coded separately.

CHAPTER 2: NEOPLASMS (C00-D49)

History of vs. Active Neoplasm Code

- A primary malignancy has been excised or eradicated from its site and there is no further treatment and no evidence of any existing primary malignancy, then use Z85.-.

Examples:
- Z85.110 – Personal history of malignant carcinoid tumor of bronchus and lung
- Z85.810 – Personal history of malignant neoplasm of tongue
- Z85.21 – Personal history of malignant neoplasm of larynx

Example:
Surveillance visit 2 years after laryngectomy for cancer
1) Z08 Surveillance
2) Z85.21 Personal history cancer, larynx
3) Z90.2 Acquired absence of larynx
4) Any additional diagnosis codes for conditions evaluated (e.g., aphonia, dysphagia)

MALIGNANT NEOPLASMS (C00-C49)

Melanoma (C43)

Diagnosis codes for melanoma are categorized by either malignant melanoma or melanoma in situ. ICD-9-CM does not have this distinction.

Wait for the pathology report before assigning the diagnosis code for the excision of skin lesion CPT codes (114xx, 116xx) as the CPT code is dependent on the final pathology.

C43.4 Malignant melanoma of scalp and neck
MALIGNANT NEOPLASMS (C00-C49)

Other Skin Cancers (C4A-C44)

Similar to ICD-9-CM, other and unspecified types of skin cancer are categorized based on location and histology:

- Basal cell carcinoma
  - C44.311  Basal cell carcinoma of skin of nose
- Squamous cell carcinoma
  - C44.321  Squamous cell carcinoma of skin of nose
- Merkel cell carcinoma
  - C44.31  Merkel cell carcinoma of nose
- Other specified malignant neoplasm
  - C44.391  Other specified malignant neoplasm of skin of nose
- Unspecified malignant neoplasm
  - C44.301  Unspecified malignant neoplasm of skin of nose

CHAPTER 8: DISEASES OF THE EAR AND MASTOID PROCESS (H60-H95)

CHAPTER HIGHLIGHTS

New chapter created in ICD-10-CM. Previously, ear and mastoid conditions were found in the Nervous System and Sense Organs chapter of ICD-9-CM.

- Diseases of external ear
  - H60 - H62
- Diseases of middle ear and mastoid
  - H65 - H75
- Diseases of inner ear
  - H80 - H83
- Other disorders of ear
  - H90 - H94
- Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified
  - H95

CHAPTER HIGHLIGHTS

- Expansion of codes in this chapter increased anatomic specificity by adding laterality.
- There are separate codes for right, left and bilateral ear conditions in most code categories.

Example:

- H60.311  Diffuse otitis externa, right ear
- H60.312  Diffuse otitis externa, left ear
- H60.313  Diffuse otitis externa, bilateral ear
- H60.319  Diffuse otitis externa, unspecified ear
## OTITIS EXTERNA (H60. -)

### Type of OE
- 0: Abscess
- 1: Cellulitis
- 2: Malignant OE
- 3: Other
- 4: Cholesteatoma
- 5: Acute noninfective
- 6: Unspecified chronic
- 8: Other chronic
- 9: Unspecified

### SWIMMER'S EAR (H60.33-)

<table>
<thead>
<tr>
<th>Category</th>
<th>Etiology, Anatomic Site, Severity</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>H60.331</td>
<td>Swimmer's ear, right ear</td>
<td></td>
</tr>
<tr>
<td>H60.332</td>
<td>Swimmer's ear, left ear</td>
<td></td>
</tr>
<tr>
<td>H60.333</td>
<td>Swimmer's ear, bilateral</td>
<td></td>
</tr>
<tr>
<td>H60.339</td>
<td>Swimmer's ear, unspecified ear</td>
<td></td>
</tr>
</tbody>
</table>

### IMPACTED CERUMEN (H61. -)

<table>
<thead>
<tr>
<th>Category</th>
<th>Etiology, Anatomic Site, Severity</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>H61.20</td>
<td>Impacted cerumen, unspecified ear</td>
<td></td>
</tr>
<tr>
<td>H61.21</td>
<td>Impacted cerumen, right ear</td>
<td></td>
</tr>
<tr>
<td>H61.22</td>
<td>Impacted cerumen, left ear</td>
<td></td>
</tr>
<tr>
<td>H61.23</td>
<td>Impacted cerumen, bilateral</td>
<td></td>
</tr>
</tbody>
</table>
**OTITIS MEDIA**

**Nonsuppurative Otitis Media (H65)**

**Instructional notes**
- Use additional code for any associated perforated tympanic membrane (H72.-).
- Use additional code to identify:
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

**Acute Serous Otitis Media (H65.0-)**

NEW in ICD-10-CM

The term *recurrent* has been added to the description for codes in the acute categories for otitis media.

- H65.01 Acute serous otitis media, right ear
- H65.02 Acute serous otitis media, left ear
- H65.03 Acute serous otitis media, bilateral
- H65.04 Acute serous otitis media, recurrent, right ear
- H65.05 Acute serous otitis media, recurrent, left ear
- H65.06 Acute serous otitis media, recurrent, bilateral

**Chronic Serous Otitis Media (H65.2-)**

**Instructional notes**
- Include with or without spontaneous tympanic membrane rupture
- Acute vs. acute recurrent
- Right, left, bilateral

- H66.00 Acute suppurative OM without spontaneous rupture of ear drum
- H66.01 Acute suppurative OM with spontaneous rupture of ear drum

**Suppurative and Unspecified Otitis Media (H66)**

**Instructional notes**
- Category H66 has the same instructional note for any smoking use, dependence or exposure, as well as, any associated TM perforation for most of the subcategories.

- **Acute Suppurative Otitis Media H66.0-**
  - Include with or without spontaneous tympanic membrane rupture
  - Acute vs. acute recurrent
  - Right, left, bilateral

- H66.00 Acute suppurative OM without spontaneous rupture of ear drum
- H66.01 Acute suppurative OM with spontaneous rupture of ear drum

Under category H72, Perforation of tympanic membrane, there is an Excludes 1 note for subcategory H66.01-.

A code from H72 is not reported in addition as TM rupture is included in the description of the code.
SUPPURATIVE OTITIS MEDIA

H66

Category
Etiology, Anatomic Site, Severity
Extension

4th Character
0 = Acute suppurative w/ or w/o TM perf (acute vs. acute, recurrent) [see previous slide]
1 = Chronic tubotympanic suppurative
2 = Chronic atticotemporal suppurative
3 = Other chronic suppurative
4 = Unspecified suppurative OM
9 = Unspecified (OM NOS, AOM NOS, COM NOS)

OTHER MIDDLE EAR DISORDERS

Eustachian Tube Dysfunction (H69)

ICD-9-CM = 381.81
H69.80 Other specified Eustachian tube disorder, unspecified
H69.81 Other specified disorders of Eustachian tube, right ear
H69.82 Other specified disorders of Eustachian tube, left ear
H69.83 Other specified disorders of Eustachian tube, bilateral

Remember: Document laterality for all ear conditions!
Right – Left – Bilateral

CHOLESTEATOMA

H71

Category
Etiology, Anatomic Site, Severity
Extension

4th Character
0 = Attic
1 = Tympanum
2 = Mastoid
3 = Diffuse cholesteatosis
9 = Unspecified

TYMPANIC MEMBRANE PERFORATION

H72

Category
Etiology, Anatomic Site, Severity
Extension

4th Character
0 = Central
1 = Attic
2 = Other marginal perforations
8 = Other (multiple vs. total)
9 = Unspecified

5th Character
1 = Right
2 = Left
3 = Bilateral
### DISORDERS OF VESTIBULAR FUNCTION (H81)

**EXCLUDES 1**
Epidemic vertigo (A88.1)
Vertigo NOS (R42)

<table>
<thead>
<tr>
<th>ICD-9-CM codes for Meniere's disease</th>
<th>ICD-10-CM codes for Meniere's disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>386.00 Unspecified Meniere's disease</td>
<td>H81.01 Meniere's disease, right ear</td>
</tr>
<tr>
<td>386.01 Active Meniere's disease</td>
<td>H81.02 Meniere's disease, left ear</td>
</tr>
<tr>
<td>386.02 Active Meniere's disease, cochlear</td>
<td>H81.03 Meniere's disease, bilateral</td>
</tr>
<tr>
<td>386.03 Active Meniere's disease, vestibular</td>
<td>H81.09 Meniere's disease, unspecified</td>
</tr>
<tr>
<td>386.04 Inactive Meniere's disease</td>
<td></td>
</tr>
</tbody>
</table>

Inactive vs. active has been removed, as well as descriptions for cochlear, vestibular, cochleovestibular.

### HEARING LOSS

**Hearing Loss (H90)**

Documentation requires the following information:

- **Type**
  - Conductive
  - Sensorineural
  - Mixed

- **Laterality**
  - Left
  - Right
  - Bilateral

**ALERT**
Currently, ICD-10-CM does not provide codes for different types of loss in each ear (e.g., conductive loss in the right ear and sensorineural loss in the left). When both conditions are documented, a code for the conductive hearing loss and sensorineural hearing loss are both coded.

### OTALGIA AND EFUSION OF EAR (H92)

**Codes are further defined by laterality: right, left, bilateral.**

- **Otalgia** H92.0-
- **Otorrhea** H92.1-
  - **Excludes 1** Leakage of cerebrospinal fluid through ear (G96.0)
- **Otorrhagia** H92.2-
  - **Excludes 1** Traumatic otorrhagia – Code to injury
TINNITUS (H93.1-)

- Subjective and objective tinnitus codes have been removed.
- Tinnitus is defined only by laterality in ICD-10-CM.
  - H93.11 Tinnitus, right ear
  - H93.12 Tinnitus, left ear
  - H93.13 Tinnitus, bilateral
  - H93.19 Tinnitus, unspecified ear

INTRAOPERATIVE AND POSTPROCEDURAL COMPLICATIONS AND DISORDERS (H95)

- Certain complications have been grouped into specific chapters rather than all complications being combined into a single chapter.
  - H95.0: Recurrent cholesteatoma of the post-mastoidectomy cavity
  - H95.1: Other disorders of the ear and mastoid process following mastoidectomy
  - H95.2: Intraoperative hemorrhage and hematoma of ear and mastoid process complicating a procedure
  - H95.3: Accidental puncture and laceration of ear and mastoid process during a procedure
  - H95.4: Postprocedural hemorrhage and hematoma of ear and mastoid process following a procedure
  - H95.8: Other intraoperative and postprocedural complications and disorders of the ear and mastoid process, not elsewhere classified

CHAPTER HIGHLIGHTS

- Many of the codes in this chapter have 1-1 mapping!!!
  - 474.00 chronic tonsillitis = J35.01 chronic tonsillitis
  - 473.2 chronic ethmoidal sinusitis = J12.2 chronic ethmoidal sinusitis
- Certain codes have been moved to Chapter 10 from other locations, like streptococcal sore throat (J02.0). Previously was in Infectious and parasitic disease chapter in ICD-9-CM.
CODING CONVENTIONS AND INSTRUCTIONAL NOTES

• Some codes have been expanded to include notes indicating an additional code should be assigned or an associated condition should be sequenced first.
  – Use additional code to identify the infectious agent.
  – Use additional code to identify the virus.
  – Code first any associated lung abscess.
  – Code first the underlying disease.
  – Use additional code to identify other conditions such.

• J01 Acute Sinusitis
  Watch code assignment for infectious agent!

Note: Code if infectious agent is known. If unknown, then an infectious agent code is not reported.

CODING CONVENTIONS AND INSTRUCTIONAL NOTES

Most codes also have instructions to:
Use additional code to identify:
  Exposure to environmental tobacco smoke (Z77.22)
  Exposure to tobacco smoke in the perinatal period (P96.81)
  History of tobacco use (Z87.891)
  Occupational exposure to environmental tobacco smoke (Z57.31)
  Tobacco dependence (F17.7)
  Tobacco use (Z72.0)

ACUTE SINUSITIS

**J01.**

**Acute Sinusitis (J01.-)**

- The acute sinusitis codes have been expanded to state whether the infection is recurrent or not.
- Use additional code (B95–B97) to identify infectious agent.

CHRONIC SINUSITIS (J32.-)

**J32.-** Chronic sinusitis

Use additional code to identify:
  Exposure to environmental tobacco smoke (Z77.22)
  Exposure to tobacco smoke in the perinatal period (P96.81)
  History of tobacco use (Z87.891)
  Occupational exposure to environmental tobacco smoke (Z57.31)
  Tobacco dependence (F17.7)
  Tobacco use (Z72.0)
PANSINUSITIS

- In ICD-9-CM pansinusitis was coded under an “other specified” code (ICD-9 = 461.8, 473.8).
- In ICD-10-CM, pansinusitis has its own codes (J01.40, J04.41 and J32.4).

OTHER SINUSITIS: NEW MEANING IN ICD-10-CM!

- Other acute (and acute recurrent) sinusitis J01.80 and J01.81
  “Acute sinusitis involving more than one sinus but not pansinusitis”
- Other chronic sinusitis J32.8
  “Sinusitis (chronic) involving more than one sinus but not pansinusitis”
  
  Change: In ICD-9-CM each sinus that was infected was coded separately unless all were infected, but in ICD-10-CM if 2 or 3 sinuses are documented as infected the “other acute sinusitis” codes will be used rather than coding each one separately.

EXAMPLES

- Involvement of 1 Sinus
  - 31256-50  473.0 / J32.0 (chronic maxillary sinusitis)

- Involvement of 2 or 3 Sinuses
  - 31255-50  473.2 / J32.8 (other chronic sinusitis)
  - 31256-50  473.0 / J32.8 (other chronic sinusitis)

- Involvement of All 4 Sinuses
  - 31276-50  473.8 / J32.4 (chronic pansinusitis)
  - 31255-50  473.8 / J32.4 (chronic pansinusitis)
  - 31287-50  473.8 / J32.4 (chronic pansinusitis)
  - 31256-50  473.8 / J32.4 (chronic pansinusitis)

ACUTE TONSILLITIS (J03.-)

- Acute Tonsillitis
  - No 6th or 7th characters

  Type
  0 Streptococcal
  8 Other specified organisms
  9 Unspecified

  Episode
  0 Acute
  1 Acute recurrent
CHRONIC TONSIL / ADENOID DISEASE

Chronic Tonsillitis and Adenoiditis, Hypertrophy (J35.-)

Instructional Note:
Use additional code to identify:
- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco use (Z87.8)
- Tobacco use (Z72.0)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J35.01</td>
<td>Chronic tonsillitis</td>
</tr>
<tr>
<td>J35.02</td>
<td>Chronic adenoiditis</td>
</tr>
<tr>
<td>J35.03</td>
<td>Chronic tonsillitis and adenoiditis</td>
</tr>
<tr>
<td>J35.1</td>
<td>Hypertrophy of tonsils</td>
</tr>
<tr>
<td>J35.2</td>
<td>Hypertrophy of adenoids</td>
</tr>
<tr>
<td>J35.3</td>
<td>Hypertrophy of tonsils with hypertrophy of adenoids</td>
</tr>
</tbody>
</table>

VASOMOTOR AND ALLERGIC RHINITIS

Vasomotor and Allergic Rhinitis (J30)

For allergy testing: Also use Z01.82 (Encounter for allergy testing).

Symptoms: R06.7 (Sneezing), R05 (Cough), R09.81 (Nasal congestion), R09.82 (Postnasal drip)

COMMON RESPIRATORY SYSTEM
DIAGNOSIS CODE MAPPINGS

Disease of Vocal Cords and Larynx, NEC (J38)

J38.0- Paralysis / Unspecified, unilateral, bilateral
J38.1  Polyp
J38.2  Nodules
J38.3  Other diseases of vocal cords (e.g., leukoplakia, granuloma)
J38.4  Edema
J38.5  Spasm [use for spasmodic dysphonia]
J38.6  Stenosis
J38.7  Other diseases of larynx (e.g., cellulitis, ulcer)

COMMON RESPIRATORY SYSTEM
DIAGNOSIS CODE MAPPINGS

The Respiratory chapter has 1:1 mapping from ICD-9-CM to ICD-10-CM for many commonly used otolaryngology codes.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>470</td>
<td>J34.2</td>
</tr>
<tr>
<td>471.0</td>
<td>J33.0</td>
</tr>
<tr>
<td>472.0</td>
<td>J31.0</td>
</tr>
<tr>
<td>472.1</td>
<td>J31.2</td>
</tr>
<tr>
<td>472.2</td>
<td>J31.1</td>
</tr>
<tr>
<td>475</td>
<td>J36</td>
</tr>
<tr>
<td>476.0</td>
<td>J37.0</td>
</tr>
<tr>
<td>476.1</td>
<td>J37.1</td>
</tr>
</tbody>
</table>
ASTHMA (J45.-)

CDI Tip
When documenting asthma the following must be documented in the patient’s medical record.

Type of asthma:
• Mild intermittent
• Mild persistent
• Moderate persistent
• Severe persistent

Status of condition:
• Uncomplicated
• With (acute) exacerbation
• With status asthmaticus

INTRAOPERATIVE AND POSTPROCEDURAL COMPLICATIONS, NEC

J95.0 - Tracheostomy complications
J95.00 Unspecified tracheostomy complication
J95.01 Hemorrhage from tracheostomy stoma
J95.02 Infection of tracheostomy stoma
  Use additional code to identify type of infection, such as:
    • Carbuncle of neck (L03.8)
    • Sepsis (A40, A41.1-)
J95.03 Malfunction of tracheostomy stoma
  Mechanical complication of tracheostomy stoma
  Obstruction of tracheostomy airway
  Tracheal stenosis due to tracheostomy
J95.04 Tracheo-esophageal fistula following tracheostomy
J95.05 Other tracheostomy complication
J95.810 Postprocedural hemorrhage and hematoma of a respiratory system organ or structure following a respiratory system procedure
  Use for post-op tonsillectomy bleed.

CHAPTER 11: DISEASES OF THE DIGESTIVE SYSTEM (K00-K95)

CODING CONVENTIONS AND INSTRUCTIONAL NOTES

Most of the code categories contain the following instructional note:

Use additional code to identify:
  Alcohol abuse and dependence (F10.-)
  Exposure to environmental tobacco smoke (Z72.22)
  Exposure to tobacco smoke in the perinatal period (P96.81)
  History of tobacco use (Z87.891)
  Occupational exposure to environmental tobacco smoke (Z72.31)
  Tobacco dependence (F17.0-)
  Tobacco use (Z72.0)
**SALIVARY GLANDS**

### Diseases of the Salivary Glands (K11.-)

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K11.0</td>
<td>Atrophy of salivary gland</td>
</tr>
<tr>
<td>K11.1</td>
<td>Hypertrophy of salivary gland</td>
</tr>
<tr>
<td>K11.3</td>
<td>Abscess of salivary gland</td>
</tr>
<tr>
<td>K11.4</td>
<td>Fistula of salivary gland</td>
</tr>
<tr>
<td>K11.5</td>
<td>Sialolithiasis</td>
</tr>
<tr>
<td>K11.6</td>
<td>Mucocele of salivary gland</td>
</tr>
<tr>
<td>K11.7</td>
<td>Disturbance of salivary secretion</td>
</tr>
<tr>
<td>R86.2</td>
<td>Dry mouth, unspecified</td>
</tr>
<tr>
<td>K11.8</td>
<td>Other diseases of salivary glands</td>
</tr>
<tr>
<td>K11.9</td>
<td>Disease of salivary gland, unspecified</td>
</tr>
</tbody>
</table>

---

**SALIVARY GLANDS**

### Diseases of the Salivary Glands (K11.-)

**Sialoadenitis (K11.2) codes** have been expanded and will require documentation to include whether the condition is acute, recurrent or chronic.

**Includes:** Parotitis

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K11.20</td>
<td>Sialoadenitis, unspecified</td>
</tr>
<tr>
<td>K11.21</td>
<td>Acute sialoadenitis</td>
</tr>
<tr>
<td>K11.22</td>
<td>Acute recurrent sialoadenitis</td>
</tr>
<tr>
<td>K11.23</td>
<td>Chronic sialoadenitis</td>
</tr>
</tbody>
</table>

---

**MOUTH, LIPS, AND TONGUE**

### Oral Mucositis (K12.3-)

| K12.30 | Oral mucositis (ulcerative), unspecified |
| K12.31 | Oral mucositis (ulcerative) due to antineoplastic therapy |
| K12.32 | Oral mucositis (ulcerative) due to other drugs |
| K12.33 | Oral mucositis (ulcerative) due to radiation |
| K12.39 | Other oral mucositis (ulcerative) |

**Use additional code for adverse effect, if applicable, to identify antineoplastic and immunosuppressive drugs (T45.1X5).**

**Use additional code for adverse effect, if applicable, to identify drug (T36–T50 with fifth or sixth character 5).**

**Use additional external cause code (W88–W90, X39.0–X39.9) to identify cause.**

---

**DISEASES OF THE ESOPHAGUS**

### Gastro-Esophageal Reflux Disease (GERD) (K21.1)

| K21.0 | Gastro-esophageal reflux disease with esophagitis |
| K21.9 | Gastro-esophageal reflux disease without esophagitis |

**Reflex esophagitis**

**Esophageal reflux NOS**
CHAPTER 12: DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE (L00-L99)

SKIN INFECTIONS (L00 – L08)

Infections of the Skin and Subcutaneous Tissue (L00 – L08)

L03.21 Cellulitis and acute lymphangitis of face

L03.211 Cellulitis of face

L03.212 Acute lymphangitis of face

L03.22 Cellulitis and acute lymphangitis of neck

L03.221 Cellulitis of neck

L03.222 Acute lymphangitis of neck

Use additional code (B95 – B97) to identify infectious agent.

L02.01 Cutaneous abscess of face

L02.02 Furuncle of face

L02.03 Carbuncle of face

L02.1 Cutaneous abscess, furuncle and carbuncle of neck

L02.11 Cutaneous abscess of neck

L02.12 Furuncle of neck

L02.13 Carbuncle of neck

SKIN INFECTIONS (L00 – L08)

Radiation-Related Disorders of the Skin and Subcutaneous Tissue (L55 – L59)

L57 Skin changes due to chronic exposure to nonionizing radiation

Use additional code to identify the source of the ultraviolet radiation (W89, X32).

W89 = Exposure to man-made visible and ultraviolet light

X32 = Exposure to sunlight

L57.0 Actinic keratosis

Keratosis NOS

Senile keratosis

Solar keratosis
**RADIATION-RELATED AND SKIN APPENDAGE DISORDERS**

**Disorders of Skin Appendages (L60 – L74)**

- L72 Follicular cysts of skin and subcutaneous tissue
  - **Excludes 1**: Congenital malformations of integument (Q84.0)

**Many codes in this category were previously classified to one code in ICD-9-CM:**

- L72.0 Epidermal cysts
- L72.1 Pilar and trichodermal cysts
  - L72.11 Pilar cysts
- L72.12 Trichodermal cyst
- L72.2 Steatocystoma multiplex
- L72.3 Sebaceous cysts
  - **Excludes 2**: Pilar cysts (72.11), Trichilemmal (proliferating) cyst (L72.12)
- L72.8 Other follicular cysts of the skin and subcutaneous tissue
- L72.9 Follicular cyst of the skin and subcutaneous tissue, unspecified

**Excludes 2**: Congenital malformations of integument (Q84.0)

**L76.2 Sebaceous cyst.**

**OTHER SKIN DISORDERS**

**Other Skin Disorders**

- Atrophic (L90)
- Hypertrophic (L91)
- Granulomatous (L92)

**Codes for scars have been classified similarly in ICD-10-CM. These codes have 1-1 mapping with ICD-9-CM.**

- L90.5 Scar conditions and fibrosis of skin
  - Adherent scar (skin)
  - Cicatrix
  - Disfigurement of skin due to scar
  - Fibrosis of skin NOS
  - Scar NOS

- **Excludes 2**: Acne keloid (L73.0), Keloid keloid scar

- L91.0 Hypertrophic scar
  - Keloid
  - Keloid scar
  - **Excludes 2**: Acne keloid (L73.0), Keloid keloid scar

- L92.3 Foreign body granuloma of the skin and subcutaneous tissue

**Other Congenital Malformation Ear (Q17)**

- Q17.0 Accessory auricle
  - Accessory tragus
  - Polytia
  - Preauricular appendage or tag
  - Supernumerary ear
  - Supernumerary lobule
- Q17.1 Macrotia
- Q17.2 Microtia
- Q17.3 Other misshapen ear
- Q17.4 Misplaced ear
- Q17.5 Prominent ear
- Q17.8 Other specified congenital malformation of ear
RESPIRATORY SYSTEM (Q30-Q34)

Congenital Malformations of Nose (Q30)

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q30.0</td>
<td>Choanal atresia</td>
</tr>
<tr>
<td>Q30.1</td>
<td>Agenesis and underdevelopment of nose</td>
</tr>
<tr>
<td>Q30.2</td>
<td>Fissured, notched and cleft nose</td>
</tr>
<tr>
<td>Q30.3</td>
<td>Congenital perforated nasal septum</td>
</tr>
<tr>
<td>Q30.8</td>
<td>Other congenital malformations of nose</td>
</tr>
<tr>
<td>Q30.9</td>
<td>Congenital malformation of nose, unspecified</td>
</tr>
</tbody>
</table>

CLEFT LIP AND CLEFT PALATE (Q35-Q37)

Documentation Tips

1) Hard vs. soft palate vs. uvula
2) Bilateral vs. median vs. unilateral lip
3) Combined cleft plate and cleft lip
OTHER CONDITIONS

Q38.1 Ankyloglossia

Q38.2 Macroglossia

CHAPTER HIGHLIGHTS

• The codes from this chapter represent signs, symptoms, abnormal results, investigative findings and ill-defined conditions when there is no other diagnosis classifiable elsewhere recorded.

• These codes should be used to describe the patient’s condition when a more definitive diagnosis has not been established or confirmed by the provider.

• Codes from this category may be reported with a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis. The definitive diagnosis should be sequenced first, followed by the code(s) for the sign(s)/symptom(s).

• Codes that are routinely associated with a disease process should not be reported separately.

SIGNS AND SYMPTOMS

• A number of commonly used codes by otolaryngology practices are found in this chapter.

• Many of these codes have not been expanded or had any revision to their titles from ICD-9-CM.

    Epistaxis 784.7 = R04.0 Epistaxis
    Hemorrhage from throat 784.8 = R04.1 Hemorrhage from throat
    Postnasal drip 784.91 = R09.82 Postnasal drip
    784.92 Jaw pain = R68.84 Jaw pain
SIGNS AND SYMPTOMS

However, some symptoms were assigned specific codes and others were expanded.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.99</td>
<td>Other symptoms involving head and neck</td>
</tr>
<tr>
<td></td>
<td>R06.5 Mouth breathing</td>
</tr>
<tr>
<td></td>
<td>R06.7 Sneezing</td>
</tr>
<tr>
<td></td>
<td>R06.89 Other abnormalities of breathing</td>
</tr>
<tr>
<td></td>
<td>R19.6 Halitosis</td>
</tr>
<tr>
<td>784.2</td>
<td>Swelling mass or lump in head and neck</td>
</tr>
<tr>
<td></td>
<td>R22.0 Localized swelling, mass and lump, head</td>
</tr>
<tr>
<td></td>
<td>R22.1 Localized swelling, mass and lump, neck</td>
</tr>
<tr>
<td></td>
<td>R80.0 Intracranial space-occupying lesion found on diagnostic imaging of central nervous system</td>
</tr>
</tbody>
</table>

SLEEP DISTURBANCES (G47)

• In ICD-9-CM sleep disturbances fall into the sign and symptoms chapter, but in ICD-10-CM these sleep problems have been reclassified to the nervous system chapter.

G47 Sleep disorders

| Excludes 2 | Nonorganic sleep disorders (F51.4) |
|           | Sleep terrors (F51.4) |
|           | Sleepwalking (F51.3) |
| G47.0     | Insomnia |
| G47.1     | Hyponomia |
| G47.2     | Circadian rhythm sleep disorders |
| G47.3     | Sleep apnea |
| G47.33    | Obstructive sleep apnea (adult) (pediatric) |

CHAPTER 19: INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

CHAPTER HIGHLIGHTS

- Injuries to the head (S00-S09)
- Injuries to the neck (S10-S19)
- Effects of foreign body entering through natural orifice (T15-T19)
- Complications of surgical and medical care, not elsewhere classified (T80-T88)
CHAPTER HIGHLIGHTS

• All injuries are now grouped by site then by type of injury.
  • Injuries to the head (S00–S09)
    • S00 Superficial injury of head
    • S01 Open wound of head

• This chapter uses the S-section for coding different types of injuries related to single body regions and the T-section to code injuries to unspecified body regions, as well as, poisonings and certain other consequences of external causes.
  • S11.011A Laceration without foreign body of larynx, initial encounter
  • T17.320A Food in larynx causing asphyxiation, initial encounter

• Another major change is the addition of a 7th character extension to some of the codes. Most categories in Chapter 19 have a 7th character requirement to make a code valid.

The 7th character must always be in the 7th character field. When a code is less than 6 characters, an “X” must be used to fill the empty character positions so the 7th character can be added in the correct position.

Invalid code = T16.1D Foreign body in right ear, subsequent encounter
Valid code = T16.1XXD Foreign body in right ear, subsequent encounter

CHAPTER HIGHLIGHTS

A, B = Initial Encounter

• While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

• The 7th character for an initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

D, G, K = Subsequent Encounter

• Used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

• Examples of subsequent care are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury.
CHAPTER HIGHLIGHTS

S = Sequela

- Used when there is a residual effect (condition produced) after the acute phase of an illness or injury has terminated.
- There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury.
- Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis.

- When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself.

Example: A patient presenting for scar revision of hypertrophic scar resulting from a severe dog bite of the right cheek.

L91.0 Hypertrophic scar
S01.451S Open bite of right cheek and temporomandibular area, initial encounter

CHAPTER 19: INJURIES

HEAD INJURIES (S00-S09)

After location, injuries are further differentiated by the type of injury.

- S00 Superficial injury of head
- S01 Open wound of head
- S02 Fracture of skull and facial bones
- S03 Dislocation and sprain of joints and ligaments of head
- S04 Injury of cranial nerve
- S05 Injury of eye and orbit
- S06 Intracranial injury
- S07 Crushing injury of head
- S08 Avulsion and traumatic amputation of part of head
- S09 Other and unspecified injuries of head

Image source: http://upload.wikimedia.org/wikipedia/commons/thumb/1/1a/Human_skull_front_simplified_%28bones%29.svg/399px-Human_skull_front_simplified_%28bones%29.svg.png
INJURIES TO THE HEAD (S00-S09)

Superficial Injury of Head (S00)

Superficial injuries are further classified by type of injury and specific location, including laterality.

1) Type of Injury: abrasion, blister, contusion, superficial foreign body, insect bite (nonvenomous), other/unspecified

2) Location: scalp, eyelid, and periocular area (right, left), nose, ear (right, left), lip and oral cavity, other/unspecified

3) 7th character extension is indicated at the code.

The appropriate 7th character is to be added to each code from category S00:

A initial encounter
D subsequent encounter
S sequela

Open Wound of Head (S01)

- Laceration – with or without foreign body
- Puncture – with or without foreign body
- Open bite

ALERT
ICD-9-CM classified open wounds either with or without mention of complication. The term complication included delayed healing, delayed treatment, foreign body or infection.

ICD-10-CM includes with or with foreign body in the code title and instructs the user to add additional codes for any associated wound infection.

CHAPTER 19: INJURIES

Fracture of Skull and Facial Bones (S02-)

A fracture not documented as open or closed should be coded to closed.

\[ S_0_2 \]

Fracture of Skull and Facial Bones (S02)

The appropriate 7th character is to be added to each code from category S02:

A initial encounter for closed fracture
B initial-encounter for open fracture
D subsequent encounter for fracture with routine healing
G subsequent encounter for fracture with delayed healing
K subsequent encounter for fracture with nonunion
S sequela

Example:

- S02.6: Fracture of the mandible (needs 7 characters)
  - S02.600: Fracture of unspecified part of body of mandible
  - S02.61: Fracture of condylar process of mandible
  - S02.62: Fracture of subcondylar process of mandible
  - S02.63: Fracture of coronoid process of mandible
  - S02.64: Fracture of ramus of mandible
  - S02.65: Fracture of angle of mandible
  - S02.66: Fracture of symphysis of mandible
  - S02.67: Fracture of alveolus of mandible
  - S02.69: Fracture of mandible of other specified site

- S02.60: Fracture of unspecified part of body of mandible
- S02.61: Fracture of condylar process of mandible
- S02.62: Fracture of subcondylar process of mandible
- S02.63: Fracture of coronoid process of mandible
- S02.64: Fracture of ramus of mandible
- S02.65: Fracture of angle of mandible
- S02.66: Fracture of symphysis of mandible
- S02.67: Fracture of alveolus of mandible
- S02.68: Fracture of mandible of other specified site

- S02.6: Fracture of the mandible (needs 7 characters)
  - S02.600: Fracture of unspecified part of body of mandible
  - S02.61: Fracture of condylar process of mandible
  - S02.62: Fracture of subcondylar process of mandible
  - S02.63: Fracture of coronoid process of mandible
  - S02.64: Fracture of ramus of mandible
  - S02.65: Fracture of angle of mandible
  - S02.66: Fracture of symphysis of mandible
  - S02.67: Fracture of alveolus of mandible
  - S02.69: Fracture of mandible of other specified site

- S02.6: Fracture of the mandible (needs 7 characters)
  - S02.600: Fracture of unspecified part of body of mandible
  - S02.61: Fracture of condylar process of mandible
  - S02.62: Fracture of subcondylar process of mandible
  - S02.63: Fracture of coronoid process of mandible
  - S02.64: Fracture of ramus of mandible
  - S02.65: Fracture of angle of mandible
  - S02.66: Fracture of symphysis of mandible
  - S02.67: Fracture of alveolus of mandible
  - S02.68: Fracture of mandible of other specified site
CHAPTER 19: INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES

• Foreign body (T15-T19)
  ▪ Entering through natural orifice

FOREIGN BODIES (T15-T19)

Foreign Body in Ear (T16)
Includes foreign body in auditory canal.
The appropriate 7th character is to be added to each code from category T16.
A initial encounter
D subsequent encounter
S sequela

[Codes and descriptions]

FOREIGN BODIES (T15-T19)

Foreign Body in Respiratory Tract (T17)
For most categories of the respiratory tract, ICD-10-CM has codes to indicate the foreign body is either food or gastric contents, as well as, a category for other foreign object causing asphyxiation or other injury.

[Codes and descriptions]

FOREIGN BODIES (T15-T19)

Foreign Body in Respiratory Tract (T17)
Additional categories to indicate specific location in the respiratory tract for larynx, trachea, bronchus, other and unspecified.
## COMPLICATIONS (T80–T88)

**Complications of Surgical and Medical Care, Not Elsewhere Classified (T80 – T88)**

- Although many intraoperative and postprocedural complications fall into specific body system chapters, some complications are classified to Chapter 19.
- Documentation must clearly indicate the cause-and-effect of the complication.
  - T81.4 Infection following a procedure
  - T81.31 Disruption of external operation (surgical) wound, not elsewhere classified
  - T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T81.4</td>
<td>Infection following a procedure</td>
</tr>
<tr>
<td>T81.31</td>
<td>Disruption of external operation (surgical) wound</td>
</tr>
<tr>
<td>T81.32</td>
<td>Disruption of internal operation (surgical) wound</td>
</tr>
</tbody>
</table>

**Thanks**

- **Kim Pollock**
  - RN, MBA, CPC, CMDP
  - 312.642.5616
  - information@karenzupko.com
  - @KarenZupkoAssoc
  - karenzupkoandassociates

**OTOLARYNGOLOGY 2015**

CODING AND REIMBURSEMENT WORKSHOPS

- Oct 16-17 Las Vegas, NV
- Nov 13-14 Chicago, IL

**KARENZUPKO ASSOCIATES INC.**

- www.karenzupko.com