

OTORHINOLARYNGOLOGY DOC POCKET TOOL

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Common Otorhinolaryngology MS-DRGs

MS-DRG	RW	LOS
Ear, nose, mouth & throat malignancy w/ MCC (146)	1.7734.....	7.1
Ear, nose, mouth & throat malignancy w/ CC (147)	1.2182.....	4.2
Ear, nose, mouth & throat malignancy w/o CC or MCC (148)	1.0070.....	2.5
Dysequilibrium (149)	0.6154.....	2.2
Epistaxis w/ MCC (150)	0.9916.....	4.0
Epistaxis w/o MCC (151)	0.6227.....	2.3
Otitis media & URI w/ MCC (152)	0.8160.....	3.7
Otitis media & URI w/o MCC (153)	0.6207.....	2.8
Nasal trauma & deformity w/ MCC (154)	1.1294.....	4.8
Nasal trauma & deformity w/ CC (155)	0.8630.....	3.5
Nasal trauma & deformity w/o CC or MCC (156)	0.7412.....	2.5
Esophagitis w/ MCC (391)	0.9565.....	4.1
Esophagitis w/o MCC (392)	0.7121.....	2.8
Parathyroid & thyroglossal procedures w/ MCC (625)	1.5928.....	5.0
Parathyroid & thyroglossal procedures w/ CC (626)	1.0183.....	2.2
Parathyroid & thyroglossal procedures w/o CC or MCC (627)	0.8169.....	1.3

Secondary Conditions

Please document the following secondary conditions, if present, for all types of patients. Conditions shall only be documented if they meet one of the following criteria. The condition was:



1. Clinically evaluated during the stay; or
2. Diagnostically tested during the stay; or
3. Therapeutically treated during the stay; or
4. Increased LOS or nursing care/monitoring



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Otorhinolaryngology MCCs

- Acute epiglottitis with obstruction
- Acute laryngitis with obstruction
- Acute laryngotracheitis with obstruction
- Acute tracheitis with obstruction
- Supraglottitis with obstruction

Otorhinolaryngology CCs

- Abscess (parapharyngeal or retropharyngeal)
- Acute bronchiolitis due to infectious organism
- Acute bronchiolitis due to RSV
- Acute epiglottitis without obstruction
- Acute post hemorrhagic anemia
- Cellulitis and perichondritis of larynx
- Cellulitis or nasopharynx or pharynx
- Chronic kidney disease (stage IV-V/GFR<15)
- Complete paralysis of vocal cords
- Peritonsillar abscess

Symptoms

It is necessary to document the known or suspected etiology for all signs and symptoms. If the etiology of a condition is not definitely known, it is appropriate to document a possible etiology with the descriptions "suspected", "questionable", "possible" or "rule out" (conditions documented as possible, probable, rule out or questionable are coded in the inpatient setting only). For example, "thyroid mass, r/o cancer" is preferred over a diagnosis of "thyroid mass", even if continued work-up for a definitive diagnosis will continue at a later time or if the results cannot be confirmed during the current inpatient stay.

Specify differential diagnoses for symptoms such as:

- Abscess
- Cicatrix
- Mass
- Necrosis
- Obstruction

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Tests

When you order a test, document the 'reason' for the test in the Progress Notes or in your orders . Include BOTH the symptom and the condition that you are attempting to rule out.

For abnormal tests results, document the condition that the abnormal result represents.

Specificity and MS-DRGS

- Acute vs. chronic
- Etiology of condition
- Causative organism in infection
- Degree of severity of diseases
- Proper staging of chronic conditions (i.e.-chronic kidney disease)
- Accompanying conditions (i.e.-hemorrhage, coma, heart failure, chronic kidney disease)
- Benign vs. malignant hypertension when specifying organ disease due to hypertension
- Congestive heart failure-specify if it is acute or chronic, in addition whether it is right or left sided (or both) and systolic or diastolic (or both)
- Specify severity of malnutrition
- If patient is receiving tube feedings or TPN, document the nutrition diagnosis
- Document the total time the patient is on ventilation if it is prolonged
- Every diagnostic test and medication ordered should have a documented diagnosis
- Clinically significant diagnoses from diagnostic reports should be documented in the progress notes
- Arrows, plus signs, and many abbreviations are not sufficient documentation (i.e.-document hypokalemia not ↓ K)